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**UNIVERSITY OF KENT
AT CANTERBURY**

**SCHOOL OF SOCIAL POLICY, SOCIOLOGY AND SOCIAL
RESEARCH**

**A Thesis submitted in fulfilment of the requirements for the degree of Doctor of
Philosophy in Social Policy:**

**The New NHS in England: Exploring the
implications of decision making by Clinical
Commissioning Groups and their effect on the
selection of private providers**

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Abstract

This work explores the commissioning arrangements in the NHS after the adoption of Clinical Commissioning Groups (CCGs). The thesis aims to explore how these new commissioning arrangements have affected the decision making process and why commissioners select the providers that they do. This data is then used to see whether or not the service is being subjected to privatisation as was feared with the introduction of the Health and Social Care Act (2012). This work will begin by exploring definitions of privatisation and marketisation before embarking on a description of the shape of the private sector in the NHS. This is followed by the development of an internal/external pressure conceptual framework, adapted from the work of Pettigrew *et al.* (1992) to understand the pressures that commissioners may face in the selection of providers. The research was underpinned by symbolic interactionism and studied the work of two CCGs, using example services to explore their decision making processes. The thesis explores the themes that emerged from the data by using the internal/external pressure conceptual framework and then discusses to what extent privatisation has occurred in the NHS using the earlier definitions. The research concludes that the ability of the commissioners to freely select providers is severely limited and that as such, the selection of private providers is clustered in specific services.

Chapter 1 - Introduction

“This is something really revolutionary”. Those were the words of Sir David Nicholson (quoted in Timmins 2012, p 15) the then NHS Chief Executive about the Health and Social Care Act (2012). It neatly encapsulates the nature of the Health and Social Care Act (2012) and what it could mean for the National Health Service (NHS). As an institution, the NHS is a significant part of English culture, with Conservative politician Nigel Lawson once remarking, “the NHS is the closest thing the English people have now to a religion”. It consistently remains one of the most popular public institutions UK (The King’s Fund 2017). For some modern politicians, notably Andrew Lansley and Jeremy Hunt, it represents a continuation of previous policy and the culmination of a long legislative process to make the NHS more responsive through the delegation of commissioning to General Practitioners (GPs) once again. The question of continuity or change, could represent a risk to the fundamental tenet of the Health service - that of free care at the point of use - encouraging the use of private providers in the service i.e. privatisation. The Act has generated intense debate about what it represents for the health service and the future impact it could have. This thesis sets out to identify the potential effects of the Health and Social Care Act (2012) and how it may have changed the commissioning landscape.

This thesis explores how the new powers gained by GP commissioners through Clinical Commissioning Groups (CCGs) - the core element of the new reforms - might influence decisions about the selection of providers. In theory, the new commissioning arrangements provide GPs with powerful new commissioning tools, allowing them to utilise a market of providers, decommission them, or fine providers that they feel are not delivering. However, the manner in which this manifests itself in practice could differ and this is the focus of the research: how commissioners use these tools in practice. These reforms take place within a new NHS framework, which it is claimed has further entrenched competition and market practices within the service (Pownall 2013). The Act has given commissioners more than 60% of the total NHS budget (Timmins 2012). Primary care commissioning has previously existed in the NHS (Miller 2012) so the concept behind the new reforms are not new. But the latest clinical commissioners appear to have more power than any previous incarnation. The objective of this study is to understand how these commissioners reach decisions about which services they commission and the rationale for those choices. Then the impact of these decisions on the health service will also be explored, to see if there is evidence of privatisation or marketisation.

The approach explored the manner in which decisions were reached and what influence the new framework has had on the commissioners. The study further categorised the framework into internal and external pressures and the effects of these were explored in the two CCGs. This indicated which types of issues could influence commissioners, and whether the regulatory framework would wield greater or lesser influence than local needs/ concerns.

Through the use of case studies, this study explored research questions relating to decision-making, how the choices of commissioners affect the delivery of these services, and whether or not they were more likely to pursue a private provider over a public one.

This chapter will provide some further context to the reforms. First it will explore the nature of privatisation and marketisation before placing the reforms in a legislative context. This includes the legislative process that the Act took through Parliament, before a brief discussion of what constitutes the core elements of the reforms. The structure of the thesis will be outlined at the end of the chapter.

Context of this study

Background – the creation of the Health and Social Care Act (2012) - Primary Care Led Commissioning

Since its inception, the NHS has relied on the medical profession for the delivery of healthcare. This arrangement was largely dependent on the government allowing the medical profession to regulate itself and control the delivery of care. During that period, from the NHS's inception until the 1980s, GPs were a smaller group of private practitioners contracted to deliver care but were largely relegated to a subsidiary role in comparison to more powerful hospital doctors (Gabe, Calnan and Bury 1992).

This changed during the 1980s and the election of successive Conservative Governments, which brought a shift towards market principles and management, replacing 'consensus management' until then the status quo (Dopson 2009). This challenged the dominance of the hospital doctors. The Griffiths Report (1983) and the introduction of private sector style managers and market principles altered the traditional 'command and control' management approach to the delivery of healthcare.

The introduction of the NHS Community Act (1990) introduced the internal market dividing the NHS into purchasers and providers, arguably moving away from a hierarchical system to a market-based one (Exworthy et al 1999). This introduced competition with the aim of creating a market to drive and improve performance, shifting the balance of power away from hospital doctors to primary care commissioning arrangements. This also indicated a move towards primary care-led commissioning, with the use of the internal market stimulating competition and creating a situation in which GPs became more powerful, through the use of mechanisms such as fundholding (Smith et al. 2004).

The creation of fundholding further altered the power balance within the NHS in favour of GPs and primary care-led commissioning. It put the onus on GPs to commission and 'spend' resources where they thought it would benefit their

populations. It also created an environment in which semi-autonomous NHS Trusts were able to act like private providers, competing with one another (Klein 2007).

The election of New Labour in 1997 brought further reform of the NHS. It led to the creation of the Primary Care Groups (PCGs) - later Primary Care Trusts (PCTs) - which integrated clinical and fiscal decision making into one body, maintaining a role for primary care commissioning, including GPs who took on leadership roles. In addition, it was during this period that there was increased use of private provision within a mixed economy of provision. This included the expansion of the Private Finance Initiative (PFI) and use of Independent Sector Treatment Centres (ISTCs) in order to help with the demands placed on the service and to manage waiting list targets. Through this, the private sector began to take on a more active role in the delivery of health services. Furthermore, Foundation Trusts were able to generate funds through the delivery of private care, blurring the lines between the public and private sectors (Field and Peck 2003). This gradually left governments open to accusations of privatisation, with the use of private provision unpopular with the public. However, Labour Governments argued that care remained free at the point of use and the way in which services were delivered was of less importance.

These reforms provided the foundation for primary care-led commissioning and the inclusion and, importantly, the acceptance of private providers within the broader health service. Subsequently, further reforms moved the NHS towards cooperative working between the public, private and third sectors – those organisations which are not part of the public or private sectors (Baines *et al.*, 2010). Since the introduction of the purchaser/provider split there existed expectations that the NHS would behave more like a marketplace and more efficiently. It was against this backdrop that there would be a change of government in 2010 and within this context the next set of NHS reforms took place.

Privatisation/Marketisation in healthcare

Since the 1980s, both privatisation and marketisation of public services have been explored by scholars (Pollock 2004, Krachler et al. 2015, Leys and Player 2011). During the 1980s there was widespread privatisation of public utilities which also came hand in hand with marketisation and the rise of managerialism (Talbot 2001). These changes have also been observed in the healthcare sector. Over the subsequent 20 years, there has been a growth of resource spent on private providers, with notable increases in the 2000s, under New Labour administrations (The Nuffield Trust 2015). However, the NHS remains largely publically funded and provided (Arora et al. 2013). There are also multiple competing definitions of what constitutes privatisation and marketisation and what role they have played in healthcare. However, the NHS remains a predominantly publically provided and funded service.

The previous section highlighted some important legislation which developed the role of private providers in the health service and other policies which attempted to replicate the effects of the market. As in many other public services, there has been a growth in the use of these techniques and the Health and Social Care Act (2012) pushed the NHS further towards operating like a market. As was stated by a previous head of Monitor, a regulatory body with the responsibility to enforce competition in the NHS, when the Act was in the process of passing through Parliament “We did it in gas, we did it in power, we did it in telecoms” (Timmins 2012, p 87). This approach to public services illustrates what the potential effects of the Health and Social Care Act could be. This thesis seeks to understand the implications it has not only for decision making but also the ramifications on the involvement of private providers and market forces within the NHS. Will the new framework, by further entrenching competition between providers and purchasers, ‘nudge’ commissioners towards using private providers? Or will the reorganisation mean that the commissioning service is unable to function as it was intended?

This study is also mindful of the wider context where public services are operating with reduced budgets as successive governments have pursued policies of ‘austerity’ (Pownall 2013). Healthcare has not been fully exposed to these policies, facing a ‘freeze’ in its budget (The King’s Fund 2015). However, this has still resulted in annual decreases to the NHS budget, with large numbers of CCGs and NHS Trusts facing large deficits (The King’s Fund 2017). On the provider side, in the 15/16 financial year over 66% of Trusts were in deficit (The King’s Fund 2017). This lack of resource is also reflected on the part of CCGs with around a quarter of CCGs also reporting deficits (Bostock 2016). The resource pressures which the NHS faces could influence the decision making processes and the manner in which commissioning takes place. These competing pressures coming from the new regulatory framework will be further explored in chapter three.

In the following chapter the definitions of privatisation and marketisation are defined. It is a complex area, with little agreement between scholars (Powell and Miller 2015) but this thesis provides a working definition which was then used in the fieldwork element. This is followed by an exploration of the empirical literature on the role of the private sector and how it has existed alongside the NHS throughout the history of the service.

The Health and Social Care Act (2012)

The Health and Social Care Act (2012) represented one of many reforms of the health service. Some argue that it is the most radical reform since the introduction of the NHS (Ham, Dixon and Brooke 2012), while others argue that it represented a continuation of previous policy (Timmins 2012). This section will outline how the Act was passed through Parliament and the discourse around the reforms. The last part will briefly outline the framework in which commissioning took place after the

CCGs were authorised and the Act took effect in England from April 2013, which will be further expanded upon in subsequent chapters.

The Act was developed by the Shadow Health Secretary, Andrew Lansley. While in opposition, Lansley was allowed to develop the policy and once in government was given the autonomy to implement it, as long as it matched the broader legislative agenda of the government (Timmins 2012). The Act represented more than just the reinforcement of the role of primary care-led commissioning after a long period of managerialism. Lansley reportedly rejected a less radical reform proposed by civil servants (Ibid 2012). The key platform of the reform was to create GP consortia to deliver commissioning for the majority of the NHS budget. This included abolishing PCTs and empowering regulatory bodies with new statutory powers (Ibid 2012). These new consortia would be universal for all GPs, who would also form the executive decision-making groups within the consortia. The initial proposals suggested that they would commission '£70-£80 billion of the £100 billion NHS budget' (Ibid 2012). They would retain geographical boundaries similar to those of the PCTs but would differ in several key ways. The GPs would not be responsible to a Chief Executive but rather to their own elected head (a clinician) alongside a new public accountability framework. This would increase the power of GPs in the commissioning process, marginalising managers (Ibid 2012). The aim was for the consortia to be responsive to the demands of their populations and further provide clinicians with the ability to alter budgets as and when required (Ibid 2012).

What made this reform differ from those previously introduced by Labour Governments was the sheer scale. It was more complex than had been intended as the whole Act broke up the existing manner of commissioning healthcare and replaced it with a system which was entirely new. This system meant to allow the service to run itself (Timmins 2012). There were also clauses which bound the regulator to 'promote competition' which increased the widespread opposition to the reform. This opposition manifested itself both through public protests and through resistance from professional bodies. Even within the Royal College of GPs, which might have been broadly sympathetic to the aims of the reforms, remained staunchly opposed (Timmins 2012). Within the Coalition, there were some who believed that private companies would be able to 'cherry pick' profitable parts of the NHS (Ibid 2012). As a result, the government accepted an unprecedented legislative 'pause'. Many critics pointed out the potential implication that the private sector would have to deliver care in the NHS (Krachler and Greer 2015). This opened up debates about the nature of privatisation and how the new regulatory framework could enable private providers the ability to work within profitable parts of the NHS (Ibid 2012).

The subsequent Act had over 2,000 amendments before it was finally passed, and the nature of the reforms meant that they were somewhat diluted. Commissioning would be carried out by majority GP consortia, now renamed 'Clinical Commissioning Groups' (CCGs) and these groups had to include some allied health professionals as a concession. They were also to be scaled up in size while maintaining universal GP membership. The new regulatory framework was still to

be enforced, with Monitor maintaining the mandate to ‘enforce competition’ (Health and Social Care Act 2012), highlighting the role of different types of providers. GPs would have oversight of the majority of the NHS budget, albeit less than initially intended. While the Act was not the first piece of legislation to open up the NHS to competition law, the new powers of the regulatory framework created a new dynamic (which is further explored in chapter two).

Arguably the reforms continued in the tradition of previous Labour health policy and some have argued that it was simply “a logical, sensible, extension of [changes] put in place by Tony Blair” (Le Grand quoted in Timmins 2012, 84). The reforms further expanded on the principles laid out by the Labour Governments; Practice-based commissioning (PbC); Total Purchasing; the role of patient choice and the use of private providers to deliver care (Miller 2012). The effect of these reforms is explored in this thesis.

Some however, argued that the policy represented a much more radical departure from previous policy maintaining their initial concerns over the ‘cherry picking’ of services and back door privatisation (Peedell 2011). Some speculated that there could be several situations in which this could happen (Pollock and Price 2011). There was also speculation that there could be other scenarios in which the NHS would become further marketised (Dixon and Ham 2010). The context in which commissioners operate, and what sort of influence it will have on the selection of providers, was investigated more fully. The access that private providers have gained was also examined. There is the additional challenge of resource savings that are required of the NHS alongside this period of considerable organisational change. This can also represent a further challenge to commissioners.

Structure of the reforms

The reforms have brought in primary care-led commissioning in the form of Clinical Commissioning Groups (CCGs). The CCGs are responsible for over 60% of the NHS budget having replaced the PCTs, the total amount being over £70 billion (The King’s Fund 2017). The remainder of the budget is delivered through the Department of Health. NHS England (NHSE) regulates the spending of CCGs while also purchasing some additional services and funding the regulatory bodies. The services that CCGs are responsible for commissioning include specialist, community, mental health and hospital services (The King’s Fund 2016). As the centrepiece of the reform and being the largest NHS commissioning group, it is the CCGs which will be the focus of this study. Exploring their decision-making process in the new NHS.

The CCGs operate in a framework that includes regulators with additional powers to promote competition while needing to assist in providing integrated care in an increasingly complex system. Some of the regulatory bodies that were initially part of the reforms have been merged, and currently there are three key regulators; NHS Improvement, the Care Quality Commission (CQC) and NHS England. When

examining the framework, the key bodies with regards to commissioners are NHS Improvement and NHS England. The CQC has a more indirect role through the management and authorisation of providers (Care Quality Commission 2017). These roles will be outlined in the subsequent chapters.

NHS Improvement is a new body which consists of several other regulatory groups which have merged (NHS Improvement 2017). The purpose of the group is to oversee and bring together several different organisations under one umbrella, maximising their effectiveness (NHS Improvement 2017). For CCGs, the key part is that of Monitor which previously existed in a stand-alone capacity. Its key responsibility is to “safeguard patient choice and prevent anti-competitive behaviour which is against the interests of patients” (Health and Social Care Act 2012). In this capacity it has the ability to intervene in behaviours contrary to this, which could potentially include cooperative working arrangements between sets of commissioners/providers (Hudson 2013), and has a role in regulating both providers and purchasers. It also has the duty to enforce competition law, ensuring that procurements are correctly undertaken. If a provider believes that a procurement was handled incorrectly, there is a mechanism for them to challenge the decisions made (Health and Social Care Act 2012). This legal mechanism further distinguishes the reforms and the new regulatory framework from previous legislation, as this could have subsequent ramifications on the decisions of commissioners.

NHS England, which commissions the remainder of the NHS budget, has a dual role of both allocating the CCG budgets and regulating the groups. The regulation of CCG financial performance is where NHS England could influence commissioners. In this capacity they can become involved in the affairs of the commissioners if they are viewed as underperforming. Currently, there are more than twenty CCGs which have been deemed financially inadequate resulting in NHS England putting them in ‘special measures’ (NHS England 2016). This accountability can conceivably influence commissioners, as many may prefer to maintain their independence (Ibid 2016).

Through the reforms there are additional bodies which have a direct role in public accountability. These include the Health and Wellbeing boards (HWB), which are intended to provide patients with a voice and to further represent the public to NHS commissioners. They are also intended to provide assistance in the commissioning of services. However, their role remains unclear, and their effectiveness in the current climate is limited (Humphries and Galea 2013). This is an additional strand of accountability that has formed as a result of the Health and Social Care Act. It provides commissioners with an additional consideration when selecting new services, having to justify their choice to an external organisation, as well as in public meetings. The reform therefore has dual accountability for clinical commissioners, to the public (both through HWB and public meetings) and to NHS England, ensuring fiscal competency, all providing additional influences on the commissioners.

The framework does not utilise new bodies, or concepts, but provides existing agencies with more power to implement their rulings/decisions. The manner in which this manifests itself while being examined and how this framework could affect commissioners will be looked at in chapter three.

The new structure has created a system in which competition needs to be promoted by the framework, while ensuring that care remains integrated. This new framework also allows for private providers to challenge the decisions of commissioners in a court of law. Such potential challenges provide some of the impetus for this research, exploring the new commissioning arrangements and what they mean for the NHS.

This thesis sets out to discover the effect these reforms would have on commissioners, whether as intended they would be able to pursue strategies they believe to be beneficial for their local populations, or if they would be forced into making decisions as directed by the framework created by the Act.

Structure of the thesis

The general research questions that will be explored in this thesis are:

1. What influences the decisions of commissioners in the/during the commissioning process?
2. Why do commissioners select certain providers over others?
3. How has this affected the private/public balance in the NHS?

The structure of the rest of the thesis is as follows, after this introduction, chapter two is a narrative review which examines the nature of private involvement in the NHS. First, it will outline the theoretical approach to the work and present competing definitions of what constitutes privatisation and marketisation. The second part of the chapter will examine the empirical literature relating to the shape and size of the private sector and how it has grown alongside the NHS.

Chapter three will examine the empirical literature relating to commissioning in the NHS. The first part will critically engage with the literature and explore how primary care commissioning has existed previously in the NHS. This provides context to the second part of the chapter which explores the regulatory framework created by the Health and Social Care Act (2012), the internal/external pressures faced by commissioners, and how this could influence the decision making processes. These internal and external pressures are characterised through a framework which explores these pressures to assist in understanding how they may affect the decision making process. The main argument here is that the commissioners will

face a myriad of pressures which could affect the decision-making process and this is explored.

Chapter four will set out the methodology used in the project. It will put forward the rationale of the research design and how the data was collected. It will also include information about how the data was analysed and what steps were taken to ensure the quality of the data. The study used an iterative methodology to explore the decision-making process in two CCGs, tracking specific services to utilise as examples. This should help to illustrate how commissioners reach decisions in the new system and whether this has resulted in growing use of private providers, or new market mechanisms to assist in selecting providers. The CCGs were chosen in order to be comparable with both having access to a range of private providers, allowing commissioners to choose these providers if they wanted to, or if the framework 'nudged' them in that direction.

Chapters five and six discuss the data gathered from the two separate CCGs and keeping with the iterative and inductive approach of the thesis, the conceptual framework was used to explore the data from the sites and then adjusted to reflect what the data illustrated between sites one and two. At the end of the sixth chapter, there is a discussion of the similarities and differences of commissioning by key decision makers. It then assesses the explanatory power of the conceptual framework created in chapter three.

The final chapter is a discussion of the conclusions that can be drawn from the empirical evidence. Further, it relates the findings to previous literature on commissioning and how the Health and Social Care Act (2012) has changed the landscape. It discusses whether or not the Act has resulted in privatisation or marketisation as well as, the implication for theory and provides an agenda for future research in a continuously changing environment.

Chapter 2 - The Development of the Private health sector in the UK, a literature review

Introduction

This chapter offers a narrative literature review which will explore how the private provision of healthcare has grown alongside state provision of care. It focuses on England as the new NHS reforms only change the English NHS. In addition, this chapter will outline the definitions that this thesis will utilise when discussing privatisation and marketisation, before moving on to discuss what shape the private sector has taken since 1948, with a particular focus on later developments since the introduction of market-orientated policies.

The NHS is one of the most popular and staunchly defended public institutions in the UK, with 65% of the British public stating that they were satisfied with the NHS in 2014, the second highest percentage recorded since such polling began in 1983 (The King's Fund 2015). That high level of popularity has not prevented successive governments from attempting to reform the NHS. These reforms have been an almost continuous feature of the service. However, the core tenet of the service – free and universal care at the point of use, remains unchanged. The high approval rating of the NHS has meant that politicians fear being seen as figures who would even bring into question this core principle of the health service. The reforms have been aimed at organising the NHS more effectively and have at times involved greater use of private providers in the delivery of care. However, the introduction of the Health and Social Care Act (2012) has led to allegations that privatisation and marketisation of the service would take place under the reforms (Davies 2013).

The new reforms devolved responsibility for commissioning from large Primary Care Trusts (PCTs) to GP-led Clinical Commissioning Groups. It has been argued that the way in which CCGs select providers will dictate the level of involvement of private providers in the delivery of care in the NHS (Krachler and Greer 2015). This would have further implications for understanding the degree to which the NHS may have been privatised as a result of the reforms.

This chapter will explore the broader context of privatisation in other public services. This should assist in understanding the background in which the NHS was also changed. The very concepts of privatisation and marketisation are contested and will be defined and discussed in a subsequent section of this chapter. The definitions informed the empirical work and assisted in producing a matrix that helps to illustrate the manner in which privatisation could take place in practice.

This will be followed by a brief history of private sector involvement in the NHS, starting with the system of provision which existed prior to the creation of the health service. It will explore the early NHS and how the private sector worked alongside it then explore the introduction of management reforms and the growing use of market mechanisms within the Health Service. It will also explore and discuss reforms prior to the Health and Social Care Act (2012). There will also be a

discussion of how the private sector has become key in the delivery of certain areas of care within the NHS.

Before the establishment of the NHS, private practitioners delivered the majority of healthcare with support by certain voluntary organisations and government elements. The introduction of the NHS limited and altered the role and importance of these groups, but did not eliminate them from the delivery of care. Private providers continued to deliver care but were restricted in the types of service they could and could not provide, and as such, they were pushed to the periphery of the system (Calnan *et al.*, 1993). Apart from that, doctors as individuals continued to generate additional income through private practice, maintaining their economic autonomy (Ibid 1993).

Broader policy context: Commissioning and procurement within public services

In order to be able to understand growing concerns about privatisation in the NHS, it needs to be situated in the context of broader public service reforms. The NHS has not been the only service that faced significant reform, and many of the principles introduced into the service had a history of use in other areas of welfare. This section will outline some of these approaches to provide a clearer understanding of these reforms, with a focus on the development of commissioning and procurement as used in public services.

From the introduction of the welfare state, the provision of services was funded, carried out and administered by the government. There was debate about the scope and scale of funding but there was a steady continuation of its development (Glennerster 1998), which saw the welfare state extend to multiple areas, such as housing, health and education. The amount of money that was committed grew continuously from the end of the Second World War, representing 25% of GDP by the middle of the 1970s (Hills 2011). This general approach to welfare financing and provision continued until the 1970s when there was a global financial recession and the election of Conservative Government in 1979, which began to decidedly change the funding of these services (Ibid 2011). The objective of successive Conservative Governments was to reduce the role of the state in the delivery of services, as they were ideologically opposed to the Welfare State (Ibid 2011). In order to achieve these objectives, the government began to seek ways of reducing the role public provision and funding, encouraging greater use of the private sector by public bodies in a variety of different ways (Burchardt and Hills 1999).

The Conservative administrations of the 1980s and early 1990s operated on a programme in which they were influenced by the ideas of New Public Management (NPM). The general aims of NPM was to make the public sector behave more like the private sector. This was achieved through several different targeted methods (Burchardt and Hills 1999). In specific areas such as defence, the budget was drastically reduced to diminish the financial responsibility of the state (Hills 2011).

Other public services were directly privatised. This included the utility and rail companies, with the process of selling these utilities to investors began with the election of Margaret Thatcher and continued under the Major Government (Burchardt and Hills 1999). The Conservatives were also successful in the privatisation of council housing which was achieved through the implementation of the 'Right to Buy Scheme'. This entitled council tenants to purchase their homes at a discount. The scheme proved popular and ensured that there was minimal opposition to the process (Burchardt and Hills 1999).

In other public services, the Conservative governments were less successful and instead, they targeted certain elements of funding. This was typified by the reduction of capital spending, with it being reduced from 2.8% of GDP to 0.9% by the end of Conservative government in 1997 (Burchardt and Hills 1999). These moves were accompanied by an increasing role for the private sector to deliver public services. The mechanism for this was the introduction of quasi-markets to introduce competition and choice. Most notably, quasi-markets were introduced in both education (Glennister 1991, Williams 1997) and health (Exworthy *et al.*, 1999). This introduced greater choice in public services (quasi-market) and also reduced the financial commitment of government to public services through the reduction of capital spending.

These approaches to commissioning public services were developed further under New Labour (1997-2010). The objectives of the Labour Government remained remarkably similar to that of their predecessors (Hills 2011). There was further expansion of the use of private providers to deliver services funded by the government (Hills 2011).

While these policies aimed to reduce the role of the state in funding public services, it was only partially effective. The popularity of public services ensured that the role of the state remained crucial and that public expenditure on services did not decrease in any significant way (Hills 2011). Activity and provision of services was still dominated by the public sector, but the type of providers varied in greater number. However, there has been further emphasis on the development of Private-Public partnerships and greater mobilisation of private providers to deliver care on behalf of the state (Boivard 2005). This trend of greater use of non-public providers in the delivery of public services has continued and was a feature under the Coalition Government (McKnight *et al.*, 2015).

These reforms have not always gone smoothly, and procurement processes run by the public sector have not always been successful. Recent use of private contractors has raised issues about the way in which procurements have been run by recent governments. This has been highlighted recently with the Public Administration and Constitutional Affairs committee reporting on widespread government failures of public sector procurement (Public Administration and Constitutional Affairs Committee, 2018). The report suggests that there is a lack of experience, skills and knowledge within civil service departments with regards to procurement (Ibid 2018). All of these issues suggest that there has been an attempt

to reduce the role of the public sector in the delivery of public services and attempt to increase competition amongst providers while generating savings. These trends have been present in British public services for a long time, and the NHS has not been immune to this treatment. There have been associated fears of privatisation due to such policies, which appear to involve the private sector in the delivery of public services (Le Grand 2013). The subsequent section will explore the concepts of marketisation and privatisation, before exploring how the private sector developed in the UK.

The concepts of privatisation and marketisation

This section will explore the concepts of privatisation and marketisation and establish a definition of these two key concepts which inform the thesis. These concepts are viewed as crucial, as critics of the Act have argued that it could lead to privatisation of the NHS (Davies 2013). After the definition of privatisation and marketisation, the chapter will explore how these processes may take place in the health system.

Privatisation is a process in which the role of the state is reduced and/or supplanted by private providers/companies, as outlined by Saltman (2003). In effect, according to this definition privatisation occurs only when assets pass directly from the public to the private sector (Ibid 2003). An asset is something which can be considered to be a utility or a public institution as per general law (Saltman 2003). In addition to this, Saltman developed a framework in which he provided definitions for what constitutes the private sector and the public sector. The public sphere comprises of the State or public sector, encompassing the largest actors (i.e., Ministry of Health). A second category of the public sphere is the public but non-state section, which, according to Saltman, includes regional bodies and organisations that fall under the auspices of local government (which should have a different remit from that of central government). He also includes public corporations in this section (Saltman 2003). In this context, an asset is considered to be an element of a service and can take the shape of either a provider or funder of a health service (Ibid 2003).

	Public		Private	
	Public but non-state		Not-for-profit (mission-driven)	For-profit (return-driven)
State				
Ministry of Health	Regional and local government		Community-based Religious	Small business
National Boards	Public corporations		Charitable NGOs	Large corporations

Figure 1 A public/private taxonomy in the health sector
Figure 1 – Saltman’s Public/Private Taxonomy

Source: Saltman (2003)

In the private sphere, the first sub-category is Not-for-Profit organisations. They include charities and NGOs that focus on health and/or those that form part of the health service in a country (as is the case in Holland) (Saltman 2003). The second sub-category of the private sphere is the For-Profit one, which is comprised of

businesses with a profit motive. Some may be large corporations (as in the US) or smaller companies which provide specialised care and only form a minor part of a health care system (Saltman 2003).

Saltman argues that privatisation occurs exclusively when assets transfer from the public to the private sector. Consequently, when assets move between different elements of the public sector, the process cannot be classed as privatisation. The key element to consider is the ownership of the assets. Here Saltman draws an important distinction, between the terms, 'marketisation' and 'atomisation'/'corporatisation' on one hand and privatisation on the other (Saltman 2003). Saltman points to a confusion about the meaning of the terms and underlines that marketisation is a different process to privatisation. He states that they are two distinct concepts and separate processes that need to be approached differently despite how they can be closely related. Marketisation refers to the introduction of 'market-style incentives' into a public institution (Saltman 2003). The maintaining of accountability to the public/local government is what makes the process different from that of privatisation. This is a very significant distinction, as it illustrates the difficulty in establishing a universally accepted definition of privatisation, as others argue that marketisation can eventually facilitate privatisation (Drakeford 2000). That approach assumes the creation of a situation in which market ideas/concepts are introduced into a public sector service (Ibid 2000). For this thesis, these two process will be considered as separate.

Saltman provides a clear definition of privatisation, which, however, can further be modified in the context of analysing healthcare provision in England. He puts forth several examples that do not fit within his typology. One example is the NHS Primary Care Trusts (PCTs), created by the Labour government (1997-2010) in 2001. These were public sector bodies given the powers to commission private providers apart from their already established statutory obligations to commission public suppliers. In addition, PCTs were given the ability to generate additional resources by delivering health care to fee-paying patients, as well as re-investing any surpluses that they generated into new services. Thereby PCTs became the first hybrid organisations, sitting between the public and private, which could commission both public and private providers, while also utilising private sector practices, i.e., generating profits that they could re-invest. The surpluses were employed to cross subsidise other services that were provided by the Trusts and were themselves required by law to generate these surpluses (Paton 2007). PCTs and the way that they work in practice were an example of a type of organisation which did not clearly fit in any category in the context of public and private and as such blurred the distinction between the two sectors.

Le Grand and Robinson (1984) argue definitions of privatisation need to be more nuanced to operationalise them. They distinguished three different forms of state involvement - provision, subsidy, and regulation. These three elements of provision are clearly visible in the NHS. Whilst the NHS remains primarily publicly funded, with limited scope for patients to subsidise costs such as prescription medicine, private companies that do provide care under the umbrella of the NHS are still

subject to strict government regulations. For privatisation to occur according to Le Grand and Robinson (1984), the state has to lose control or have it severely diminished in one of the three elements which in turn would move under the control of either private for-profit companies or charitable/third sector non-profit organisations (Ibid 1984). Over the last 20 years the role of the voluntary sector has grown with many voluntary/third sector organisations deriving a large proportion of their income directly from government contracts (Bennett 2008) and as a result these organisations are becoming more vulnerable to market forces (McKay *et al.*, 2015). A key aspect of this model is that different elements of the service could be under the control of competing groups. The authors argue that therefore there is not a clear dichotomy between public and private as suggested by Saltman, although they do agree that there needs to be a change of state provision for privatisation to occur. The next section will explore various characterisations of how privatisation may take place.

Tuohy *et al.*, (2004) argue that privatisation in healthcare occurs through 'passive' privatisation or it can be actively encouraged by governments. They identified four key types of healthcare systems - Parallel, Co-payment, Group-Based and Sectoral systems. The division between the public and the private sector is seen to be the most important factor in such the process of privatisation as opposed to the question of which sector provides which service. In that context, the dominant question is not about the providers but the maintenance of high quality of care.

Privatisation can manifest itself as 'passive privatisation' which is a distinct process (Tuohy *et al.*, 2004). In this scenario private providers do not directly challenge the role of the public sector, but utilise technological change to their advantage. Privatisation occurs when services, previously delivered in hospital settings, are transferred to private companies that deliver the care in outpatient or community settings. This is seen to be mostly a consequence of technological advance, which afforded the private sector the ability to represent itself as an attractive option to those who commission health services in any specific area of care provision. State provision is being replaced by a variety of providers rather than there being a clear dominance of any single group. This could represent a broader trend within health service delivery if and when the private sector achieves sufficient growth to additionally challenge the public sector in more and more areas of provision delivery (Saltman 2008). Another possible cause of this process could be the growing financial pressures on health systems and the related need for these limited resources to be allocated effectively and efficiently (i.e., the perception that the private sector is more efficient).

A similar argument is presented by Klein (2010) who argues that the change in policy in the NHS is the result of gradual shifts in the approach to commissioning. He argues that rather than being ideologically driven, policies pursued by different governments were simply a response to the different issues they faced and under the banner of a desire to allocate resources effectively.

Tuohy *et al.*, (2004) suggest that the process of 'passive privatisation' does not address the role of active actors involved in the decision-making process. Some politicians may be more inclined to move health services out of the public sector while others may want to nationalise some services, depending on their ideological preferences. This process can, arguably, be traced back to various Conservative Governments under Margaret Thatcher, when there was a deliberate policy of privatisation and the private sector expanded faster than in many other European countries, and yet, support for the public system remained high (Calnan *et al.*, 1993). In more recent cases, this is also linked to other public services and spending in times of 'austerity,' such as the policies pursued by the Coalition (2010-15) and Conservative Governments (2015-17) (Bach 2016). The claim that it is only technology driving privatisation seems to relegate the state to the role of a passive actor, incapable of driving or initiating policy changes. This is especially untrue in the UK context, where the government is a powerful actor. This can restrict/increase the autonomy of decision makers in health settings, affecting the decision-making process by enabling greater freedom in the selection of providers. To some extent it also overstates the role of the private sector, which would need to be very effective in identifying the service areas in which it will be able to provide a more efficient service.

Another characterisation of privatisation is provided by Drakeford (2000) who observes two main models. Drakeford attempts to explain privatisation in more detail by placing a focus on previous healthcare policy and its development. The first model is that of private ownership in which he mirrors the ideas of Schumpeter to a limited degree ("*Private ownership, per se*" [emphasis in original] (Drakeford 2000)). This transformation is justified with an argument that services will benefit from the simple transfer of assets from the public to private sectors. Whether or not the transfer results in a monopoly or competitive market is of secondary importance. The justification goes on further by claiming that the development of private sector practices as a result of this method of privatisation will be a growth of "*enterprise, innovation and entrepreneurial zeal*" (Drakeford 2000; p 22).

In his second model of privatisation, Drakeford put emphasis on the development of competition (i.e., marketisation), rather than the transfer of assets (market coordinating). In this scenario, while it may be more desirable for the service to be owned by a private provider, it is competition that will ensure the best service outcomes. In the extreme, this approach can even argue against private ownership (Veljanovski and Bentley 1987). This model presumes a difference between privatisation (the transfer of assets), and market replication (the development of market like incentives). Ownership is not the primary concern as even public corporations can enjoy similar advantages, providing they operate in a competitive market (Drakeford 2000). Drakeford states that this may be better described as marketisation rather than privatisation, demonstrating that these concepts can simultaneously be distinct and related. Thus, Drakeford supports the conclusion of Saltman by acknowledging the differences, although further discussing the association between marketisation and privatisation.

This highlights the differences between marketisation and privatisation as two distinct and separate processes. Scholars argue that marketisation and privatisation are very distinct concepts that need to be treated as such (Saltman 2003, Collyer and White 2011). Hence, for this thesis, these two concepts are considered separate. Marketisation does not necessitate a role for private provision; rather it seeks to replicate the market. Privatisation, on the other hand, requires there to be a transfer of assets. There is room for the presumption that a period of marketisation may lead to an increase of the privatisation of any public service. Hence, these two concepts are related even if they are separate and different.

Relating specifically to privatisation, Drakeford uses certain practical methods to define and characterise the process. Utilising the work of Letwin (1988), he examines the processes of privatisation enacted by the Thatcher Government (1977-1990) and how certain public services became increasingly privatised in that period. Drakeford uses examples of other public services that were privatised with a focus on two characterisations – market replication and private ownership. Both of these models were utilised by the government of the day to achieve their aims.

Drakeford's characterisation of the process of marketisation and privatisation is significant. The first characterisation can aid in understanding how certain organisations, such as semi-autonomous Foundation Trusts in the NHS, were created, and then competed with one another and independent sector providers. The characterisation of the privatisation process refers to the manner in which healthcare fits within a broader public sector context, with other public utilities also increasingly working with the private sector in the delivery of care and services. However, both of Drakeford's characterisations can be thought of as incomplete, as they do not explain why either marketisation/privatisation may take place. Hence, Drakeford's framework seems more valuable as a method of explaining the consequences of policy decisions which affect the NHS.

Klein (2010) argues from an incrementalist perspective that privatisation may take two forms. In the first form, the private sector simply replaces services that have traditionally been in the public sector, echoing Saltman's arguments. The second and more relevant characterisation for this thesis is how the public sector begins to provide fewer resources (i.e., underfunding), primarily for the provision of services. In this case, the system remains predominantly publicly funded, but with a greater number of services being provided by the private or third sectors and charges being introduced into the remaining public services. An example of this is dentistry in the NHS. Rather than the services being transferred to the private sector, public funding was decreased in combination with a simultaneous expansion of competition. This process has also been termed 'backdoor privatisation' (Birch 1986) and is similar to a degree to the previously discussed 'passive privatisation'. In this case, it is not technological advances which dictate changes but rather the government. Another example of this process are the attempts of the Conservative Government (1987-1991) to reform resource allocation by introducing the internal market, despite the opposition of the Medical profession and the public (Le Grand *et al.*, 1998). The introduction of the internal market resulted in a situation in which

hospital doctors, i.e., the medical profession, could be challenged by the commissioners, mostly through the ability to select any service providers they wished. The introduction of the internal market mandated the creation of regulators to enforce the new rules, which in turn became an additional source of pressure on the decision-making processes. The decisions reached by commissioners and the various internal contradictions were a major factor in commissioning services and ultimately the development of the private sector.

Rondinelli *et al.*, (1989) argue that privatisation can occur in parallel to the decentralisation of power from central government to local decision-making bodies. He argues that this can be an opportunity for “overburdened central government” to shed some responsibility onto local decision-making bodies. This does not only mean that privatisation can take place exclusively during a period of decentralisation as the transfer of powers to local bodies can also be an indicator of greater market activity. Through decentralisation, government increases the stake by the local decision makers and hence their share in the responsibility for the effects of those decisions. More specifically, Rondinelli refers to the concept of devolution in the UK.

Health policy has been devolved to the Scottish, Welsh and Northern Irish assemblies in the UK. This is in line with Rondinelli’s approach in which he argues that political, not economic reasons drive privatisation. According to his theory, devolved institutions should utilise a greater number of private providers. However, the greatest increase in the use of independent sector providers in the NHS is in England. The NHS in England has been under the control of the Department of Health which is under the jurisdiction of the central government. In the devolved NHS systems, the dominant role of the public sector is protected (Greer 2004). In other words, the policy of the national devolved assemblies goes against the arguments of Rondinelli (Pollock and Godden 2008). This thesis will further explore the usage of private sector providers in the NHS.

The significance of this characterisation of privatisation is that it introduces the idea of a potential comparison of the development of the health service in England and the UK’s constituent nations. Other analyses of privatisation do not explore that possibility as being key determinants of privatisation. An advantage of this theory is that its application can be easily monitored when observing devolution in the UK as there have been measurable changes in commissioning services in the different constituent nations.

The Rondinelli characterisation allows for the study of how changes may take place under existing constitutional arrangements in the UK. It allows for the analysis of each service individually so that judgements can be reached as to whether or not privatisation has occurred. However, Rondinelli does not take into account marketisation, reducing the effectiveness of this characterisation whilst exploring the current market based reforms of the NHS.

Developing a matrix

Privatisation is a complex and contested concept. There is no universally accepted definition, and it is open to different interpretations. However, for the purpose of this thesis, privatisation will be defined as occurring when there is a direct transfer of assets from the public to the private sector in either the funding or the provision of a service. The nature of what constitutes an asset is primarily drawn from the work of Saltman (2003). Privatisation will also be considered as related but separate from marketisation.

According to Le Grand and Robinson (1984), there are three key components of a healthcare system. Like Klein (1984) they claim that the key elements of determining whether privatisation and marketisation have occurred are changes in funding and provision which take place on the supply side of the NHS. Changes to funding and provision can occur for a variety of reasons as outlined in the previous section. Being able to track changes within these key areas will enable an exploration of whether or not privatisation has occurred. The first area is the issue of finance or funding; i.e., which actor finances any given service. In practice, this can be quickly and easily determined. There are, however, some circumstances in which there is a mixture of funding organisations. On those occasions, it is important to precisely determine which actor (public/private/third sector) provides the major part of the funding.

The second area is provision, i.e., which group provides the services (private/public/third sector). If there is a mixture of providers, it is important to determine which is the most prominent i.e., it would be classed as the one delivering the service.

The third and last area is organisation/governance structure. Here the emphasis is on how the service is administered and on what kind of management structure is applied in the organisation (i.e., the introduction of market orientated management principles). This would also include the directives that any regulator may have been given by central government. The role of the regulator may have an effect on the choices of decision makers and this thesis will also explore how this may take place.

For the purposes of this work, marketisation will be defined as whether or not the management of any given service is dominated by private sector management practices, such as NPM, as introduced earlier in this chapter. An example of this would be the introduction of management practices, drawn from the private sector and implemented in a service that is wholly state-funded and provided. The service does not leave the public sector, but there is a move to replicate the effects of the market to improve efficiency.

Privatisation is in this context defined as a change in the funding or provision of a service as opposed to a management/organisational change. Under this definition, privatisation occurs not only with a simple change from a public actor to a private organisation but also when the public provider loses its status as the dominant

group due to a diminishing role. A dominant role is one where the majority of services would no longer clearly be provided by one actor. This transfer can be to any non-public sector group, and it provides the basis of a matrix which can aid in visualising and tracking the changes.

As previously stated, privatisation and marketisation are separate processes, but are also linked. This definition should ensure that these two processes are clearly distinguished to avoid any confusion and to determine whether one or both of them is detected in the data gained in the empirical study.

The complexity and the multiple different elements of these concepts suggest that utilising an ideal type matrix to help delineate them and be able to track the change in the system would be beneficial. It allows observations of various elements of a system, and whether it is subject to processes of privatisation or marketisation.

Ideal type Matrix

	<i>Types of Privatisation</i>	<i>Provision</i>	<i>Funding</i>	<i>Governance</i>	<i>Comments</i>
Fully Public System		Public	Public	Public (command and control)	<ul style="list-style-type: none"> • Pure system, public control and command • Can be compared to early NHS
	Marketisation	Public	Public	Management – competition through the internal market	<ul style="list-style-type: none"> • Competition should drive quality and improve costs • Public sector uses competitions (Saltman 2003)
	'Passive privatisation'	Private	Public	Regulatory	<ul style="list-style-type: none"> • Private companies utilise technological developments to compete with public providers (Tuohy <i>et al.</i>, 2004) • This may be due to changes in regulation/availability of contracts • State continues to regulate the system
	Regulated Privatisation	Private	Public	Strong State control/intervention	<ul style="list-style-type: none"> • Transfer of assets through Government policy (Tuohy <i>et al.</i> 2004) • Government Regulation still plays important role • For profit private providers, such as PFIs
	Third-sector provision	Third sector/not for profit	Public	Strong regulation	<ul style="list-style-type: none"> • System with a large number of third sector providers • Diminishing role of State provision, hence still effective privatisation (Le Grand & Robinson 1984)

Mixed System		Mixed provision	Mixed sources of funding	Mixed governance/role of both public and private sector	<ul style="list-style-type: none"> Partnerships between public, private and third sector
	Privately financed, public provision	Public	Private	Self-regulation/competition	<ul style="list-style-type: none"> Private sources of funding (i.e. insurance) used to encourage private sector provision of services Competition and regulation regulate costs and quality
	Privatisation via decentralisation	Private	Public	Local Government	<ul style="list-style-type: none"> Decentralisation of political power precedes privatisation Local government tenders contracts to the private sector Privatisation via decentralisation (Rondinelli 1989)
	Private ownership per se.	Private	Private	Government regulation	<ul style="list-style-type: none"> Private ownership of the healthcare system Private ownership per se. can confer advantage (Drakeford 2000)
Fully Private System		Private	Private	Private (self-regulation)	<ul style="list-style-type: none"> System in which market is dominant No State intervention/regulation Competition and choice regulate market place (Supply and demand)

*Bold denotes
Ideal type

Table 1 – Ideal type Matrix

Using ideal type definitions, with a fully public system on one end of the matrix (provision, funding, and governance), and a fully privatised system on the other, would allow to explore how changes in one area would affect the system as a whole and whether it can be said to be undergoing a period of marketisation/privatisation. This would include an understanding of how the system could be changing from a public one to a private one. The matrix also allows for the visualisations of a fully mixed system. Thus, the matrix allows for tracking of shifts in privatisation/marketisation throughout the system over time.

The template also helps by providing a methodology with which to track changes in the selection of providers and the overall effect on the NHS. Equally, we can follow any changes in commissioning of provision, i.e., the balance between public and private. Finally, the matrix helps in identifying the effects of the regulatory framework on any one of the three areas, i.e., how the regulatory framework may dictate/affect the behaviour of commissioners and how this may have an effect on the system as a whole.

Pre-NHS provision: A pluralistic healthcare system

This second section of the chapter will examine how private provision existed before the creation of the NHS. The purpose of this section is to understand the role that the private sector has played in the delivery of healthcare in the UK historically and how it has developed and changed over time. Parts of this analysis will also explore the various factors that had a role in the development of policy. The section will follow a chronological order and expand on developments leading to the Health and Social Care Act (2012).

Prior to the NHS, the health care 'system' was a mixture of different types of providers, the majority of which were private sector and charity providers, regulated by the medical profession (Ham 2009). That system was based on Victorian concepts of poverty – a distinction between the 'deserving' and 'undeserving' poor. Those categorised as 'deserving' poor were deemed to be so through no fault of their own and hence deserved assistance. In contrast, the 'undeserving' were poor were in that situation due to their own choices and consequentially should be left to their own devices. The enactment of the 1848 Public Health Act brought with it a shift to improving public health and enhanced the professionalization of medical practitioners which itself grew in importance as the dominant actor in the delivery of healthcare (Ham 2009).

The voluntary sector provided the majority of health provision for those who were unable to directly pay for their own care. In the main, they were either associated with churches or charities dedicated to the benefit of those who were considered to be 'deserving' poor. These voluntary hospitals were primarily funded through donations, but also received government grants (Cherry 1997). The poor were provided with healthcare to enable them to participate in the workforce. Those with no other alternatives would seek to be admitted to a workhouse, where in return for their labour they would have their most basic needs met, including healthcare. Many of the first hospitals evolved from such arrangements (Ham 2009). This was supplemented through an additional system of charitable voluntary organisations, workhouses and hospitals which were finally formalised and implemented through the Poor Law reform and administered by local government. The later Local Government Act 1929 shifted the responsibilities of delivery of healthcare to larger local authorities as they began to run hospitals and infirmaries, taking over from the Poor Law Unions. This was accompanied by increasing usage of public (i.e. state funds) to pay for and run medical services. By the 1940s this resulted in a well-established network of local authority hospitals and accompanying services which provided the majority of hospital care.

In the same period, healthcare was available to those who could pay from an increasingly professionalised core of practitioners (i.e., doctors, pharmacists, and general practitioners). Wealthy patients' access to healthcare did not change very much in its essence from the previous century when they also had access to doctors and other medical professionals through direct payment (Ham 2009). The most

dramatic changes and improvements to healthcare in the late 19th and early 20th centuries actually occurred in relation to the poorer elements of society.

Intervention and provision of health services grew in importance in the first decades of the 20th century. It was placed firmly on the legislative agenda due to the need for a healthy population; after widespread malnourishment during the Boer Wars the government was faced with a much smaller pool of potential military recruits (Webster 2002). After the Boer Wars the government became much more active in the provision of healthcare in response to a growing demand. This culminated in the Health Insurance Act of 1911 which is seen as a first step in the direction of a universal health system (Hacker 1988). Under this system employers, employees and the government contributed to the scheme which allowed insured individuals to see GPs at regulated prices. However, additional treatments and care would have to be paid for by the patient (Digby and Bosanquet 1988). This was followed by a pattern of general shifts, with many voluntary and poor hospitals being taken over gradually by government (Webster 2002). Responsibility for payment for healthcare services moved from the individual to the state.

Prior to the establishment of the NHS, there was a mixed system of care. Those individuals who were wealthy enough would purchase their own care, while those who were unable to, relied on limited public services or on voluntary hospitals. As the role of the state grew, the burden of payment shifted from the individual towards the state, with the establishment of insurance schemes and of growing public bodies.

The Creation of the NHS: A fully public system?

The Second World War led to the formation of the Emergency Medical Service (EMS) and further public health policy developments (Webster 2002). This led to a wider use of health services and ensured its popularity, with it being the first time that many families were well fed and cared for (Timmins 2001).

Before and during the Second World War there was no political consensus between the two major parties on the further development of healthcare. However, in 1942 William Beveridge published what is considered a radical report in which he identified five 'Giant Evils' that plagued society (Timmins 2001). One of those evils was 'Disease,' the solution to which proposed the creation of a National Service that treated people's illnesses. The report was embraced by the Labour Party, and then became part of the so-called Welfare State in the post-war UK. In relation to health services this meant the merging of the different disparate elements of existing provision into a single organisation. The reforms included the consolidation of the for profit private hospitals and clinics, voluntary sector hospitals, and the workhouse hospitals. Control of these institutions was given to the newly created National Health Service (NHS). Public health and community services were given to local government (Webster 2002).

The post-War Labour Government (1946-50) was faced with the challenge of combining these various elements into one functioning service. It had to negotiate and pacify the concerns of the medical profession which resisted the perceived loss of its autonomy, but whose cooperation was key to the success of the project. The medical professionals were particularly resistant to surrendering their economic autonomy to the state and negotiations with the Government at one point seemed likely to fail (Webster 2002). Final agreement was reached only when the medical profession was satisfied that their earning potential was protected. This included allowing General Practice to remain as private contractors working for the NHS, but who had the ability to undertake some private practice.

The agreement with the medical profession was described by the then Health Secretary, Aneurin Bevan, as having: 'stuffed their mouths full of gold' (Timmins 2001), underlining the size of the financial compromise made to create the single unified health service. Existing facilities were appropriated by the government and a new building programme of hospitals was announced (Ibid 2001). The provision of healthcare would be carried out by government/public control with doctors earning the majority of their income while working for the state (either as private contractors or as salaried employees). Hence, medical professionals were allowed to simultaneously work in the public sector and draw a private income – the use of NHS pay-beds and was a large source of income for consultants - which continued until the 1970s when this practice was gradually phased out (Richmond 1996). The majority of the high earners in the service were hospital doctors and the conditions and salary of GPs remained inferior until the late 1950s (The Kings Fund 2011). Even with much of the system being under direct government control after a form of nationalisation, private provision of health services continued to exist, though over time it became more focused on private insurance than on out of pocket payments (Doyle 2000).

It has been argued that in its early stages, the shape of the NHS was significantly influenced by the conflict between the government and hospital doctors, who dominated and had a privileged position within the healthcare system at the time (Klein 1990). Hospital doctors succeeded in maintaining their clinical and also economic autonomy by retaining income from private pay beds and undertaking some limited activities in the private sector (Doyle 2000). The government of the day had no choice but to compromise with the profession through negotiation, to successfully create a universal service. The government accepted the role challenging the medical profession, formally allowed to dictate the actual delivery and organisation of care services. The service was wholly funded by the state, yet organised by the medical profession (working for the government) and so consequentially was to a large extent self-regulated. This formed the basis of the NHS for the early part of its existence. Disparate elements were combined under one umbrella, and the dominant role of the medical profession was confirmed (Klein 2010). It is important to reinforce the point that GPs at the time were relatively marginalised, as they had more limited earning potential compared to their hospital colleagues (Doyle 2000).

At this point the health care system can be viewed as consisting of three separate areas for the first time; provision, funding, and organisation. The post-War government took control of both funding and the majority of provision (with GPs being a notable exception) but allowed the medical profession to maintain responsibility for how treatment was carried out.

While the majority of the population registered with the NHS in 1948, private practice continued alongside, primarily through private insurance and pay beds. The use of private insurance was initially limited to a small proportion of the population and reached its peak in the 1980s, with participation at just over 11% of the population (Propper 2000). Some medical professionals continued to work outside of the scope of the government; for example, dentists who were initially a part of the NHS but quickly became a fee-charging service soon after top-fees were introduced in 1948. Ophthalmology developed in a similar way. These heralded similar future disagreements between the government and public sector groups who were as a rule opposed to services being placed outside of the scope of the public service. Once such example was the controversy regarding the introduction of prescription charges in 1952 (Webster 2002).

In the early years of the NHS, there was an assumption that the cost of the service would gradually decrease as the population became healthier with better care (Ham 2009). However, after this initial period of consensus, and contrary to expectations the costs of healthcare continued to increase. As a result, the issue of resource allocation became one of the key political debates of the period, and the two major parties started to move away from the classic model (i.e., full public type system or command and control) of health care in the UK (Powell and Hewitt 1998). The very nature of commissioning deals with the allocation of resources and the most effective dispersal of funds. This was one of the major contributing factors to the decision to introduce prescription charges and allow dentistry to become a fee-charging service. It was, however, an unpopular measure with the general public and considered to be a significant contributing factor to Labour's defeat in the election of 1951 (Webster 2002). There were additional reforms of GP pay with incentives created to improve their working conditions and to maintain GPs as a gateway to the rest of the system (Ham 2009). But overall the post-War consensus between the two major political parties, regarding the funding of the NHS persevered until the late 1970s. The approach was colloquially known as 'Butskellism,' a combination of the names of a Conservative and Labour Chancellor (Powell and Hewitt 1998). The annual budget of the NHS in this period was gradually increased, with new facilities being built as and when they were needed (Ham 2009). As to the reasons for the consensus, some claim that it was not coordinated but rather the result of an accidental or coincidental policy agreement or consequence of political necessity (Powell and Hewitt 1998). Whatever the reason, this consensus allowed the NHS to develop and expand until the late 1970s with the model in which the medical profession kept its dominant role.

In summary, in its early years the NHS was dominated by the medical profession to which the government was forced to give concessions on issues relating to clinical

and economic autonomy. The independence and power of the medical profession was not challenged by the government. The government's role is perceived largely as one of resource provision whilst trying to generate savings when and where it was thought possible. There was also a focus on hospital and medical services, enabling the privatisation of peripheral services, as seen with dental and ophthalmic services, which began to charge fees. This state of affairs prevailed until the election of the Conservative Government in 1979 when there was a change in policy (Klein 2010).

The growth of management in the NHS post 1979

The political values of post-War governments dictated their approach to health policy and both of the major parties were committed to the increased funding of the NHS and the dominant role of the medical profession. However, after victory in the election of 1979, the Conservative Party challenged the prevailing economic theories, adopted monetarism (the principle that inflation should be kept low, while maintaining the value of the currency) and began advocating the 'rolling back of the State' (Wilding 1997), which in itself was in contradiction with and repudiating the previous 'consensus' on healthcare (Powell and Hewitt 1998). Whilst determined to carry out the wider reform of the public sector the Conservatives were aware of the popularity of the NHS amongst the public and so wishing to maintain their electoral prospects were very cautious in their approach. The government avoided a direct and open disagreement with the medical profession but managed to carry out reforms, as they had with other public services (Harrison and McDonald 2008). The first of those reforms of the NHS was the commissioning of the 1983 Griffiths report, which argued that the NHS was too bureaucratic and poorly organised and that it should be made more 'efficient' and market like (Wilding 1997, Greener 2001).

The Griffiths Report is the first example of New Public Management (NPM) principles being introduced into the NHS. A basic tenet of NPM is that public services should attempt to be managed in a similar fashion to businesses. For the NHS, that meant making the service 'efficient' and 'cost-effective' – tackling the 'bottomless pit' (Ferlie and Pettigrew 1996). As a result, new managers were introduced into every level of the health service, with a brief to commission services and to reduce waste (Macfarlane *et al.*, 2012). This was in direct contrast to the previous organisation of the NHS, in which the medical profession was dominant, self-regulating, and delivered and organised care independently from the government. That dominant position was now threatened by the introduction of full-time managerial staff. This led to conflicts between the clinicians and newly introduced managers, primarily in how resources should be allocated, with clinicians wanting to maintain control of how and where the NHS budget was to be spent. These reforms would lay the basis for future involvement of both clinicians as managers and of additional market based reforms (Ibid 2012). In addition to making the NHS more market like, the Conservative administration lessened the

controls on the private sector in terms of healthcare to encourage a greater number of private providers to begin operating (Ferlie and Pettigrew 1996).

There were other changes in health policy, some of which brought with them a greater emphasis on the private provision of healthcare. One such example was the Health Service Act (1980). Rather than directly expanding the private sector, the aim of the Act was to create more favourable conditions for its growth and expansion. This was primarily achieved through tax breaks for companies which provided private health insurance to their employees, as well as extending coverage to family members (Calnan *et al.*, 1993). During this period there were the first attempts to entice private providers from the United States to start operating in the UK (Ham 2009). This was one of the first cases of external (i.e., foreign) private providers being invited to deliver care in the UK healthcare marketplace (Ibid 2009).

Whilst the government's attempts to create favourable conditions for the expansion of private providers had mixed success, as the growth of these providers remained limited, it did represent a significant departure from previous policy. Private companies started to bid and win tenders to provide services within the NHS, with a resulting expansion of the private sector (Klein 2005). However, the majority of these providers were based in the south-east of England, where they could meet a demand primarily from a more affluent population, with these services generally being 'periphery' services relying on funding from private insurance schemes (Propper 2000). So while it can be said that growing the private sector as an alternative to the NHS did not achieve as much success as was initially intended, it did create the groundwork for a future partnership between the public and private sector (Propper 2000).

The early 1980s marked the beginning of outsourcing certain elements of hospital provision to private providers (Cousins 1988). This included catering and cleaning on hospital wards, and generally consisted of non-medical services (Greener *et al.*, 2014). This signified the beginning of a new approach - public funding but private delivery. This approach became further entrenched in the NHS over time. Private companies regularly competed for and were awarded contracts. The primary aim of the government was to reduce public expenditure, and the awarding of these first contracts to private contractors did not register in the public domain as services remained free at the point of use. However, this later became a topic of wider public debate with the spread of the MRSA virus in hospitals in which the cleaning contracts were carried out by private contractors (Ibid 1988). This also highlights a trend in which privatisation took place on the periphery of services, similar to the earlier changes to dentistry and ophthalmology (Greener 2001).

These first years of Conservative Government can be described as a period in which health policy shifted towards the acceptance of a greater role for the private sector, i.e., a shift to marketisation rather than privatisation or, more precisely, introducing elements of marketisation but with limited privatisation. The transfer of assets from the public to the private was very limited in regard to medical services per se (with the exception of contracting out the aforementioned services), though there

was an increased focus on the use of market mechanisms in the management of the service. There was also a growth of the use of private funding, in the form of private insurance schemes. While neither were as far-reaching as originally intended, these processes did set the scene for future health policy reform by later governments. Popular discourse changed and moved towards the acceptance of certain narratives including that the NHS is an inefficient, over-bureaucratised organisation. In effect, this was the start of a critical view of the NHS, as opposed to the benevolence of the wider public towards the service previously. However, it is important to say that this change of discourse was only possible in parallel with reassurances that the service would remain free at the point of use.

Another significant marker of this period was the first open challenge to the dominance of the medical profession by the government. The government insisted and prevailed in the decision to introduce managers into the NHS under the guise of ensuring better use of financial resources. This also led to the inclusion of private sector management practices becoming the norm. The medical profession managed to retain some clinical autonomy and so remained self-regulating, but in turn was faced with much stricter control of resource spending than previously, and clinicians had to share in decision-making processes with non-medical professionals to ensure the continued delivery of care. While there were few direct confrontations between the competing interests in this period, this new arrangement would further develop under subsequent Conservative Governments, and this will be discussed in the next section.

The rise of marketisation?

After further election success in 1983, the Conservative Government became more active in its attempts to reform the NHS with the prevailing belief that that to improve the co-ordination of services and increase the efficiency of the health service, the NHS would need to behave more like a business (Greener *et al.*, 2014). In addition, the late 1980s also represented a period of increasing financial pressures on the NHS, both from government policy and the weak state of the UK economy (Day and Klein 1991). This continuous reform resulted in a conflict between various groups over influence on the future direction of the NHS. The government's next step was the introduction of the internal market, which was implemented with the NHS and Community Care Act (1990). This represented a key moment in the history of the NHS. The stated aim of the Conservative Government was to further improve the management of the NHS by replicating the effects of a market in pursuit of more effective resource allocation (Le Grand *et al.*, 1998). The government wanted to achieve better “value for money” and to improve the competition with the NHS (Allen 2013). These new reforms built upon previous changes such as the Griffiths Report, which had already introduced new management structures into the NHS and helped to facilitate the continued development of private insurance outside of the health service. This new internal market divided the NHS in an organisational context into two different groups – providers and purchasers. The providers were organisations such as hospitals, which in this new structure offered their services to the purchaser organisations,

which in turn searched for the best possible financial package (Ibid 1998). This form of competition was explained as a replication of the perceived positive effects of the market. Therefore, this period can best be characterised as marketisation rather than privatisation. It is, however important to note that policy cannot be analysed in isolation, but rather needs to be viewed over time and as a gradual shift/evolution from previous policy, with many health reforms developing previous policy (Greener *et al.*, 2014).

The introduction of the internal market was met with widespread opposition, including the medical profession, political parties, and the public at large, with whom the reform was particularly unpopular (Baggott 1997). The medical profession entered into an open disagreement with the government, but they were unable to gain significant concessions. The reform was pushed forward by the then Health Secretary, Kenneth Clarke, who demonstrated that reform could continue even when faced with significant opposition (Greener *et al.*, 2014). It appeared to be a success for the government in implementing its own legislative agenda.

During this period there was a further increase in the involvement of private providers in the NHS including treating patients, albeit in a limited capacity (Klein 2010). This was encouraged further by government policy which continued to deregulate the rules regarding the introduction of new private providers (Ibid 2010). This was significant because this policy only had limited success, and it was the creation of a symbiotic relationship between the private and public sector, within NHS that actually ensured the policy's continued existence (Ibid 2010). The internal market ensured that some NHS resources would under specific circumstances be allocated to the private sector (Ibid 2010). So, it can be said that the most far-reaching consequence of the introduction of the internal market was the new relationship between the private sector and the NHS, which in effect ensured a market for private providers and which carries on to the present day (Mohan 1986).

Another consequence of the introduction of the internal market was its weakening of the dominant role of the medical profession in the development of health policy. The medical profession, represented by the Royal Colleges and British Medical Association (BMA) amongst others, was strongly opposed (Lapsley 1994, Ham 2009, Greener *et al.*, 2014). However, the government ignored their opposition and enacted the reforms. This set the tone for the future relationship between the government and medical professionals, as the authorities continued to enact reforms in the face of opposition from medical professionals, who were as a rule unable to alter the substance of the changes (Lapsley 1994, Ham 2009).

Despite their desire to generate additional competition against the NHS, the Conservative Governments of this period were ultimately unsuccessful in that goal for a number of reasons. The public was still heavily in favour of a fully publicly funded NHS (The King's Fund 2015). In those circumstances, the major legacy of these governments was not the creation of a private alternative to the NHS, but rather the beginning of competition between NHS bodies and the growth of the

private sector participating in the delivery of services in cooperation with the NHS. The aims of the internal market were to increase value for money, and to further integrate and coordinate services (Ham 2009). The growth of private providers was primarily through gaining contracts from the NHS, and it became a source of revenue which ensured the survival of the private sector. Whilst there was little direct privatisation of the NHS, this period was marked by numerous reforms that replicated market behaviour particularly regarding efficiency. The government, on the whole, maintained its stance in regards to health policy, while still relying on the medical profession to implement the changes despite its opposition to them. From a wider perspective, a significant factor in this is that market replication policies were relatively popular in the public narrative, which strengthened the government's hand when dealing with any opposition from the medical profession and other actors (Greener *et al.*, 2014).

Health policy developed in a context of constant disagreement and negotiation between competing actors. The government was generally successful in pushing forth its legislative agenda, and the medical profession managed to retain some of its clinical autonomy, while further gaining economic autonomy. Despite being unable to enact all of its envisioned market-based reforms, mostly due to public opposition, the government did manage to introduce internal competition in the NHS, between purchasers and providers. They were also able to continue the use of private providers in a limited scale. The focus of this period was very much on attempting to address the financial issues facing the NHS by strengthening management and introducing more competition, arguing that a market-based system would more effectively allocate resources than the previous centrally planned system (Butler 1992).

From purchasing to commissioning

After the General Election victory in 1992, the Conservative Government took a more conciliatory approach in further reforms of the NHS. The key element of health policy of this government was the introduction of the General Practitioners fund-holding scheme (GPFH). First established in 1991, it was developed further as a plan to devolve funds and commissioning power to GPs who in turn would act as fundholders, purchasing services for their local communities (Croxson *et al.*, 1998, Wainwright and Calnan 2012). In the context of the internal market, the GPFH represented a new form of local purchasers.

The central drive behind the reforms was that the use of market mechanisms would be the most effective way in which to distribute resources (Wainwright 1998). GPs would be ideally suited to purchasing relevant services for their local populations, rather than central planners. The reforms enjoyed limited success (Glennester *et al.*, 1994). They succeeded in generating savings in certain areas of secondary care, focussed on local needs, and better care (Glennester *et al.*, 1994, Wainwright and Calnan 2012). However, it was soon recognised that administering this new system was more expensive than the savings that were made (Le Grand 1998). As Le Grand said with regards to competition in the health service, the 'incentives were too

weak and the constraints too strong' (Le Grand 1999). So while this scheme did not directly involve the private sector, it did represent further marketisation of the NHS. Competition as an organisational principle was embedded even deeper into the health service in an attempt to replicate the market. The GPFH scheme by its very nature was an attempt to utilise greater market tools through moving away from central planning and developing decision making (Wainwright and Calnan 2012). They also positioned the GP as a "patient champion" (Ibid 2012, p 168) which further helped to push the idea that this scheme represented the entrenching of marketisation.

The Conservative Government continued the work of previous governments in its attempts to replicate private sector practices in the public sector. In effect, the goal of the government was to create a more market-based system rather than to privatise the service directly (Wainwright and Calnan 2012). In that context, the use of private providers did not markedly increase, although there were some tentative steps to expand their role further. The more significant policy development in this period was the introduction of the Private Finance Initiative (PFI) schemes. While this is not a form of direct privatisation, the assets are publically owned, it does represent a further move to merge the public and private sectors in the delivery of healthcare services. Private companies financed the building of new hospitals in return for the right to charge rents to the relevant body over a longer period of time (Exworthy *et al.*, 2011).

Despite the previously mentioned conciliatory approach the Government's conflict with the medical profession persisted. The majority of GPs were opposed to their involvement in commissioning though there was some disagreement amongst them. As stated by Hunter (1994), there were three groups of doctors, some who were opposed to managerialism, some who attempted to find ways around it and those who embraced the new principles. This is another example of the power of the government as this reform was enacted despite opposition from the medical profession.

'Blurring' the boundaries between the public and private sectors

After the Conservative administration's commitment to the introduction of market-style reforms and private providers into the NHS, New Labour was elected on the promise to abolish the internal market and to reconcile the service (Greener *et al.*, 2014). However, in practice, Labour would only build on and entrench the principles of previous reforms (Ibid 2014).

Initially, the Labour Party remained committed to matching the spending commitments of the outgoing Conservatives, and this included the NHS (Ham 2009, Webster 2002). In that sense, the Labour party's health policy developed that which was introduced by their predecessor.

The first new policy of the Labour Government was *The New NHS* (1997). In line with the Comprehensive Spending Review (Webster 2002), New Labour announced an increase of the NHS budget of an additional £21 billion over three years (Ham 2009). This was in contrast to other public services where the government had reduced public spending. This stood in contrast to previous administrations which looked predominantly at improving the way in which resources are allocated. There was however, a focus on improving economic efficiency with the increased funding (Harrison 2002).

In this period the Labour Government also retained the internal market despite signalling differently in the past. In so doing, the Labour Government embraced the principles and language of private sector management practices (Cutler and Waine 2000). One element of the internal market that was abolished was the GPFH scheme. The new administration eliminated it upon coming to power in 1997. It had been argued by the Labour Party that GP Fundholders had led to the creation of a two tier NHS (Dixon and Glennerster 1995, Ham 2009). However, the Labour Government decided to continue the concept of primary care led commissioning through creating new Primary Care Groups (PCGs) (Miller *et al.*, 2012). These new groups were larger organisations than the GPFHs that preceded them (Miller *et al.*, 2012), but operated using similar principles, with the goal of moving commissioning further into primary care (Ham 2009). This change represented a set of new policies as well as, a continuation of reforms under previous governments. In effect, they highlighted the wider acceptance of the view that the NHS must continue to be cost-effective, operating in a similar fashion to a private company.

New Labour also continued to use PFI schemes. These schemes became more common under the Labour Government than under previous administrations as they were primarily used to build new facilities. PFI schemes fit well with the broader Labour commitment to limiting spending and so were seen as a useful tool (Ham 2009). Whilst in the short term PFI schemes helped with the provision of hospitals, from a government standpoint lowering the cost of building, it left the NHS with long-term repayments (Greener *et al.*, 2014). Significantly, this represents a continued 'blurring' of the lines between the public and private sectors, with the private sector building the majority of hospitals in this period (Ibid 2014). The overarching need for investment into the NHS, combined with the notion that the private sector is inherently more efficient, resulted in an apparent acceptance of the PFI schemes by various actors.

Growing usage of private providers – the PFI scheme

PFI was initially proposed by the Conservative Government (1990-97). However, usage of the scheme became more widespread under the Labour Government (Grimsey and Graham 1997). The PFI is a method of financing investment in new facilities (capital investment) where the public and private sectors work together. The private sector delivers the construction of facilities and then charges annual fees to the NHS Trust, whilst also providing non-clinical services (Treasury Select Committee 2011). Initially, PFI was utilised as a mechanism to allow the Labour

party to fund the building of new hospitals whilst adhering to Conservative spending commitments (Webster 2002). Later, PFI would be argued to be a means of sharing the risk between the public and private sector (Shaoul *et al.*, 2011). Clearly, the expansion of the PFI schemes meant a larger role for private providers who would ensure the necessary capital for the building of a hospital. In return, the private company would gradually recover its investments by leasing the newly built facility to the NHS for a period of 25-35 years for a fixed fee – regardless of the use of these new facilities (Shaw 2003).

PFI became one of the central elements of New Labour health policy, despite opposing their use during the Conservative government (Shaw 2003). The new administration used the PFI scheme as a way of keeping expenditure on the building of new schools and hospitals 'off the balance sheet', by maintaining that the capital for the projects came from the private sector and not public funds. In this way, the Government managed to match the spending targets it committed to in the 1997 election (Shaw 2003). In practice, the direct management of the hospital remained the remit of the public sector and rents were paid to the private investors. Additionally, those investors had the right to provide certain services as agreed to in the initial contract, such as cleaning and catering (Froud and Shaoul 2002). This bore similarities with the contracting out of cleaning and catering services in the 1980s. However, in this instance there were multiple issues with the process. This included the price which NHS providers had to pay, which were prohibitive. It also remained the only method available to NHS Trusts to gain funds for capital expenditure and as the PFI schemes embedded the process of sub-contracting in favour of the private sector, which remains one of the main expenses in PFI hospitals (Shaoul *et al.*, 2011).

One key argument used by the proponents of PFI was that of shared financial risk with the private sector, thereby a lessening of the financial burden on the state (even though the risk did ultimately remain with the public sector (Treasury Select Committee 2011, Froud and Shaoul 2002, Shaoul *et al.*, 2011)). The same proponents argued that other perceived qualities of the private sector, such as the more efficient provision of services (cost-cutting and competition), would also simultaneously be introduced into the public sector. This did not occur, with PFI schemes pushing many NHS Trusts into deficit positions (Shaoul *et al.*, 2011).

The PFI scheme led to the signing of the Concordat between the Labour Government and the Independent Healthcare Association (IHA), a representative of private health companies (Maynard 2005). It allowed for the further growth of the private sector in the NHS and was the direct precursor of the Independent Sector Treatment Centres (ISTCs). The ISTCs were in effect a partnership between the public and private sectors in which non-public providers were contracted to ensure that government targets were met. These were different to earlier examples of private involvement in the NHS in that they were directly created through government policy (Naylor 2015). In addition, whilst privately owned, they exclusively treated NHS patients (Ibid 2015). This represents another example of

the increasingly blurred lines between the public and the private sector which were now more difficult to delineate.

Both PFI and the Concordat increased the role of the private sector in healthcare. Apart from the obvious enabling of the private sector which was now extracting rents from the NHS over an extended period, the Concordat additionally altered the nature of the relationship between the public and private sectors in this area. Private companies had started to work in the public sphere under contract to the government, which was in line with the policy of encouraging 'co-operation' rather than competition between the public and private sectors (Exworthy *et al.*, 2011). In the early 2000s, the number of surgeries carried out by the private sector on behalf of the NHS tripled (Powell 2002) as the government attempted to alleviate pressures on the NHS and meet its targets by utilising private providers. This arguably constitutes a form of privatisation as a service which was previously dominated by public providers changed into what can best be described as a 'mixed economy of provision' in which the line between public and private became 'blurred' (Mohan 2006). In addition, the purported benefits of the PFI schemes did not materialise. The facilities which have resulted from the initiative have been smaller in capacity than those which have been funded directly by the government, as well as of a poorer standard (Dunnigan and Pollock 2003). The costs of the PFI schemes have continued to grow and combined with contracting methods made the situation more severe. 'Payment by Results' (PbR) contracts were the method through which NHS Trusts would secure payment for their services through charging commissioners by the volume of cases treated with the aim of eventually reducing costs (Marini and Street 2007, Shaoul *et al.*, 2011). From a more recent evaluation carried out by the Health Select Committee: "Private finance is invariably more expensive than direct government borrowing" (Treasury Select Committee 2011, p15).

The PFI and the Concordat can be characterised as forms of privatisation, with a growing acceptance of the use of private providers. For instance, the Concordat introduced private providers into the NHS in a process described as 'overt privatisation' (Pollock *et al.*, 2004). It has also been argued the opposite, that this was not true privatisation, rather a 'market replication' (Rustin 2000). In either case, it can be argued that this was a significant step, as it did result in moving public services in the direction of the markets and market orientated management.

The introduction of the PFI and the Concordat can also be viewed from the standpoint that it represents a continuation and development of concepts such as competition into the healthcare system. For the first time in the history of the NHS, the private sector gained a direct role both in the delivery of care and facilities. In effect, private providers were now allowed to generate profits through the provision of NHS services and NHS activity. Parallel to this, NHS managers had the added responsibility to coordinate not only the work of public, but also private providers in the delivery and coordination of care.

Partnership and marketisation

In 2000, the pressures on the NHS became more acute with the perceived notion that the general public was demanding additional funding for the health service (Ham 2009). The Government responded with a commitment to a 'patient centred' NHS, for which it agreed to provide additional resources (Ibid 2009). As a result, the next White Paper, *The NHS Plan* (2001), represented an expansion of previous policy but with a focus on increased investment in parallel with reforms. These had the explicit aim of making the service more 'performance orientated' and 'modern' (Le Grand 2002).

To deliver the organisational changes needed to enact the new *NHS Plan*, there was an initiative titled '*Shifting the Balance of Power*' (2001). This new policy outlined the manner in which the Primary Care Groups (PCGs) would transform into Primary Care Trusts (PCTs) and what their goals would be (Stevens 2004). These PCTs would be commissioning bodies which would purchase the majority of NHS services (Ibid 2004). The overall aim was to enable the PCTs to commission 75% of the NHS budget (Ibid 2004). There were also plans to allow 'high-performing' NHS Trusts to transform into NHS Foundation Trusts, a form of not-for-profit public corporation (Greener *et al.*, 2014). The aim was to have all NHS Trusts gain Foundation status by 2004. The benefit of gaining Foundation Trust status was increased fiscal and clinical autonomy from the Department of Health (Ibid 2014).

The exact workings of the newly formed Foundation Trusts were set out in a publication called *Building on the best. Choice, responsiveness and equity in the NHS* (2003). The two key elements of the new proposal were patient choice and an increased plurality of providers in the healthcare market (Ham 2009). A key component of the new reforms would be a role for the private sector to help deliver waiting list targets (Ibid 2009). NHS Foundation Trusts would be allowed to send patients to private providers and use them to a greater extent than under previous policy. This growth of private providers took place through the usage of Independent Sector Treatment Centres (ISTCs) (Pollock and Godden 2008). These ISTCs would treat patients that NHS Trusts could not see in the allotted time, thus the private sector was working as part of the public sector to treat patients.

This change was further entrenched through the use of the national tariff which developed the PbR contracts (Ibid 2008). From a wider perspective and parallel to this process New Labour announced further NHS budget increases, with annual growth approaching 7% in real terms every year for the next five years (Ham 2009). The then Prime Minister, Tony Blair, stated that the purpose of this increase was to bring the funding of the NHS to a level equal to the majority of other European nations (Ibid 2009).

Taken as a whole, these plans represented a shift from the early days of New Labour rule, openly encouraging more partnerships between the public and the private sector in the NHS. In this sense, this represented a clear intention to move the organisation of the NHS towards a market (Mays *et al.*, 2011). As mentioned

previously, this even deeper acceptance of the private sector in the delivery of care additionally blurred the lines between the two sectors (Mohan 2009). This is typified by the Foundation Trusts (FTs), as they exist on the boundary between the public and private, in that they are a public body which can also generate income from private patients. Similarly, the plans further entrenched the concept of competition within the NHS. The creation of the Foundation Trusts represented a victory for the so-called 'modernisers' over the Labour 'traditionalists' (ibid 2009). Due mostly to the influence of the Treasury, performance targets were introduced which had led to direct effects on finances of NHS bodies (Greener *et al.*, 2014). The Government's aim was to encourage co-operation between the public and private sectors, and the plans should also be viewed in this context. This approach continued during the remainder of the New Labour's time in government. These new arrangements were encouraged and they reiterate the New Labour ideological approach to the system: 'what works is what counts' (Klein 2010).

In a continuation of policy, New Labour introduced the *NHS Improvement Plan* in 2004. Its purpose was to further expand the plurality of providers and competition within the health service. This plan also represented the first time that patients were explicitly given the right to choose where they would be treated in the system and by whom (Ham 2009). The policy was intended to help define how additional expenditures could best be deployed, with an emphasis on reducing waiting times for patients and providing them with an additional choice regarding providers (Ibid 2009). In effect, the new policy was a confirmation that the Government had committed itself to the use of the private sector to support the NHS and illustrates of how new reforms had roots in previous policy.

Another important aspect of the reforms was the additional role of PCTs to act as commissioners within the internal market rather than providers and to focus on 'practice based commissioning,' in a manner similar to the previous GP Fundholding scheme (Klein 2010, Miller *et al.*, 2012). Certain groups of medical professionals recognised these similarities and were vocal in their opposition of PCTs fearing they would lead to privatisation of parts of the NHS (Ibid 2010).

Responding to criticisms that the reforms would increase the involvement of the private sector, the government did to some extent change and limit its plans. It did, however, continue with its aim to enlarge the PCTs to a similar size as healthcare providers (Ham 2009). The government also gave further guidance regarding the mix of healthcare providers functioning in the NHS (Ibid 2009). They enacted policy in which provider networks were to function in future and how 'money would follow patients' (Klein 1998). Simultaneously, patients exercising their new right to choose their provider further increased the demands on the NHS and thereby indirectly the use of private providers. Whilst as a proportion of total NHS activity, these ISTCs only account for 1.79% of total elective surgical procedures by 2008, this was a rapid expansion compared to the 0.07% of electives in 2003 (Naylor 2009). These policies can be categorised as a combination of marketisation and privatisation. Regarding the latter, there was continued growth of the private sector within the NHS, primarily through the ISTCs and their relationship with NHS

Foundation Trusts. Regarding marketisation, there was a continued emphasis on choice and competition under the reforms. The new concept of funds following successful providers increased internal competition which was seen as a positive in ensuring that the quality of services was high and the costs low.

The New Labour objectives of increased patient choice and outsourcing of contracting can best be characterised by the growing funding of private providers for elective surgery. Private providers were contracted by the NHS to deal with excess demand in electives (Hutt *et al.*, 2010). Between 2003 and 2008 the total number of electives carried out by the ISTCs increased from 3,633 to 105,604 (Naylor 2009). It was envisioned to cut down the waiting lists and meet government targets. The lasting achievement of New Labour was that it managed to shift the relationship between the NHS and the private sector, giving the latter a much more explicit role in the delivery of services. No longer would companies and Trusts work solely with the State, but there would be contracts between private companies and GPs/Trusts.

Table 1 ISTC activity as a proportion of total NHS activity

Year	ISTC activity (FCEs)* (from HES** data)	Total NHS elective activity (from HES** data)	ISTC activity as proportion of elective activity (%)
2003/4	3,633	5,544,864	0.07
2004/5	36,599	5,530,359	0.66
2005/6	53,388	5,821,062	0.92
2006/7	67,210	5,590,579	1.20
2007/8	105,604	5,900,000***	1.79

* Finished Consultant Episodes - represents a patient's completed period of care under a consultant.

** Hospital Episode Statistics

*** Audit Commission estimate

Source: Audit Commission (2008)

Table 2 - ISTC Activity as a proportion of total NHS activity

(Source: Naylor 2009)

When Gordon Brown replaced Tony Blair as Prime Minister in 2007, it was expected that there would be some form of retrenchment of the market-based NHS reforms (Mays *et al.*, 2011). Brown had previously been a relatively vocal opponent of markets in health care. During his premiership, limits were placed on the activity of the ISTCs though there was an expansion of the public/private mix of providers within the primary care available to patients (Ham 2009). There were also further reviews of the NHS and how it would be able to cope with future challenges (Ham 2009). It was clear that Brown did not take steps to further expand the marketplace, but rather consolidated existing reforms. In addition, the large annual

budget increases to the NHS also ceased during the years of the Brown premiership (Ham 2009).

The major debate regarding the New Labour reforms was whether it was the increased funding or the structural changes that were the key factor in the recorded increase in performance and public satisfaction with the service (Ham 2009). The private sector benefitted greatly during this period mostly as a result of the increased annual budgets and activity related to NHS policy of quickly reducing waiting times/lists. This enabled the private sector to gain patients. The number of private treatment centres also grew during this period. Parallel with these changes, there was an expansion of the use of market mechanisms in the management of the NHS with the aim of increasing efficiency. Fundamentally, Brown's policy was the continuation of the principle of 'what counts is what works' (Klein 2010). The NHS was further marketised with an emphasis on controlling expenditures whilst simultaneously increasing the number of available providers to commissioners. Private providers benefitted from the fundamental element of New Labour health policy which was dominated by the desire to meet waiting list targets.

The New Labour administration continued to utilise the private sector and encouraged its usage. Its policy was built on those of the previous Conservative Governments and represented a continuing shift towards primary care-led commissioning. The Labour Party's ideological justification was the so-called 'Third Way' which was focused on 'what worked' in an attempt to find a middle road between socialism and the free market (Klein 2010). This kind of overt approach to the use of private providers unsettled the medical profession and the general public, which was generally unfavourable towards it. However, with its emphasis on targets and its readiness to add resources to the NHS, Labour managed to enact their policy with only limited opposition. Linked to this is the growing acceptance of the concept of public/private partnership in the delivery of services, i.e., the 'blurring of the lines' (Mohan 2009). The same period was marked by a growing involvement of the private sector, and it can be said that privatisation did occur, though only in a limited fashion with most of the new actors working in both the public and private sectors. The ability of the private providers to offset waiting time was offset by the NHS being overcharged for treatments (Mays *et al.*, 2011). It is at this juncture that a clear delineation between the ideological approaches of the two major parties appears. New Labour's vision was one of the private sector supporting the delivery of public care, building on policy of previous Conservative Government.

The policy of New Labour resulted in the creation of additional competing interests within the NHS. The framework that developed in this period, which saw the introduction of PCTs and Foundation Trusts, was such that varying elements of the health service had separate aims and objectives (Checkland *et al.*, 2009, Mannion *et al.*, 2008). In the meantime, the Government pursued its own goals which were different from those of the various elements of the NHS. While there was not an overt conflict and opposition to the government's programme, this variance of interests could offer an explanation as to why the commissioning reforms may not

have developed as intended (Smith *et al.*, 2004, Smith *et al.*, 2010). In fact, many of the market mechanisms that the New Labour Government introduced were not fully brought into practice. There is an argument that the effects of competition were limited but that the financial uplifts were key in understanding the improvement in NHS services (Pollitt 2007).

During the years of the New Labour Government, it became increasingly clear that the private sector in healthcare relied on the NHS, and in fact on government spending for its business (Mohan 2009). Essentially, the private sector not only secured its existence but even thrived throughout the 2000s. This was achieved primarily through the changing contractual relationships it had with the NHS. Accordingly, the acceptance of the principle of the private sector being a part of the NHS gained even wider acceptance and could even be described as the new normal. Much of the above policy was conducted under the umbrella of cost reduction despite increasing budgets, which amongst other things included an expansion of private sector management techniques and the introduction of new actors on both sides of the purchaser-provider split. The private sector became integral in the delivery of elective procedures, albeit it with a very small proportion of total activity. They became a key tool in the meeting of delivery targets.

Unifying privatisation and marketisation?

After the defeat of Labour in 2010, a Coalition Government (2010-15) was elected, with both of the participating parties, the Liberal Democrats and Conservatives, stating there would not be further reform of the NHS (Timmins 2012). However, the health service was, like other public services, ultimately subjected to a change in policy in line with one of the themes of the new administration: 'Big Society' (Kisby 2010). After years of increased funding, the NHS was to have its annual budget frozen, a significant change in circumstance compared to the preceding decade.

The latest reform of the NHS began with the Government White paper titled '*Equity and Excellence: Liberating the NHS*' (2011). This paper was shaped by the then Secretary of Health, Andrew Lansley, who had been shadow Health Secretary since 2006. He spent his years in Opposition developing his vision of the NHS, which he saw as ultimately free of the control of central government building on previous policy (Timmins 2012). Lansley's influence was critical in formulating the Coalition Government's White Paper. This new policy suggests that the role of government would still be important, but that the NHS would be run as an arm's length body, with the new NHS Commissioning Board overseeing the day to day running of the service (Ibid 2012). The White Paper also provided an outline in which the private sector could become much more involved in delivering care in the NHS (Ibid 2012).

Under Lansley's proposals the NHS would further work in partnership with the private sector, but there would be a significant change. This would see 'Any Willing Provider' being able to compete for contracts. In parallel there would be an expansion of primary care-led commissioning with the introduction of new GP consortia, while the overall budget of the NHS would be frozen, fitting within the

broader public sector funding pressures (The King's Fund 2015). Indeed, the development of commissioning policy has continued its focus on more effective resource allocation. These proposals were met with widespread opposition both from the general public and the medical profession (Ibid 2015). The Government's response to such opposition was to announce a temporary pause in the reforms and a so-called 'listening exercise': the NHS Future Forum. The subsequent six-month consultation period ended with new proposals which were published as the Health and Social Care Act (2012). In it, the language and legislation were changed, with many of the controversial elements of the initial White Paper diluted. The NHS would not be open to 'Any Willing Provider' but rather to 'Any Qualified Provider' with increased minimum standards to alleviate public concerns (Speed and Gabe 2013). The basic concept remained that any provider, whether public, private or third sector could compete for NHS contracts (Ibid 2013). This concept was not new, having been brought in under the last year of New Labour government. However, it was expanded and shifted the NHS professionals into an "explicit market context" (Ibid, 2013, p4) with the overarching aim of reinforcing market-like competition. In addition, the new contracting arrangements were subject to European competition laws which had not been the case in the past (Ibid 2013). This meant that contracts over a certain value would have to be opened to providers. There were guarantees on the maximum total number of private providers the NHS would be allowed to generate funds from, with both CCGs and Trusts being limited to generating the majority of their funds from the public sector.

When the Coalition came to power, satisfaction with the NHS was at an all-time high (British Social Attitudes Survey 2012). Such popularity could be a part of the explanation of why the Coalition Government met with such resistance to their reform programme and why the medical profession seemed to be once again able to exert its influence, the critical factor being the support of the general population. Possibly in the same context is the explanation of why the Coalition Government, unusually in recent British politics, was ultimately unable to secure the support of its MPs to pass its original plans through Parliament. The real possibility of the Coalition Government falling provided the impetus to agree to significant concessions and dilute the original plans of reform (Timmins 2012). This involved capping the amount of private income that NHS bodies could generate and stricter controls for the types of providers who could compete for NHS contracts.

Critics of the proposals were concerned, and argued there was room for what they described as 'backdoor' privatisation, citing the clause related to 'Any Qualified Provider'. The then Secretary of State for Health, Jeremy Hunt, opted to focus on the issue of quality rather than the type of provider that would deliver services. In the context of commissioning care, the Health and Social Care Act (2012) created a framework in which commissioners were given the power to tender contracts to the private sector within a broadly more market-based system (Gabe and Speed 2013). This was of particular significance as the service was to operate in an environment of reduced funding and in which private providers, promising to deliver care more cost-effectively, could prove a particularly attractive option to commissioners. In other words, the new reforms created a significant space for the

expansion of privatisation in the context of limited public funds, i.e., austerity. Under the new arrangements commissioners were, as previously mentioned, given the ability to choose any service provider they thought best, while the NHS Trusts and other providers were now to compete not only amongst themselves but also potentially with new private sector providers. The concern was that commissioners working in circumstances of reduced resources might opt for particular types of provider over others (i.e., private over public). In contrast, others have argued for the likelihood of a more conciliatory approach arising from the new framework, i.e., that competition would be quite limited (Checkland *et al.*, 2009).

Another principle of the Health and Social Care Act (2012) was the stipulation that patients must have a choice of providers when being cared for. The sector regulator, Monitor, was mandated to protect this right of choice and was given the power to intervene in mergers of NHS Trusts and explicitly apply competition laws to the NHS (Monitor 2015). Monitor came to prominence when under the banner of protecting patient choice, it intervened in the proposed merger of Bournemouth and Poole NHS Trusts. This resulted in a drawn-out process and a final decision which took nearly two years to reach (HSJ 2013). The merger was rejected by Monitor's intervention on the basis that the perceived loss of choice would be detrimental to the 'customers' of the service (Ibid 2013). However, Monitor also has a responsibility to promote cooperation, which makes its regulatory role difficult to clearly understand (Allen *et al.*, 2017). The Poole and Bournemouth case was an example of how the new regulatory framework could prioritise patient choice ahead of the improvements in quality of care provision. Thus, it seems the priorities of the regulatory framework were in contradiction to those of the Trusts (delivery of the best possible clinical outcomes). In practice, this meant that the Trusts had to alter their aims and priorities. There is some evidence that these priorities might change with the further maturation of the regulatory framework and as the political agenda changes (Collins 2015).

Another notable example of the Coalition Government's health policies was the increased use of private providers as the primary providers in specific services (Gabe and Speed 2013); for example, when the Government allowed Circle, a private company, to run Hinchingsbrooke NHS Trust. In this instance the private sector in the form of Circle, took over the management of the Trust while the facilities and services themselves remained in public ownership. Hence, an organisational element of the NHS was overtly moved from the public to the private sector. This is a further example of the private sector becoming more involved in the delivery of public services. The purpose of allowing Circle this kind of control was to establish if other such partnerships were viable in other parts of the country (Owen 2015). This kind of introduction of a private company into an NHS body would ultimately test the ability of the private sector to operate within public sector constraints (Ibid 2015). This is then another example of the Government entrenching private sector practices in the NHS. The contract with Circle was widely opposed (Scourfield 2016). However, its ultimate failure was not due to opposition but rather because Circle withdrew from the contract realising that they would not be able to fulfil its terms, i.e. to generate a pre-agreed level of savings (Owen 2015, Scourfield 2016). The goals that Circle had set were unprecedented in NHS history,

stating that £311m would be saved over the lifetime of the contract (Scourfield 2016). Circle withdrew after three years of the ten year contract, being unable to deliver its aims of generating savings and eventually a profit (Ibid 2016). Despite this arrangement not being permanent, it represents evidence of expanding privatisation under the Coalition Government.

The Coalition Government reforms still provided the GP-led CCGs power to select any providers they thought best (Timmins 2012). This opened the debate on whether or not that would lead to an expansion of private providers in the NHS (Davies 2013). The private sector was successful until then, and commissioners were now given a new tool by which they could even further expand their activity within the NHS (Allen *et al.*, 2017). Similarly, it was not clear what effect other pressures such as smaller budgets and fiscal deficits would have on the commissioning process and thereby the eventual size of the private sector in the NHS. This concern was further heightened by other elements of the Health and Social Care Act (2012) which pointed to the possibility of increasing privatisation such as the clause which allowed Foundation Trusts an increase in the amount of money they could earn from providing private care. Another concern which emerged was that PbR contracts could prove to be unworkable or too costly for continued use in the context of decreasing public resources (Petsoulas *et al.*, 2011). Commissioners would be unable to affect demand and yet under PbR would have to continue paying for treatments to ensure the stability of Trusts.

The shape and size of the private sector has changed over the last 20 years. There has been continued growth of public spending on the NHS (The Nuffield Trust 2015). The amount of money which has been spent on private, out of pocket payments, has also held steady since 2010, at just over £25 billion per year, compared to public spending which during the same period remained over £125 billion per year (Ibid 2015). The introduction of market-based policies into the NHS has led to a considerable growth of private providers working on behalf of the NHS (Powell 2015). The Concordat, as previously mentioned, began this process with the development of ISTCs and other private providers (Sheaff and Allen 2016). This was combined with FTs needing to utilise a certain number of Any Qualified Provider (AQP) contracts and only having access to PFI schemes to finance new capital projects (Ibid 2016). By 2013/14 private providers held contracts with CCGs with a total value of £9.3 billion, which represented 16% of all CCG contracts (although not all of these contracts were for medical services) (Ibid 2016). It is worth noting that of these contracts over half were won by private for-profit companies (Ibid 2016). Private providers are also responsible for 20% of the knee and hip replacements carried out on the NHS (Ibid 2016).

While these figures may represent a growth in the amount of activity that private providers are generating, the total amount of spent on private providers has been in steady decline since the early 1990s, triggered partly by the financial crisis in 2008 (Arora *et al.*, 2013). The amount spent in private hospitals has experienced a slight annual decrease, but increases of the use of private providers in both community care and mental health services of 12% (The Kings Fund 2014, Sheaff

and Allen 2016). The activity of private providers has increased with non-NHS providers carrying out 471,000 inpatient cases in 14/15, compared to 73,000 in 06/7, representing an increase of over 600% (Sheaff *et al.*, 2016). In total terms of cost, private hospital care accounts for just over £6 billion (representing over 7% of total spend in the NHS) of treatment spread across 250 facilities – the majority of which come from private patients and some very limited NHS use (ibid 2014).

At the same time as the number of private surgeries has increased, there has been a steady decline in the number of people who rely on private medical insurance (PMI). The population covered by PMI declined from 12.9% in 2006 to 10.9% in 2012 (Arora *et al.*, 2013). In addition, many private providers began to rely more on NHS patients and were treating fewer private patients (Ibid, 2013). This is thought to be related to the economic crisis of 2008, and has further bound the income of private providers to the NHS. This highlights the link between the private sector and the NHS, with private providers increasingly becoming embedded in the service. The variation in the levels of activity that private providers carry out on behalf of the NHS has changed with the Government of the day. While the Thatcher Governments encouraged PMI and the contracting out of non-medical services, and the later Conservative Governments would expand the internal market, it was under New Labour that there was an expansion of private providers working in the NHS (Sheaff and Allen 2016). The private sector now appears to be very reliant on the NHS to continue its existence (Arora *et al.*, 2013).

The framework which emerged after the enactment of the Health and Social Care Act (2012) could have a significant effect on the future shape of the NHS on many different levels, only one of which is the way it would affect the commissioning process. If commissioners were to opt for private providers to a greater degree, they could create a momentum of policy which future Health Secretaries may have no choice but to build upon even further. The Coalition Government displayed a willingness to involve the private sector even overtly in the management of the public sector (Hinchingsbrooke) claiming that it was only building on previous policy. During the past decade, the level of PCT spending on private providers increased from £4.74 billion in 2006/7 to £8.33 billion in 2011/2, which represents a growth of 76% (The Nuffield Trust 2013). As a total of the NHS budget, this represented an increase from 3% of the total spend to just over 5% of total NHS expenditure (see Table 1). The vast bulk of this was spent on independent sector providers (ISPs). So overall, the private sector has continued to grow in this period of reforms with the potential for further growth in the future.

Table 1: Total commissioner spend on independent sector providers for the following services and as a proportion of Department of Health total spend on services (2014/15 prices).⁶

- General and acute services
- Accident and emergency services
- Community health services
- Maternity services
- Mental health services
- Learning and disability services
- Primary care services

Year	Total (£bn)	Trend	Proportion (%)	Trend
2009/10	4.55	–	4.3	–
2010/11	5.09	↑ 12%	4.7	↑ 11%
2011/12	5.64	↑ 10%	5.2	↑ 11%
2012/13	6.46	↑ 15%	6.0	↑ 14%
2013/14	6.56	↑ 1%	6.1	↑ 1%
2014/15	6.91	↑ 5%	6.3	↑ 3%

Table 3 - Total amount spent by PCTs on independent providers

(Source: The BMA 2016)

During the introduction of the Health and Social Care Act (2012), it is clear that there has been a marked increase in the usage of private providers. This represents both marketisation and privatisation. Concerning marketisation, there was a concerted effort to increase competition amongst both public and private providers. NHS providers were now operating in a very explicit market setting (Gabe and Speed 2013). They had to act much more like private businesses to succeed, and this was encouraged throughout the latter years of New Labour and the over the Coalition government.

Privatisation has taken place in the NHS. Private organisations provided care on behalf of the NHS, rather than competing against it. This can be illustrated by the growing amount that the NHS spent on private providers (BMA 2016). Utilising the matrix provided above, it represents how the private sector increased its involvement in the provision of services, becoming a key provider in some areas of care (Shaeff and Allen 2016). The private sector also at times looked not only provide some aspects of care but to run whole services. Some cases, such as Hinchingsbrooke, were unsuccessful, but other companies continue to explore how they may be able to succeed (Shaeff and Allen 2016). It is during this most recent period of the NHS's existence that private providers have become more integral in the delivery of health services, becoming a mainstay on the provider side of the market, integral to the NHS.

Conclusion

In summary, the private health sector has always existed in some form or another alongside the NHS in England. It has been in a symbiotic relationship with the NHS, never managing to supplant it or even be a serious competitor, while at the same time becoming reliant on it for its continued survival. The size and growth of the private sector was very dependent on the policies of the Government of the day. In some periods the private sector supported the NHS in the delivery of services (i.e., reduction of waiting lists) while in others, its role was to provide an alternative to it.

The manifestation of private provision has altered throughout this period, dependent on the policies and priorities of the government of the day: ranging from a provider of private insurance to the provision of services such as private hospitals and other facilities. Overall, the private sector represents a relatively small part of the mixed economy of care that has emerged over the years. The recent focus on the commissioning of services could represent a policy shift which results in an increased role of the private sector in the NHS.

This chapter has also set out a matrix for tracking the degree of privatisation of any or all of the three components of a healthcare system. While privatisation can theoretically occur within any of the three categories, it is most likely to happen in the categories of either provision or funding of services. For Conservative Governments it can be said on the whole they thought it desirable that the NHS has at least some external competition and, to that end, it did introduce private providers who were able to compete with the service. In contrast, the Labour Governments generally saw the private sector as a complement to the health service and focused on its relationship to the public sector, i.e., contracts with private providers. However, there is some scope for privatisation to occur concerning regulation, as has been seen with the more recent example of Hinchingbrooke.

The next chapter will explore how the Health and Social Care Act (2012) has changed the nature of commissioning in the NHS and the how the regulatory framework has been created. This will include a discussion of the tools available to commissioners and how the various regulatory bodies may work alongside commissioners. It will also explore the manner in which different pressures may affect commissioners, and how this was researched during the fieldwork.

Chapter 3 – Implementing commissioning in the NHS

The Health and Social Care Act (2012) changed the manner in which healthcare commissioning took place in the English NHS. The majority of NHS services are now commissioned via the CCGs, meaning that primary care-led commissioning has once again become the chief method of commissioning within the NHS (Checkland *et al.*, 2013). Apart from introducing CCGs the Act has changed the legal framework of the NHS, granting new powers to existing regulatory bodies and creating new ones. The new framework is responsible for regulating providers and purchasers, for enforcing competition law and rules, and promoting the further integration of care (Health and Social Care Act 2012).

The purpose of this chapter is to gain a better understanding of the Health and Social Care Act (2012), with a particular focus on how the new commissioning groups shall reach decisions about the selection of providers, and the external regulatory framework that was developed alongside the new reforms. To further understand the new commissioning arrangements, this chapter will develop a conceptual framework that explores the broader socio-political context in which commissioners make decisions. The chapter will start with a definition of commissioning before exploring the shape commissioning and contracting has taken since it was first outlined in the White Paper, *Working for Patients* (UK Government *et al.*, 1990). Commissioning was first developed in UK healthcare in parallel with the first market-based reforms of the Conservative government in the late 1980s and was developed by further governments. Contracting mechanisms, as a separate process, will also be looked at in this chapter. The legal regulatory framework that developed as a result of the Health and Social Care Act (2012) will be analysed in the latter part of the chapter. This will all feed into a conceptual framework, with the aim of identifying the factors that influence commissioners' decision-making, with a particular focus on the selection of providers (private, public and third sector).

As detailed in the previous chapter, the Health and Social Care Act (2012) was enacted by the Coalition Government (2010-15) and was at once a significant and controversial piece of legislation (Timmins 2012, Greener *et al.*, 2014). In the Coalition agreement there was no provision for NHS reform and there had been a lack of coverage of the NHS in the 2010 General election (Greener *et al.*, 2014). However this quickly changed with the publication of the White Paper, *'Equity and Excellence: Liberating the NHS'* (Timmins 2012). This White Paper proved to be very controversial, even amongst some members of the ruling coalition (Timmins 2012). The White Paper in its original form proposed replacing the existing PCTs with primary care-led CCGs and large efficiency savings (BMA 2010, Ham *et al.*, 2015). The White Paper also allowed for competition based on price and the entry of 'Any Willing Provider' into the bidding process, which critics feared would open the NHS to private providers (Ham *et al.*, 2015). Some of these clauses were altered after a prolonged and unprecedented listening exercise, the ultimate result of which was a softening of the role of the private sector, competition on price and the changing of the legislation to 'Any Qualified Provider' (Ham 2013). The Health and Social Care

Act (2012) was thus passed in Parliament and in its final form retained some of the core elements of the White Paper, i.e. GP-led CCGs and the new regulatory framework - though as mentioned, it now included a diluted role of marketisation and a more limited role for private providers (Greener *et al.*, 2014). On the whole, these reforms suggested a shift in commissioning policy, moving away from relatively large-scale commissioning and moving back towards primary care-led commissioning. Some have argued that the new CCGs resembled smaller versions of the PCTs that they were replacing, with other similarities to GPFH (Greener *et al.*, 2014). Primary care-led commissioning is not a new concept, having been introduced previously under the Conservative Government (1992-97), with the development of GPFH (Checkland *et al.*, 2016). While New Labour abolished GPFH, they continued many of the principles of it in their reforms (Greener *et al.*, 2014). The concept of primary care-led commissioning has been developed with all subsequent commissioning reforms involving primary care physicians.

A brief history of commissioning in healthcare

To understand the possible implications of the new Act on commissioners' decision-making, it is important to define what commissioning is and examine how previous reforms have laid the basis for the Health and Social Care Act (2012).

Commissioning in the NHS has been defined as a process in which: *"an organisation, and/or a group of clinicians, acts on behalf of a population to decide which health services to buy, using tax funds allocated by the Department of Health according to a formula based on health needs. It entails decision-making about needs assessment, resource allocation, service purchasing, monitoring, and review."* (Smith *et al.*, 2010, 12). At the very core of commissioning is the allocation of available resources.

This section will focus on the literature concerning commissioning and contracting. While commissioning in the NHS is a relatively new phenomenon, elements of it have existed in some form since the inception of the service in 1948. It was only in the early 1980s, with the Conservative Government's market reforms, that commissioning and contracting came to prominence (Cairney 2002). Therefore, it can be said that the concept of commissioning is not new to clinicians but that more recent developments have shifted the onus of resource allocation onto a mixed group of managers and medical professionals (Health and Social Care Act 2012). There will be an examination of the key policy developments in the NHS in the context of commissioning and a discussion of how they have shaped the delivery of care.

Forms of commissioning

As already stated, commissioning is the manner in which resources are allocated and includes the purchasing of services (Smith *et al.*, 2010). In this section, the

different forms of commissioning will be explored, as well as the mechanisms that introduced contracting, the vehicle through which commissioning takes place.

In the early years of the NHS, during the tripartite (Hospital services, community services and primary care) split, decisions as to the allocation of resources were made by the clinical staff, and the list of potential service providers included few private sector organisations (Powell and Hewitt 1998). Commissioning was implicit in the allocation of financial resources and did not include large numbers of private for-profit providers (Turner and Powell, 2016). There was no formal divide between the providers and purchasers of health care and the NHS functioned in what has been termed a 'command and control' manner, wholly funded by the State and with the dominant role given to the medical profession, and supported by a post-war public commitment of both major political parties (Webster 2002). Funds were allocated as and when they were needed, with little political oversight of central government. Over the period of Conservative government (1979-1997) the resource allocation process became more formalised, and this was reflected in a wide variety of reforms. This most notable of these early reforms was the introduction of NPM (new public management) principles in the Griffiths Report (Macfarlane *et al.*, 2012) and the adoption of the quasi-market, which brought with it a formal division of purchasers and providers of health services in the NHS (Propper *et al.*, 2008). These reforms also increased the importance of GPs who became the first primary care commissioners through the introduction of GPFH schemes, as purchasers within this new model. As such, this was the first piece of legislation to introduce commissioning as an explicit manner of resource allocation; and therefore the logical starting point for a detailed examination of the shaping of commissioning over time.

Making commissioning explicit - the NHS Quasi-Market

To understand the quasi-market and its significance in British health policy, it needs to be clearly defined. There are several competing definitions of what constitutes the quasi-market in the literature. In social policy during the 1990s, the quasi-market was discussed alongside other similar forms of organisation, which sought to replicate the market within the public sector, attempting to incentivise improvements in efficiency (Mays *et al.*, 2011).

In the words of Le Grand: *"the intention is for the state to stop being both the funder and the provider of services. Instead, it is to become primarily a funder, purchasing services from a variety of private, voluntary and public providers, all operating in competition with one another."* (Le Grand 1991, p 10). The primary method by which this would occur would be contracting, allowing the NHS to purchase services and enter into arrangements with the providers which offered the best possible terms (Flynn *et al.*, 1995). The primary goal is to replicate the efficiencies of the market to introduce competition between public sector providers and thus increase efficiency (Mays *et al.*, 2011). One of its purposes was to alter service delivery in the NHS, from a hierarchical organisation to one dominated by market principles (Allen 2013).

At the initial stage of the introduction of the quasi-market, the Conservative Government was inspired by the work of Enthoven, who spoke of 'perverse constraints' within the NHS that limited its efficiency (Enthoven 1985, Macfarlane *et al.*, 2012). The suggested remedy for the public sector, in which there was little incentive to change, was mimicking the workings of a market which by itself was to reform and modernise the NHS.

One of the earliest analyses of the quasi-market was carried out by Le Grand (1991) who also examined other public services (education and welfare). Consequently, Le Grand and Bartlett (1993) defined a quasi-market as a mechanism for breaking the monopoly of the state, by introducing competition through the adoption of new rules allowing existing providers to compete with one another; and therefore mimicking the incentives that can be found in a 'normal' market. Fundamentally, quasi-markets aim to replicate the market and competition without resorting to the introduction of private providers.

A different definition is presented by Harden (1992). He argues that for a true quasi-market to exist it has to have three distinguishing characteristics. The first is that the quasi-market creates incentives that lead to greater efficiency within the service in question. The second is that the organisation has to decentralise by delegating authority. And lastly he argues that the distribution of the financial resources must be led by demand as expressed by the needs of the patients/users of the service.

Boyett and Finlay (1995) defined the quasi-market as one in which the state has a reduced role and no longer acted as the funder and provider. Similar to Le Grand, they agree that the quasi-market is one for public services only and not a truly open market. Boyett and Finlay (1995) however, do not envisage private providers having an integral role in this process.

Walsh (1995) put forth another definition in which three key features confirm the existence of a quasi-market; separation between the 'purchaser' and the 'provider'; contracts that link these two distinct bodies; and finally the development of a system of accounting and charging. In such a system, once it matures, providers would generate their funds which they would be mandated to reinvest into the service.

The Le Grand and Bartlett (1993) definition of a quasi-market is precise and is applicable in the context of the NHS as it refers to both of the essential elements: the provision of, and the funding of, services. A fundamental concept of quasi-markets is that there must be a divide between the State and the public service whilst remaining the critical provider at least at the level of funding. Their only connection will be through contracts, which themselves are arranged in a system which becomes increasingly decentralised as it matures. This implies that competition is a key component of a quasi-market (Powell 2003).

Competition, as a motive and market mechanism, has been analysed in social policy, and its effectiveness has been questioned (Pollock *et al.*, 2004, Greener *et al.*, 2014). It has often been argued that the introduction of competition can herald the start of an actual privatisation process (Hunter 2005). However, the purported benefit of the market is to provide patients with greater choice in their treatments, as a result of the competition generated by a greater number of suppliers (Powell 2003). In the case of the NHS, the quasi-market has increased the level of competition, i.e. the number of eligible providers. Such a process does not represent direct privatisation, but it can herald a change which would see the greater use of private providers within a health system.

Whilst there may be the impression that the quasi-market is relatively new to the NHS and other public services (Le Grand 1991), its origins can be traced back to the interwar period (Powell 2003). The role of the quasi-market was weakest in the years of the classic NHS during the post-War consensus regarding the Health Service (Powell 2003). Its role was then strengthened, as Powell highlights, during New Labour's second term (2001-05) when it became "harder, direct and external" (Powell 2003, p737). Further moves to increase competition would take place during this period to entrench the system (Greener *et al.*, 2014). This would suggest that competition and choice as concepts have been associated with markets for a longer period. Le Grand (2013) argues that this is a process which represents "*evolution, not revolution*" in which competition and choice have been expanding as concepts as a result of the policy of the New Labour Government (1997-2010) which the Coalition Government only built upon and expanded further.

On the question of the effectiveness of a quasi-market as an organisational tool, literature seems to be divided and describes them as being only partially successful. Those that are critical of the introduction of quasi-markets, claiming they have an adverse effect point to research showing that the quality of care has not improved, indeed quite the opposite (Propper *et al.*, 2008). Others argue that the link between competition and improved outcomes is weak (Greener *et al.*, 2014). However, Le Grand (1999) is more favourable to the idea of quasi-markets and he argues that the problem is with their application. As one of the first to evaluate the effects of the market during the Conservative Administration (1987-1997), he argues that: "*The incentives were too weak and the constraints were too strong. Put another way, the motivations for change were relatively weak, especially when compared with the pressures for stability from the outside*" (Le Grand 1999). This implies that the quasi-market in the NHS in its early form was less effective than anticipated in the delivery of its stated aims, with competition not leading to an improvement in care.

What the quasi-market managed to achieve was to involve primary-care commissioners in the allocation of resources. The role of GPs grew in importance as they became more involved through the GPFH scheme which gave them more power as local decision makers (Glennerster 1998, Wainwright and Calnan 2012). Effective GP commissioners also became relatively dynamic compared to many other colleagues, able to affect budgets and care outcomes (Wainwright and Calnan

2012). The increased role of GPs fit neatly within the agenda of the quasi-market as it encouraged further competition amongst providers and delegated decision making to a more local level. This will be explored in the subsequent sections.

There are still others who argue there has been a mixture of different governing structures, but that they did not occur in isolation. Instead, they state there is a "*changing mix between quasi-hierarchies, quasi-markets, and quasi-networks.*" (Exworthy *et al.*, 1999, 15). Le Grand (1999) claims that whilst markets have only had limited effect on improving the core elements of the NHS, they have shifted the nature of discourse about the service, putting a greater emphasis on competition rather than the 'command and control' ethos that used to exist. So it can be said that competition and choice as concepts have a minor effect on the system. The more significant consequence of the introduction of quasi-markets, supported by all Governments since the 1990s, is the apparent growing acceptance of market approaches within public services, even though implementation has not been as widespread. The most significant change to the NHS with the introduction of the quasi-market is that it led to the introduction of contracting and with it a formalisation of the new divisions of the service, purchasers, and providers.

Quasi-market as an organisational tool

It can be argued that quasi-markets represent a step towards greater use of market-like initiatives in healthcare by developing the role of both choice and competition in British healthcare. While this is not true privatisation, it has resulted in more choice and thus it can be argued that the introduction of competition could be a stepping stone towards a more market-based or even a full market system. There is evidence that the quasi-markets have increased choice and competition in practice (Le Grand 1998), and that the role of the private sector is now greater than in any previous period in the history of the NHS (though not to the extent desired by those who originally proposed inserting the quasi-market into the NHS) (Biro and Hellowell 2016). This is an ongoing process which in its later incarnations increased the involvement of private and third sector providers in the NHS, primarily through the introduction of commissioning and contracting.

The development of the internal market also managed to achieve a greater use of primary care-led commissioners. The primary form that this took was the involvement of GPs as commissioners. Primary care commissioning aimed to allow local doctors to purchase the services that best suited the needs of their local populations, while also developing an accountability framework where local people can scrutinise the decisions of these clinicians (Smith *et al.*, 2004). Primary care doctors were seen as the ideal agents to challenge the dominance of the hospital doctors and to provide a voice for care in the community as an alternative to hospital settings (Ibid 2004). GPFH was the first such scheme to utilise these principles, and its effects will be explored in the following section. This form of commissioning further entrenched the ideas of competition, but also linked the

commissioning of services to geographical areas and started involving choice in decision making.

Primary Care-Led Commissioning

GP Fundholding and Total Purchasing Pilots

One of the outcomes of the creation of the quasi-market was the increased importance of primary care-led commissioners (Miller *et al.*, 2012). GPs became key purchasers, or commissioners, of healthcare within the internal market. The purpose of these was to allow local GPs to volunteer to purchase non-elective elective, and community care, with generated savings being made available to GPs to re-invest into local services (Mannion 2011). The local knowledge of GPs would allow for services to be somewhat tailored towards the local populations. The role of primary care-led commissioning would be a key element of health policy reforms over the subsequent 20 years, with all new forms of commissioning involving or being led by primary care physicians. The first manifestation of this was small scale GP fundholding (GPFH) in which GPs commissioned small contracts for the local community (Ibid 2012). In 1992, GP Fundholding schemes were further developed in order to begin commission services. The GPFH was voluntary and GPs did not have to take part. This increased role of GPs in the quasi-market was based on a belief, which is further embedded in practice; that local GPs were in the best position to select the providers to meet local demands and empower local patients (Harrison and McDonald 2008). This combination of an awareness of local needs and medical knowledge was seen as an effective solution to the perceived problem of resource allocation across the NHS.

The purpose of the GPFH schemes was to improve the way in which resources were allocated for their local populations (Glennister 1998). In addition to improving the quality of care, they were intended to assist in generating savings, as the GPs were meant to be able to purchase only those services which were necessary and reduce excess expenditure. Although they did fit in with the narrative and desire to devolve power from the central authority and involve local decision-makers in commissioning, the government did not commission any studies to measure the impact of the reforms (Coulter 1995).

The GPFH scheme did achieve some success. Namely, the majority of GPFHs managed to generate yearly savings. Initially, GP Fundholding was a voluntary scheme and it proved popular, growing year on year as it gave GPs greater autonomy (Ham 2009). The government attempted to expand the scheme further to cover larger districts (further expanding primary care-led commissioning) in the belief that that would maximise savings as evidenced by the pilot (Jones 1993).

As the GPFH schemes began to become more common, they managed to reduce the number of referrals to hospitals for particular kinds of procedures (predominantly electives), as well as reduce waiting times for some types of care

(Propper *et al.*, 2002). Most evidence suggests that GPFHs were most successful in developing local services. They were effective in community and primary care, areas where traditionally GPs had the most expertise (Miller *et al.*, 2012). Some of the services included dermatology, ophthalmology, and urology (Ibid 2012). There is also evidence to suggest that GPFHs 'learned while doing', utilising their new powers to ensure that they gained adequate data from local providers through the use of contractual mechanisms (Ibid 2012). In short, the ability of GPs to commission led to increased development of provision on a micro-level, in areas where the commissioners had experience. Further improvement of services was thwarted by local Health Authorities (Ibid 2012).

The fact that GPFH was voluntary meant that not all GPs engaged with the process. Amongst those who did engage, the scheme was very popular (Coulter 1995, Miller *et al.*, 2012). Under the GPFH arrangements, GPs had a high level of autonomy due to having control over their budgets. This enabled them to develop services they had the most experience of, and this in turn ensured that there was engagement from GPs (Coulter 1995).

While the scheme managed to achieve some successes compared to its initial objectives there were also issues with the GPFH schemes (Petchey 1995). One was the accusation that the schemes were creating a two-tier NHS, in which better care was afforded to populations in areas where GPs were a member of a scheme (Dixon and Glennerster 1995). In many cases the schemes did manage to generate savings, but these were offset by increases in administration costs (Dixon and Glennerster 1995, Le Grand 1998). The GPFHs also focused on the areas of care which they knew best, and only moved on to commission other areas of care after they had gained additional knowledge of the commissioning process (Miller *et al.*, 2012). The use of GPFH helped to highlight how GPs could affect the development of services, but at this point it was unclear whether or not the benefits locally could be transferred to a larger population.

The Conservative Government (1992-1997) were keen to further develop primary care-led commissioning. This took place with the development of the Total Purchasing Pilots (TPPs) which began operating in 1994. These schemes aimed to allow, indeed relied upon, any GPFH to volunteer in order to purchase all community and hospital services in their area (Miller *et al.*, 2012). Some GPs were very willing to participate in the programme. While the TPPs had the power to purchase all services, very few exercised this right. Rather, they worked in areas where they had experience (Miller *et al.*, 2012). This extension of the GPFH has been argued to be "selective purchasing" (Miller *et al.*, 2012, p 4), as GPs restricted themselves to those areas they were comfortable in, giving back commissioning responsibilities for areas in which they lacked experience. These programmes represent the first full attempt at delegating all commissioning responsibility to GPs. The TPP scheme was successful in some areas, with some evidence of the TPPs being able to reduce hospital admissions (Smith *et al.*, 2004). While most TPPs did struggle to affect changes in secondary care, they were successful in developing primary care services (Smith *et al.*, 2004). These successes were achieved in areas

such as mental health, maternity services and community care (Miller *et al.*, 2012). This was achieved through the commissioning of additional local services and changing the services of providers, which fit within their stated objectives (Ibid 2012).

The GPFH system was not without some flaws. There was a lack of coordination with other purchasers in the system. GPFHs were able to generate their savings due to their relatively small size. This allowed them to change providers without any risk of destabilising large local providers (Le Grand 1999). There was no change in the number of elective procedures that GPFHs referred compared to non-Fundholding colleagues, which again underlined the limited effectiveness of the scheme (Ibid 1999). The reforms also incurred additional costs of the holding and management of new contracts, and the greater time that commissioners had to dedicate to them (Greener and Mannion 2006).

The TPPs also demonstrated that even if a commissioning organisation is scaled up, it does not always represent an increase in efficiency. As the TPPs were larger organisations than the GPFHs, they encountered costs when attempting to engage GPs (Howie *et al.*, 1998). Additional resources were spent on attempting to encourage local GPs to become involved in the commissioning process. These doctors were not always easily convinced of the advantages of becoming involved in commissioning (Howie *et al.*, 1998). There is a lack of evidence to suggest that the additional GPs were 'worth' the investment, but most evidence highlights that the greater the involvement from GPs there were greater service improvements (Miller *et al.*, 2012).

In the context of the balance between privatisation and marketisation, the GP Fundholding scheme proved to be closer to the latter. It assisted in the promotion of competition in the NHS, primarily through the devolution of budgets from large centrally controlled institutions to smaller local organisations. Similarly, it brought with it elements of private sector-type management, with its focus on achieving savings. This, it is claimed, is not typical of the public sector in general.

The GPFH scheme's significant impact on commissioning was that of involving clinicians in the resource allocation process (primarily to meet local demands). It demonstrated their ability to affect elements of primary care provision, especially areas such as minor surgery, dermatology, ophthalmology and urology. Commissioners further demonstrated that they could affect services if they are engaged with the system and given the autonomy to do so. The scheme advanced competition in the NHS as it was accompanied by greater use of private and third sector providers (which led to accusations of a two-tier NHS). Under the GP Fundholding scheme, 'choice' was also advanced as one of the leading principles of reform of the NHS. However, on the available evidence it only resulted in modest improvement in its primary aim of shortening the waiting times for patients (Williams *et al.*, 1997). On the other hand, the scheme laid the basis for primary care commissioning processes to cover larger geographical areas in future

incarnations, as well as involving greater numbers of commissioners (Smith *et al.*, 2004).

During the brief period of its existence, GPFH and TPPs did not introduce any new actors to the NHS involved GPs in the commissioning process. It also further developed the role of competition in the delivery of care. The schemes were partially successful as they linked clinical decision-making to purchasing of services with the aim of meeting local demand. Commissioners did use their local expertise to deliver improved services in their areas. However, their ability to affect care outside of these relatively small areas was limited. In conclusion, some evidence that the GPFHs brought benefits to some areas of commissioning, there was no rigorous Government sponsored evaluation of the scheme (Dixon and Glennerster 1995, Klein 1999, Le Grand *et al.*, 1998, Petchey 1995, Propper *et al.*, 2002). It is important to note that participating GPs were faced with a number of limitations which restricted the use of the tools at their disposal. There were supply side issues with a limited number of non-state providers, and their ability to affect other local hospitals was limited so the GPs focused only on services with which they had prior experience, hesitant to get involved in services with which they were not comfortable (Dixon and Glennerster 1995). Importantly though, it was the first policy development which gave GPs a key role in the selection of providers, a process they would be involved in over the course of the next 20 years.

Primary Care Groups and Primary Care Trusts (PCTs)

After its election victory in 1997, Labour discontinued the GPFH scheme, arguing that it was creating a two-tier health system (Le Grand *et al.*, 1998). However, in its reform programme Labour introduced Primary Care Groups (PCGs), which were similar but they commissioned services over larger geographical areas than the GPFH schemes. This allowed the new government to claim that they had discarded previous reforms while introducing their own, however it has been argued that the new PCGs allowed Labour to: "*universalise Fundholding while repudiating the concept*" (Klein 1999). Within the new PCGs, the lead role of GPs remained. But these new bodies were larger, had more responsibility, even if the budget was held on behalf of the local Health Authority. Labour claimed to have removed the two-tier NHS whilst at the same time increasing the responsibility of primary care-led commissioners, who became an integral element of the new reforms. Vital elements of the internal market, such as the purchaser/provider distinction were retained, and arguably the PCGs built on previous policy (Klein 1991, Bevan and Skellern 2011). The new organisations retained elements of primary care-led commissioning, with clinicians maintaining an important role in the selection of providers, and they even drew on the lessons of the GPFH and TPP schemes (Miller *et al.*, 2012). By 2001 the PCGs had been merged and transformed into PCTs. The distinction between GPFH and the PCTs were the size and scale of the commissioning arrangements, and the role of clinicians within the groups, with PCTs being viewed as a scaled up version of GPFH (Klein 2010).

The PCGs were established by the first New Labour Government (1997-2001) in an attempt to prevent the development of a two-tier NHS. The Primary Care Groups were given responsibility for larger geographical areas than the GPFH schemes were, whilst maintaining the crucial role of GPs, ensuring that primary care doctors still shaped the selection of providers (Le Grand 1999). One key difference between PCGs and, previous arrangements was that all GPs were members of PCGs, rather than being able to opt-in (Ibid 1999). At the same time, the new PCGs were intended to address the weaknesses of the GPFH scheme; being too small to tackle prescribing and elective procedures; possessing modest budgets, which allowed Trusts to see them as peripheral commissioners; and not being universal across the country (Le Grand 1999). PCGs created a universalised commissioning system in which all patients were now covered and services were commissioned by primary care physicians (Turner and Powell 2016). The PCGs were structured in such a way that the commissioning decisions were taken by the Boards in which the majority of the membership were GPs, with the Chair always being a GP (Harrison and Ahmad 2000). On the other hand, there was concern that the PCGs were, in reality, less autonomous than their predecessors, as there was a much more formal accountability structure where they were directly accountable to local Health Authorities (Ibid 2000). While many GPs were happy to be involved in commissioning, they viewed the development of PCGs as encroaching on their autonomy and ability to reach decisions, especially when compared to the autonomy that they possessed under GPFH (Miller *et al.*, 2012).

Initially, the fact that the PCGs had a GP Chair meant that there was a high level of clinician involvement in decision-making processes. Similarly, to the TPPs the PCGs focused on their local areas, mostly working on primary care services (Miller *et al.*, 2012). They were also able to affect prescribing costs (Ibid 2012). However, many PCGs were restricted by their Health Authorities which did not always want to devolve power and their budgets (Smith *et al.*, 2000). While GPs were the key decision makers within PCGs, from this point there was a general decrease in the involvement of commissioners within PCGs.

After an initial implementation of PCGs, there were discussions in Government to increase further the size of commissioning bodies, as the average size of 100,000 patients was not viewed as optimal (Bojke *et al.*, 2001). PCGs were rapidly grouped and merged into 303 larger PCTs which were to become the cornerstone of the New Labour reforms of the NHS. The average patient size nearly tripled to 284,000 (Naylor 2012). The PCTs were to be given the responsibility of over 80% of the commissioning budget to secure the provision of primary and secondary care (Robinson 2004). PCTs were also given their own budgets, and were not subject to oversight from Health Authorities, having full control over their budgets. Finally, they were to interact directly with providers, and they would have the responsibility of managing contracts.

Crucially, the move from the PCGs to PCTs also represented a low point in the engagement of GPs in commissioning (Miller *et al.*, 2012). Under PCGs the Chair of

the key board of each body was a GP. This allowed them to exert influence over commissioning, even if this represented the power of individual commissioners rather than a group. PCT leadership structures limited the power of GPs by involving nurses and a greater number of managers in the executive boards. There were direct steps to curb the power of GPs, and to reduce their role in the commissioning process (Bate *et al.*, 2007). In part this came from the view that PCGs had been dominated by GP commissioners (Smith *et al.*, 2000). As a result, the commissioning process during this period became controlled by the managers within these organisations and, the decision making ability of the GP commissioners decreased (Ibid 2007).

The overall aim of these PCTs was to: “*be powerful agents for change in a more devolved, clinically driven, and locally responsive NHS*” (Smith *et al.*, 2004). As the core element of New Labour's reforms throughout the early 2000s, the PCTs were given full control over their budgets and the power to commission primary and secondary care for their local areas, meaning that there was not oversight from local Health Authorities (Smith *et al.*, 2004). However, their autonomy remained somewhat limited as overall control of commissioning remained with the Department of Health. This highlights the contradictory push and pull of health policy, with moves to increase the autonomy of commissioners while also ensuring that central control remained strong (Mohan 2009). There was a crucial difference with the PCTs compared to earlier primary care-led commissioning, that commissioners now had the power to commission private providers, as well as public and third sector providers (Harrison and McDonald 2008). These new rules led to an expansion of private provision in the NHS, encouraged by government policy, as typified by the usage of private providers to assist in lowering waiting times. In 2004 the number of PCTs was halved, as a number of the new commissioning bodies failed to achieve their aims with mergers taking place as a result (Robinson 2004). Being in size similar to the Health Authorities they indirectly replaced, PCTs did not possess the flexibility to respond directly to the needs of their populations. This occurred primarily because the PCTs had to be large enough to consolidate risk, reducing the liability of the organisation in cases where there were financial issues, but as a result their size meant that they could not react as well to local needs and pressures, something that effective GPFHs had achieved (Ibid 2004). Despite this perceived flaw of the PCTs, there was insufficient evidence to support changing their size (Goodwin 2007). An outline of the various essential elements of legislation can be seen in the text box below.

Key Legislation under New Labour (1997-2010)

- **1997** - *The New NHS: Modern, Dependable*: The White Paper maintained the internal market, but abolished the GP Fundholding Scheme and planned to establish new Primary Care Groups (PCGs)
- **1999** – *Saving Lives: Our Healthier Nation*: The White Paper established the PCGs and outlined how they would become Primary Care Trusts (1999). This included the responsibility for public health to be given to these new bodies.
- **2000** - *The NHS Plan*: The Act was a ten-year plan for the NHS. It included commitments to sustained budget increases as well as, to create new hospitals, using PFI schemes. The ‘concordat’ between the NHS and private providers was also signed, where excess patients would be treated in private hospitals. It also laid out plans for the creation of Independent Sector Treatment Centres (ISTCs).
- **2001** – *The Health and Social Care Act*: Formalises *The NHS Plan*.
- **2002** – *Shifting the balance of power within the NHS: Securing delivery*: Secured the evolution of PCGs into PCTs and the abolition of Health Authorities, which are replaced by Strategic Health Authorities.
- **2002** – *The NHS Reform and Health Care Professionals Act*: This confirmed and enacted the recommendations of the *Shifting the balance of power* White Paper. It also involved the rating of hospitals.
- **2003** – *The Health and Social Care (Community Health and Standards) Act*: This Act created NHS Foundation Trusts, semi-autonomous organisations with the freedom to work with the private sector in the delivery of care.
- **2004** – *Practice-based commissioning: Engaging practices in commissioning*: The Government provides GPs and other primary care practitioners the ability to purchase services for their local areas, working in tandem with PCTs, this is named Practice Based Commissioning (PBC).
- **2005** – *Commissioning a patient-led NHS*: The rollout of PBC is accelerated, with all PCTs told to have PBC by the end of 2006. PCTs and SHAs were also given instructions to support PBC and contract management.
- **2006** – *Changes to Primary Care Trusts: Government response to the Health Committee’s report on changes to PCTs*: The total number of PCTs declines as many merge to generate additional savings, reducing the link between local areas and the PCTs.
- **2009** – *Care Quality Commission*: The Care Quality Commission (CQC) is established to act as the regulator for all health and social care organisations.

Figure 2 - Key legislation under New Labour (1997-2010)

The PCTs were introduced and operated during a period in which the NHS budget was being increased continuously at a greater rate (4%) than at any other point in its history (Bevan and Skellern 2011, Darzi 2007, Mohan 2009, Stevens 2004). Thus, it is not straightforward to assess whether the increase in funding or the organisational changes were responsible for the relative success of the NHS during the late 2000s - waiting times were cut, patient satisfaction remained high but significantly the service had a greater number of private providers (Klein 2010, Smith *et al.*, 2010). PCTs continued to work in areas in which previous primary care-led commissioning had achieved success, such as community care (Smith *et al.*, 2010). There is some consensus that the increase of non-public providers helped the NHS reach its targets and attain specific improvements despite already being in a state of constant reform. This expansion of private providers was possible due to

the ability of the PCTs to engage private providers through new legislation (Miller *et al.*, 2012).

These developments in commissioning arrangements encouraged the further use of private providers in the NHS. The key driver for this expansion was the development of the Concordat, as mentioned in the previous chapter. Under this arrangement, the NHS and the private sector would focus on cooperating rather than on competing against one another (Turner and Powell 2016). In the political arena, this was explained as a creation of a partnership between public and private sectors, rather than privatisation of the service (Perkins *et al.*, 2010). The onus of this new policy was placed on the PCTs as the bodies responsible for the commissioning of services. The PCTs relied on clinical commissioning, further entrenching the usage of primary care-led commissioning as part of the internal market.

In a bid to develop what were perceived of the advantages of GPFH, and the lack of GP engagement in PCTs, the New Labour government developed Practice Based Commissioning (PBC). Introduced in 2004, PBC represented a further evolution of primary care-led commissioning, with clinicians holding indicative budgets for the commissioning of services (Miller *et al.*, 2012). Similar to the GPFH arrangement, GP's engagement was voluntary, and the commissioners had freedom with developing their own internal decision making structures (Checkland *et al.*, 2009). While technically operating as a subcommittee of the PCTs, the PBC scheme aimed to enable GPs to continue to purchase local services but with additional oversight, and administrative support (Checkland *et al.*, 2009). It represented the continued development of the usage of local GPs as commissioners in the belief that they were best suited in selecting providers and understanding the needs of patients (Miller *et al.*, 2012). While PBC commissioning represented a small percentage of total commissioning, as the scheme was initially voluntary, it further enabled commissioners to refer patients to a private sector service provider (ibid 2012). Any savings which were generated would be kept in the local area and reinvested into new services (Checkland *et al.*, 2009). These new commissioning arrangements were successful in holding local providers to account over the amount they charged and, in the providing impetus for other developments in their local health economies (Coleman *et al.*, 2009)

The ability of PBC commissioners to affect larger change was limited. The ability of PBC arrangements to be successful depended on the relationship between the commissioning group and the PCT that they belonged too (Miller *et al.*, 2012). In cases in which there was a good relationship, in which the PCT leadership trusted the PBC group, there was evidence of success, with clinical commissioners being able to affect activity levels (Ibid 2012). However, in some cases the poor working relationships meant that clinical commissioners did not feel that they were able to work to their fullest abilities.

In summary, the primary care-led commissioning arrangements in the NHS have been subject to near constant reform since the introduction of the quasi-market by

the Conservative Government (1987-91). In its early years, the quasi-market introduced the split between purchasers and providers, which further developed primary care-led commissioning in the form of GPFH schemes. This established the principle of clinicians being responsible for commissioning to meet local demands, in which it was thought best that they had a level of autonomy. The GPFH scheme enabled GPs to change the commissioning of many primary care services, being able to focus on those services which were not the sole responsibility of hospitals (Miller *et al.*, 2012). This was further compounded by GPFHs being unable to shape other elements of care due to the oversight of Health Authorities and the Department of Health. The ability of the GPs to affect local services was partial due to not having full control of their budgets and the ability to engage other GPs in the work. One clear drawback of the process was the inability of commissioners to affect certain providers and their limited scope. They were limited by the scale of their ability to commission and by other commissioning bodies within the broader framework (Health Authorities). Under subsequent arrangements, including both PCGs and PCTs, the ability of GPs to affect commissioning continued to be limited. While GP Commissioners did achieve some changes in the provisioning of services. Under PBC arrangements there were further developments as GPs became more involved in the commissioning process.

The effectiveness of commissioners to change the provision of services depended on the autonomy that they had from strict oversight. Under GPFH, commissioners were able to exercise a large amount of autonomy within a limited space. As their budgets were limited, GPs focused primarily on the areas of care they knew best. In this sense, when free to develop services with little oversight, many commissioners were more engaged, learnt more, and were more effective at changing services (Miller *et al.*, 2012). Under subsequent reforms, the autonomy of GPs to act decreased, and with that their effectiveness. With the development of the PCGs and PCTs, the power of GP commissioners was deliberately curbed by managers. It is under these arrangements that primary care led-commissioning was least effective on a local level. GPs could not really affect primary care as they were not as powerful as the PCT boards. This was remedied under PBC arrangements to some degree, with GPs again being given the power to commission, however the ability of those consortia to function was severely limited by the relationship with the PCT. The evidence from previous primary care-led commissioning suggests that GPs are at their most effective when they are given autonomy, a clear mandate and, the ability to influence secondary care (Miller *et al.*, 2012). They can be affected by a variety of different pressures or other actors who may impinge on them as has been the case under previous arrangements.

Primary care-led commissioning has been one key vehicle for the selection of services in the NHS since 1992. The Health and Social Care Act (2012) theoretically provides GP commissioners with more freedom to select providers, compared to previous commissioning arrangements. To be able to understand how these commissioners may be affected, there needs to be a clear delineation of the structures which may affect the autonomy of commissioners to use their new powers. Thus, the next section of this chapter will explore the new policy

framework which has been developed. The Act did not create an entirely new framework, but instead developed many existing bodies, giving them more considerable oversight over the NHS and new powers to enforce rules. There was also the development of some key new regulators, such as NHS England, which have their agendas and power to act differently to some other regulators. This will be explored in the following section.

Health and Social Care Act (2012): The development of a new external regulatory framework

This section explores the regulatory framework that has been developed by the Health and Social Care Act (2012). It will further explore the potential impact of the regulatory framework on the decision-making of clinical commissioners and will outline a conceptual framework for analysing the influences which may affect clinical commissioners. The aim is to understand how commissioners select providers and if they will be able to utilise the powers given to them by the Health and Social Care Act (2012). The question put forth is whether the commissioners will have the freedom to utilise all the tools the new Act granted them and what influences may restrict their ability to select providers.

The Act has not radically altered the bodies that regulate commissioning in the NHS. Instead, the Act has empowered existing regulatory bodies whilst removing direct control of the NHS from the Department of Health (Timmins 2012). The regulatory framework has the potential to have more influence on the choices of commissioners in the selection of providers, and the way in which they can achieve this will be explored in this section.

This chapter will discuss the role of key organisations that comprise the external policy framework, such as, Monitor (now part of NHS Improvement), the Care Quality Commission (CQC), Office of Fair Trading, Competition and Markets Authority (CMA), NHS England (NHSE), as well as, the relationship of the new reforms with previous policy.

Monitor

The first part of the external policy framework that will be examined is the sector regulator for health, Monitor. With the introduction of the Act (2012), Monitor's role was expanded to oversee the commissioning process and the restrictions placed on CCGs. Previously the role of Monitor was to operate as a watchdog, maintaining the marketplace in health (Paton 2007).

Monitor, which has recently been incorporated into NHS Improvement (NHS Improvement 2017), has the following responsibilities as outlined in the Health and Social Care Act:

"1) The main duty of Monitor in exercising its functions is to protect and promote the interests of people who use health care services by promoting the provision of health care services which— (a) is economic, efficient and effective, and (b) maintains or improves the quality of the services." (Health and Social Care Act 2012).

Monitor ensures that health service providers are adequately licenced under the terms of the Care Quality Commission (CQC), as well as to regulating NHS mergers and finally determine what constitutes 'value for money' (Health and Social Care Act 2012). The objective of Monitor ensures that there is competition and choice within the healthcare market. There is very little interference from the Secretary of State for Health, who only issues guidance to Monitor on specific issues and can only override it in the event of a critical failure (Ibid 2012).

Monitor and choice and competition in the health service

- Monitor has a duty to enforce the Competition Act (1998), this entails overseeing mergers between NHS organisations and operating as the arbiter in NHS cases rather than the CMA.
- It also has a duty to ensure that NHS organisations abide by the Enterprise Act (2002).
- The NHS is now subject to EU procurement law, meaning any contract of over £100,000 needs to go through a legal process (Baeten and Hervey *et al.*, 2010)
- This has manifested itself through the blocking of mergers in the name of patient choice (Health Services Journal 2013)
- These decisions are made alongside the Competitions and Markets Authority and the Office for Fair Trading – which further reflects the opening of the health service to competitions laws, which has not been the case previously.

Figure 3 - Monitor and choice and competition in the health service

The original intention of the Act was to promote competition and thereby increase patient choice, and the possibility of NHS Trusts merging was seen as a contradiction of that same goal. Hence the Act gave Monitor the power to restrict the conditions under which mergers were possible (Poole NHS 2013). The actions of Monitor in preventing mergers was supported by the OFT and the then Health Secretary, Jeremy Hunt (Ibid 2013). As the ultimate arbiter of whether mergers are allowed or not, Monitor can significantly influence the number of providers in any particular area, which would also affect the commissioners. The actions of the external framework could also affect the way in which commissioners interact with their local NHS providers, as has already been discovered under previous NHS reforms (Harrison and Lim 2000).

Monitor also oversees the work of the new CCGs. Section 75 of the Health and Social Care Act (2012) stipulates that Monitor has the power to investigate decisions made by CCG commissioners in the case of complaints made by a provider that any process has not been handled according to the new guidelines

(Health and Social Care Act 2012). This arrangement provides a formal process by which a provider (i.e., private companies that may have unsuccessfully competed for a contract) can challenge the outcomes of any procurement process through a lengthy and costly legal process. This is the first instance in which private providers have directly gained the right to challenge decisions reached by the purchasers. Most evidence would suggest that legal challenges have taken place, but that they are still the exception rather than the rule (Ham *et al.*, 2015,). However, these new provider abilities could affect the behaviour of commissioners as they seek to avoid situations in which they may face legal challenges.

There already is evidence that they have blocked mergers (Poole NHS 2013), but Monitor has also allowed for other mergers as it has gained experience in the healthcare sector (HSJ 2015). This may lead to commissioners opting to avoid some commissioning processes to reduce this risk. It could further encourage cooperation between NHS providers and commissioners rather than encouraging working with the private sector.

Monitor and privatisation/marketisation

When exploring how Monitor may affect privatisation or marketisation, it is important to briefly examine how each of its responsibilities plays out in everyday practice. In its role of ensuring competition, Monitor is, in practice, promoting the marketisation (market principles) of the health service, by prioritising competition and choice over the interests of the existing health care providers (i.e. Trusts), while also having a duty to improve patient care. Monitor does not overtly support privatisation as there is no apparent shift of assets from the public sector to the private/third sector.

A more significant manifestation is Monitor's encouragement of the NHS to function as a market, which should theoretically result in efficient allocation of resources. While the system itself is not being overtly opened to external companies, it is being subjected to a legal framework, the Competition Act (1998) and the Enterprise Act (2002), which therefore may open the system to further privatisation/marketisation. Another way in which Monitor could facilitate the privatisation of the NHS is through its inherited role from the Department of Health, as a sector regulator. Utilising Rondinelli's (1984) characterisation of privatisation, this form of decentralisation, from the DoH to Monitor, consequently increases the possibility of the selection of a broader range of service providers.

A more explicit relationship of Monitor with the commissioners is through its power to provide guidance to the new CCGs as stipulated by the Health and Social Care Act (2012). Apart from helping to shape the market, Monitor defines the information which commissioners can expect from potential providers. As mentioned previously, it is also at this point, the adjudicator of complaints. Using Tuohy *et al.*'s., (2004) characterisation, Monitor here acts as a regulator as a manifestation of

the state that increases regulation but is simultaneously liberalising access to the quasi-market, reflecting the aims of the new Act.

In summary, Monitor has become much more powerful as a regulator of the health care sector under the reforms. In effect, Monitor has kept the provider landscape similar to what it was before 2012 (Ham *et al.*, 2015). It does, however, enforce competition law and the fear of legal challenge is a serious one amongst NHS commissioners (Ibid 2015). The role of Monitor could facilitate further marketisation over privatisation, as the management of NHS has been reformed while the provision of funding remains within the public sector, which is reflected in the relatively small size of the private sector (Ham *et al.*, 2015).

Office of Fair Trading, Competition Commission, and the Competition and Markets Authority

The Office of Fair Trading (OFT) (now part of the Competition and Markets Authority) was another part of the external regulatory framework, with a focus on enforcing competition laws. Its primary concern was the protection of consumers' rights by ensuring the maintenance of choice. In the context of the NHS, the OFT had a significant role in judging whether proposed mergers between Foundation Trusts could go ahead in the context of protecting choice, working alongside Monitor. It was expected that the OFT would decide in favour of any such move even at the expense of the interests of patients, focusing on the legal enforcement of the rules (Monitor 2013), however, its role has been relatively limited (Ham *et al.*, 2015).

The OFT relied on recommendations from Monitor to reach its own conclusions and would not come to any final decision without its advice (Monitor 2013, Ham *et al.*, 2015). As mentioned above, there were some high-profile cases of Trusts (Foundation and NHS Trusts), not being allowed to merge their management structures. In one, the OFT rejected the final appeal to allow the Poole and Bournemouth Trusts to merge in 2013 after a long and drawn out process which lasted nearly two years (HSJ 2013). The merger was rejected because the resulting loss of choice would be detrimental to the 'customers' (Ibid 2013). However, after the dissolution of the OFT and the establishment of the Competition and Market Authority (CMA), this approach seems to have been changed, and certain mergers have been allowed, due to a greater understanding of the resource pressures on the NHS (Health and Social Care Act 2012, NHS Improvement 2016). These new mergers have taken place with approval from the DoH and additional funding put in place in order to make them work (Collins 2015).

In addition to Monitor and the OFT, the Competition Commission (CC) also has a limited role in a decision relating to the formation of mergers on the provider side. The CC contributed to the shaping of the provider landscape and as such had an indirect influence on decisions made by commissioners. The CC's involvement was, as implied, limited only to the few cases in which it was asked to provide guidance.

The CC had a potentially much more significant role as a regulator of the private healthcare market, which encompasses companies that worked both in and outside of the NHS. The CC, in its report in April 2014 about the functioning of the private healthcare market regarding competition, noted that private providers are highly 'concentrated' and dominated by individual companies (Competition Commission 2014). The report was also significant as it outlined how private providers look to target specific areas of provision in which they already have experience. Furthermore, the report referred to how NHS England has become more reliant on the private sector. At that time this primarily referred to the perceived potential further expansion of NHS Private Patient Units (PPUs) (Competition Commission 2014). The CC believed that the reforms would lead to future growth of private companies in the NHS as the result of a decision to remove the private patient income cap in NHS Trusts (Competition Commission 2014). However, the removal of the patient cap and role of PPUs did not have the influence imagined, even if they represent a system similar to the old NHS pay beds (Bayliss 2016).

The role of the Competition Commission in the context of marketisation and privatisation can best be explained by using the same set of theories as with the OFT. The CC furthered marketisation through its support for an organisational change of publically funded and provided services. Utilising Tuohy *et al.*'s (2004) characterisation, the CC's activities can be viewed as contributing to the creation of additional levels of regulation.

In 2014 the OFT and CC were merged into a new body, the Competition and Markets Authority (CMA). The new organisation was tasked with a goal to further 'strengthen competition' in the UK (Government 2014). There seems to be room for the behaviour of the framework to change as the new body reconsidered the merger between Poole and Bournemouth Trusts, three years after being blocked by the CC (Hazell 2016). This was interpreted as the beginning of a new approach to the application of competition rules as regards the NHS (Ham *et al.*, 2015). This is also a reflection of the government understanding the financial pressures that the service is under, as this is often cited as a reason that mergers which had been blocked were now allowed to take place (Ibid 2015).

NHS England – the day-to-day regulator of the NHS

NHS England (NHSE) is the non-departmental public body (NDPB) that administers the NHS in England (other constituent nations of the UK administer their own NHS groupings). NHS England is mandated to lead work on commissioning within the NHS. This includes: ensuring that performance targets are met; that performance of the NHS in England is kept to a specified standard (clinical and financial); and the management of resource distribution to different CCGs (NHS England 2017). It has an explicit role in monitoring and maintaining the commissioning element of the internal market with a responsibility for £105.9 billion (The Kings Fund 2016). NHS England's primary responsibility is administering the CCGs, and works directly with the CCGs to assist in commissioning of services. This allows NHS England significant influence over the providers that commissioners may select (NHS England 2017).

This further illustrates the influence of the external policy framework on commissioners and has a number of implications on their autonomy. For instance, NHS England has the power to place 'inadequate' CCGs under special financial measures which it has already done in several cases, under the NHS England area teams (NHS England 2016). These powers of NHS England apply to other parts of the system, and as such it has been described as 'First Amongst Equals' (Ham 2013).

The ability of NHSE to regulate CCGs is the most influential tool that it has to affect the behaviour of clinical commissioners. If a CCG is facing a significant financial deficit, the local NHSE team can place that group under special measures (NHS England 2016) meaning local commissioners would lose their autonomy in the selection of providers (Ibid 2016). Under special measures, the commissioners would agree to a formal plan to reduce the deficit (Vize 2016). As a result of these types of plans, there is potential to limit the number of new providers that the CCG may work with, as new contracts or money for new services would be limited. NHSE also acts as an arbiter between the Trusts (i.e., providers) and the commissioners in disputes. In its role as arbiter of disputes, 25% of all local NHSE teams have been active (HSJ 2015). Many of these disputes have been related to the NHS tariff and issues associated with finances (HSJ 2015, Sheaff *et al.*, 2015).

NHSE has also taken a more active role in the development of NHS targets since the introduction of the reforms. In 2014, NHSE released the *Five Year Forward View* (NHS England 2014). The purpose of the document was to suggest how the NHS can move forward and develop new models of care (The Kings' Fund 2017). It also outlined new responsibilities for the NHS, such as public health and greater access to services which commissioners would need to take an active role in (Ibid 2017). This further increased the type of providers that commissioners would need to engage. In this sense, NHSE also sets out additional forms of providers which need to be commissioned and dictate the future direction of the NHS/clinical commissioning.

NHSE is also responsible for commissioning additional primary care and some specialist services (NHS England 2016). This highlights that commissioning responsibilities under the new NHS reforms are given to three key actors, NHSE, CCGs and local authorities (Ham *et al.*, 2015). During the course of the study, some of these additional commissioning responsibilities for primary care have also been devolved from NHSE to CCGs (Ibid 2015). This places additional responsibility on commissioners and as such can affect other areas of commissioning. In addition, many commissioners are also unclear about procurement rules and regulations which could affect commissioning decisions (Ham *et al.*, 2015, Holder *et al.*, 2015). This demonstrates the complex nature of the commissioning changes, with commissioners facing an environment where commissioning roles and rules are not clear.

Regarding this thesis, the creation of NHSE represents a form of marketisation of the NHS, according to the definitions presented in the previous chapter. It represents another level of regulation as classified by Tuohy *et al.*, (2004), with the

'centre' delegating more power to other regulatory bodies rather than exerting direct control. It can also be viewed as an illustration of how decentralisation is one of the leading principles in this area of the NHS as there is now formally less direct oversight from the Secretary of State for Health. Specifically referring to the CCGs, NHS England has the responsibility to allocate annual funding to CCGs, ensuring fiscal responsibility and acts as the day to day regulator for CCGs, dealing with a variety of requests (Shaeff *et al.*, 2015). Senior leadership positions in CCGs also require ratification from NHS England, even if those individuals are elected to those roles (Checkland *et al.*, 2016). NHS England still has a duty to ensure fiscal responsibility and enforce the use of procurement in relevant cases, it could indirectly, alongside other parts of the external framework lead to the use of additional private providers, even if they do not directly encourage the growth of private provision (Ham *et al.*, 2015). The work of the regulatory framework appears to favour competition rather than collaboration and the ability of the framework to affect the behaviour of commissioners (Hudson 2013).

In summary, NHSE represents the most influential body in the external regulatory framework, with regards to commissioning. Under these new arrangements, several organisations that form part of the external framework (i.e., commissioning bodies external to CCGs) have the potential to significantly influence whether and to what degree, private providers are selected by commissioners. They can affect the decisions of commissioners either directly, through the application of rules, such as placing a CCG in special measures and affecting commissioning choices, or indirectly, by shaping the provider landscape. Most evidence seems to indicate that there is a light touch approach to regulation in the NHS, outside of financial special measures (Ham *et al.*, 2015), although some commissioners believe that they are being given contradictory guidance, especially to do with procurement (Allen *et al.*, 2017).

The new NHS reforms have continued previous policy of primary care-led commissioning, turning to local clinicians with the belief that they are best situated to commissioning care. However, the new regulatory framework continues to utilise competition. There is concern that the emphasis of the regulatory bodies on expanding competition and choice could take priority over the quality of care in the process of selecting providers. There is some evidence of this, with the framework blocking the mergers of NHS bodies immediately after the introduction of the reforms (NHS Poole 2013). Additionally, the ability that providers now have to challenge the results of procurement processes also could influence the selection of providers. Moreover, procurements have to take with certain contract values and not adhering to these results could lead to punishment (Allen *et al.*, 2017). These competing pressures will influence the commissioners in some way, especially considering the broader context of a lack of resources for the provision of healthcare (Robertson *et al.*, 2017). Commissioners will need to balance the requirements of their populations and their decreasing financial funds and explore new ways of commissioning (Ham *et al.*, 2015). However, as the regulatory framework has matured, there is evidence that many of the behaviours of the regulatory framework have been relaxed (Allen *et al.*, 2017, Ham *et al.*, 2015,

Sanderson *et al.*, 2017). There is now more discretion in the workings of the system and some suggestions that the commissioners may now be able to exercise their decisions with less interference than was initially believed.

In these circumstances, there is a concern as to the priorities of commissioners and whether they will be led by pressures from the external regulatory framework or will give preference to local clinical needs. The most obvious implications of this are the way in which providers will be selected. The commissioners are bound by the guidelines laid out by the external regulatory framework whilst simultaneously, attempting to meet demands within their commissioning areas.

This thesis will explore how commissioners select providers, i.e. the new commissioning arrangements. It is one of the first studies to explore this relationship in detail. To do so, it will utilise a conceptual framework, from the work of Pettigrew *et al.*, (1992) to understand and explore the pressures on commissioners and how this affects their selection of providers. There will be an exploration of various internal (i.e. local) factors, as well as those which stem from external sources, to understand how limited the commissioners are when choosing a new provider for a service; and whether or not commissioners are more or less likely to select a private over a public provider.

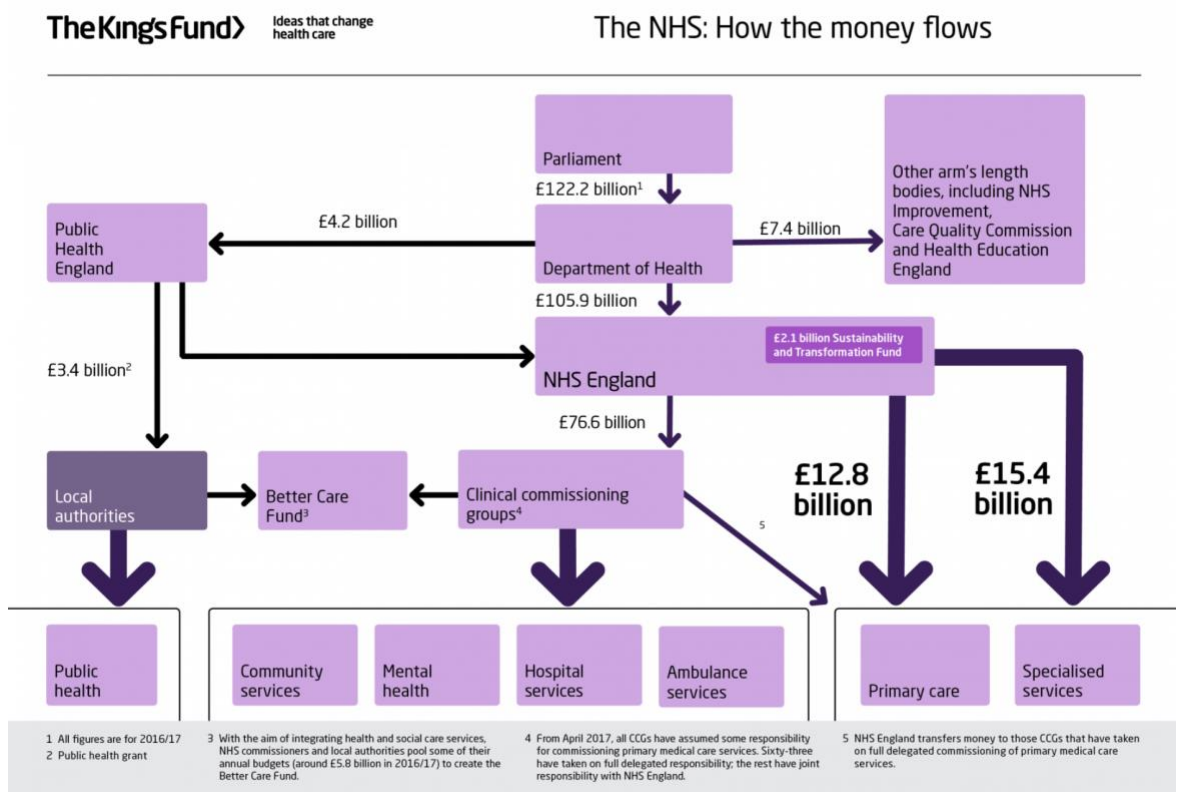


Figure 4 - The NHS: how the money flows

Source: The King's Fund (2016)

Developing a conceptual framework: exploring CCG decision making

CCGs are responsible for commissioning over 60% of the total NHS budget (The King's Fund 2016). They have the most control over the selection of a provider and thereby the participation of the private sector in the health service. The CCGs do not make their decisions in a vacuum defined by their statutory obligations and rights but in a much broader context in which they are exposed to different and often contradictory pressures. This section of the thesis will outline a conceptual framework to better understand the environment in which commissioners' work and reach decisions.

The new Act stipulated a new commissioning process by establishing CCGs and a new regulatory framework to support the system and ensure compliance. These radical reforms to which the NHS has been exposed have provided commissioners with the challenge of operating in an unfamiliar system that is simultaneously exposed to an increased scarcity of resources. The commissioners were formally given greater levels of autonomy in the selection of providers than their colleagues in previous incarnations of primary care-led commissioning. However, this autonomy could, in practice, be severely restricted by the confluence of a variety of different influences, bringing into question their ability to select the provider they genuinely think is most suited as the new Act allows. It is reasonable to presume that the commissioners could have their choices affected by the behaviour of the external framework which could create an atmosphere in which private providers may be the most likely to be selected, or vice versa. Separately commissioners are obliged to consider the local context and demands when commissioning services, as utilising local decision-makers is one of the core purposes of the Act (Health and Social Care Act 2012). These local concerns include the needs of their populations as well as how their own prior experiences of commissioning could affect their choices. As of yet, it is unclear how this combination of various pressures could affect the real autonomy of commissioners.

To gain a better understanding of the commissioners' autonomy in the new arrangements, this work utilises an approach that focuses on the managerial autonomy of the commissioners (Harrison and Ahmad 2000). In this context, managerial autonomy is taken to represent the ability of commissioners to make decisions based on their assessment of strategic needs and available financial resources. This ability is the overtly expressed goal of the new reform. However, because there are concerns that the commissioners will be exposed to various pressures, which they may find difficult to resist, there is a need to explore how both the external regulatory framework and the internal issues within the CCGs, will likely affect the commissioner's decisions in regards to selecting any new provider. In other words, both internal and external pressures could, in practice, limit the real autonomy of the commissioners. This is significant as the commissioners are purportedly autonomous in coming to their decisions. They should be independent from oversight of regulatory bodies whilst utilising their

knowledge of their local market to select the best-suited provider to meet the needs of their populations (Bossert and Mitchell 2011).

When constructing the conceptual framework to examine the decision-making process, there is a focus on the external and internal pressures that resulted from the new organisational set-up of the NHS as stipulated by the Act. The principle approach taken in this thesis when conceptualising the CCG environment is an adapted version of Pettigrew *et al.*'s (1988) framework of the dimensions of strategic change. Written during a similar period of upheaval in the NHS, with the introduction of the market reforms of the 1980s, it provides a good starting point for exploring the effects of new reforms. The work of Pettigrew *et al.* (1992) developed as a response to what they termed the need for more research in the field, which was “processual, comparative, pluralist and historical” (Ibid 1992, p268). As a result, there was a focus on the effects of change in a context which considered three areas, Context, Content and Process (Ibid 1992). The starting point for studying change is that any reform involves managing both an internal and outer context (Ibid 1992). This is situated within the element of context, which has a clear division between internal and external contexts.

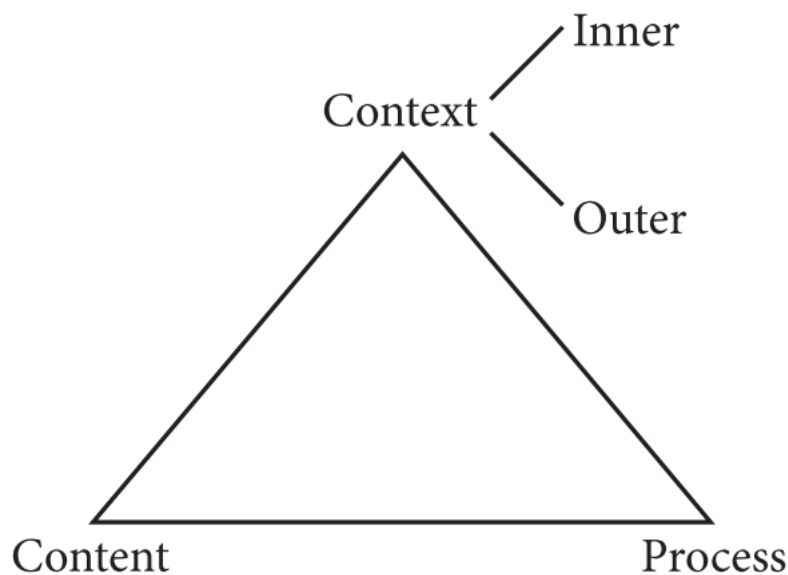


Figure 5 - Pettigrew *et al.*'s Context, Content and Process

Source: Pettigrew *et al.*, (1988)

Content in this refers to the area under study, in this case the development of the commissioning introduced by the new Health and Social Care Act (2012). The context of the reform can further be explored through an outer and inner lens. The outer context “refers to the national economic, political, and social context for

district as well as the perception, action, and interpretation of policies and events at national and regional levels in the NHS” (Pettigrew *et al.*, 1988, p 301). A key weakness of previous research was that there was little attention paid to the context in which reforms took place (Pettigrew *et al.*, 1992, Locock and Dopson 2012). This research will therefore explore the effects of this “outer context” on the decision-making of commissioners and how restricted they may be in their selection of providers. The inner context is the ongoing strategy, structure, culture, management and political process of the area which help shape the processes through which ideas for change proceed. Also important to consider is the process of change, which refers to: “actions, reactions, and the interactions of the various interested parties as they seek to move the district from its present to its future state.” (Pettigrew *et al.*, 1988, p 301, Pettigrew *et al.*, 1992, Locock and Dopson 2012). Through the conceptual framework utilised here, there will be an exploration of the various local concerns of commissioners, the structure of the CCG and other concerns which may emerge from the local health economy. Thus the model should be able to explore the decision-making process within CCGs, understanding how various factors may together affect the decisions of commissioners and what the outcomes of these processes are.

Similar frameworks have been applied in several empirical-related studies which have explored both the provider and purchaser side of the NHS; hence providing a tested guide for the understanding structural change (Locock and Dopson 2012, Robert and Fulop 2014, Hunter *et al.*, 2015).

The Health and Social Care Act (2012) marked a significant change from previous arrangements in the commissioning process. It empowered clinical commissioners to a much greater degree than under any previous commissioning arrangement. To understand the internal and external pressures on the CCGs, this thesis, through empirical work, will explore these new pressures that could affect the breadth on the commissioners’ autonomy in the empirical work. Earlier research into the accountability structures of CCGs utilised a similar model which explored the relationship between CCGs and the new structures (Checkland *et al.*, 2013, Checkland *et al.*, 2016).

The external pressures relate primarily to the regulatory policy framework created by the Act, as well as the environment which the organisation is operating in (Pettigrew *et al.*, 1992). The internal pressures are ones which arise from the local communities (i.e. geographically local) and the structure, culture and context of the CCGs themselves. In the new regulatory framework, the HSCA has created new bodies and also expanded the responsibilities of some previously existing regulators. As a newly formed body, NHS England has, among other things, been tasked with ensuring that targets on competition, efficiency and fiscal responsibility are met. This is accomplished through its control of the CCG budgets, its power of placing any underperforming CCG under special financial measures and also being able to ratify senior appointments within CCGs (Checkland *et al.*, 2016, NHS England 2016). Under previous elements of primary care-led commissioning, budgetary pressures were a significant influence in the

work of commissioners, restricting their ability to operate freely (Majeed *et al.*, 2012). Alongside a changing commissioning system, under the HSCA, there is a duty to generate £20 billion of efficiency savings which the regulatory bodies were tasked with enforcing (Health and Social Care Act 2012). These pressures are further exacerbated by additional financial stresses on the provider side of the NHS which reported a deficit of £1.85 billion deficit (The King's Fund 2016). It is highly likely that this deficit will exert an effect on commissioning, as it will inevitably result in providers altering their behaviour; and therefore will directly influence the options available to the commissioners. This set of circumstances is not wholly unfamiliar, and there is evidence that previous commissioners struggled to solve some of the issues they were faced with, particularly concerning decommissioning services and responding to local demand (Robinson *et al.*, 2011).

Another external element that would affect the decisions of commissioners is the provider marketplace. New providers are entering the marketplace and competing with existing providers at an increasing rate, winning over a third of new contracts tendered out (Iacobucci 2015). There is evidence that primary care-led commissioning did in the past improve certain aspects of care (Miller *et al.*, 2016), although there remain questions about its potential for overall positive effects (Smith and Mays 2012). Possibly the most significant issue with which commissioners could be faced regarding the provider marketplace is the behaviour of large NHS Trusts which dominate by their sheer size (i.e., budget, number of patients). The major part of the overall NHS budget is spent and committed to the NHS Trusts, which provides the majority of beds in the system. This is still viewed as a key descriptor of the overall performance of the NHS (Smith *et al.*, 2014). However, this dominance of the Trusts, due to their size and scope of services makes them vulnerable to financial pressures which characterise the present environment (Ibid 2014). In response, the Trusts are exploring various solutions and methods. There is also the question about the size of the private and third sector markets and how the new reforms may stimulate their growth (Matchaya *et al.*, 2015). Commissioners, on the other hand, may have little alternative but to continue to purchase services from the Trusts even if they cannot affect their behaviour in any significant way. In addition, commissioners are also exposed to the threat of losing their financial autonomy (i.e., be placed under special measures by NHSE). At the core of their work, the commissioners are faced with the challenge of finding a balance between available resources and the selection of providers, some of which they cannot effectively influence.

Other elements of the external pressures that may influence the CCGs come from NHS Improvement, the health regulator that has gained more power in the new reforms, and the Competition and Markets Authority (CMA). NHS Improvement can shape the provider marketplace by blocking mergers of NHS organisations (i.e., Trusts – which dominate the provider marketplace) to ensure compliance with choice and competition legislation, just like Monitor did (West 2014). The logic here is that patients must have a choice of where and by whom they are treated in the NHS (Ham 2012). Thus the fate of these organisations, especially if they are Trusts,

can have a significant effect on the provider landscape. Previously, mergers of NHS organisations were a method of pooling resources to achieve savings and other efficiencies (economies of scale), but with the exposure of the NHS to competition law, those options have become much more limited (Davies 2013). An example of this is how Monitor and the CMA blocked a merger between Foundation Trusts in Bournemouth and Poole (The Health Foundation 2014). That decision affected the local CCGs, as they had no choice but to deal with Trusts that were subject to considerable changes because of the necessity to achieve further savings. In essence, the CCGs were suddenly faced with a change in the services available in their area.

CCGs are also exposed to internal pressures, which can arise from a variety of sources. One is how the commissioners perceive their role and their autonomy (Checkland *et al.*, 2013). The reasons that the commissioners become involved in CCGs can be numerous, but the predominant one appears to be a desire to affect positive change. There are also those commissioners who had previous involvement in primary care-led commissioning and have continued this role in the new structure (Checkland *et al.*, 2015). Moreover, there are differences in opinion between GPs, as believe that GPs are best suited to deliver local savings while others have a desire to preserve their autonomy as a body (Iacobucci 2016). There is evidence that in previous primary care-led arrangements, commissioners disregarded external pressures and pursued their own commissioning arrangements which favoured local providers (Smith *et al.*, 2004). Often this took the form of working alongside local providers over other arrangements (Flynn *et al.*, 1996). Some commissioners may refuse to invite bids from companies, instead preferring to keep things 'in-house' with providers they have cooperated with over an extended period (which would most likely be public rather than private) or through circumventing rules as best they can (Hunter *et al.*, 2015). Furthermore, commissioners may choose to ignore regulations regarding choice and opt to control the care pathways rather than deferring to patients/regulatory framework, seeking new ways in which to improve services. In addition, the internal pressures can also result from the internal structure of a CCG. There are no fixed rules in how a CCG would need to structure and operate, outside of its Governing Body (Checkland *et al.*, 2015). This variation could lead to internal conflicts or methods of working amongst the CCG staff and could shape the selection of providers.

Another internal pressure on commissioners is the structure and relations within the CCG. According to Pettigrew *et al.*, 's (1992) model, the internal aspect relates to the structures and relationships within the organisation. In this context, this could refer to the power dynamics between key members and how decision making is structured. This is made more acute as many CCGs do not have similar structures outside of the mandated Governing Body (McDermott *et al.*, 2017). The priorities of commissioners and how this may play out is key in understanding how the internal dynamics may affect decision-making and the selection of providers. This can be explained by exploring the power relations which exist between actors.

This thesis also explores the way in which actors used power within the CCGs. In

sociological contexts, power has been viewed as a means of influencing the behaviour of others to do something they may not have otherwise done, usually with some form of punishment (Dahl 1976). This study borrowed from the work of other scholars in the field, when adopting this approach (Harrison et al., 1992). In their conceptualisation of power, they argued that there were three 'faces' of power, which they used in their empirical work. The first face of power is used when there is direct conflict between two actors. One of these actors acquiesces to the demands of the other, usually due to them believing that they may be deprived of something if they do not agree (Ibid 1992). This definition of the first face of power has been defined and used by Bachrach and Baratz (1970).

The second face of power was developed in response to the perceived inability of the first face of power to capture the use of power in an entire organisation (Bachrach and Baratz 1970). This second face of power related to agenda-setting, where one actor devotes their energies to ensuring that the only elements considered on any agenda are ones which they view as being in their interests and avoiding threats to their own interests (Harrison *et al.*, 1992). This is not always explicit, and rather it can take place in a context in which a subordinate may choose not to create conflict with a manager or senior member of staff (Ibid 1992). In the words of Harrison et al., "The powerful remain powerful without having to act." (1992, p6). However, this face of power has been argued to be insufficient in analysing macro-level distributions of power. There is, therefore another face of power to consider.

The third face of power argues that power is exercised when one actor influence another so that their 'desires' are made to align (Harrison *et al.*, 1992). In this instance, one actor is attempting to enhance their authority to make their views more legitimate and to have other actors behave in such a way that their agendas are aligned. There is concern that as there is no overt conflict, it is difficult to track when this face of power is being used. However, it has been argued that a researcher can make judgements about when one actors manipulates another, concluding what may or may not be in the interests of involved actors (Ibid 1992).

In addition to the faces of power, Harrison *et al.*, (1992) also post that there are two other elements that need to be taken into consideration when studying power. These are 'collective action' and 'luck' (Ibid 1992). Collective action refers to a situation in which resistance appears to be lacking, due to a lack of organised opposition. Multiple actors may oppose a dominant party, but these actors may each have slightly different aims and cannot coordinate effectively, thus meaning that dominant groups do not have to exert the first or second faces of power (Ibid 1992). The power dynamics may also be affected by luck more than other factors. Harrison *et al.*, (1992) argue that power relationships have been affected by crises such as epidemics, and other long term trends, which place some groups in more or less powerful positions (Ibid 1992).

Figure 3 illustrates how these pressures might be combined or interact to influence the commissioners.

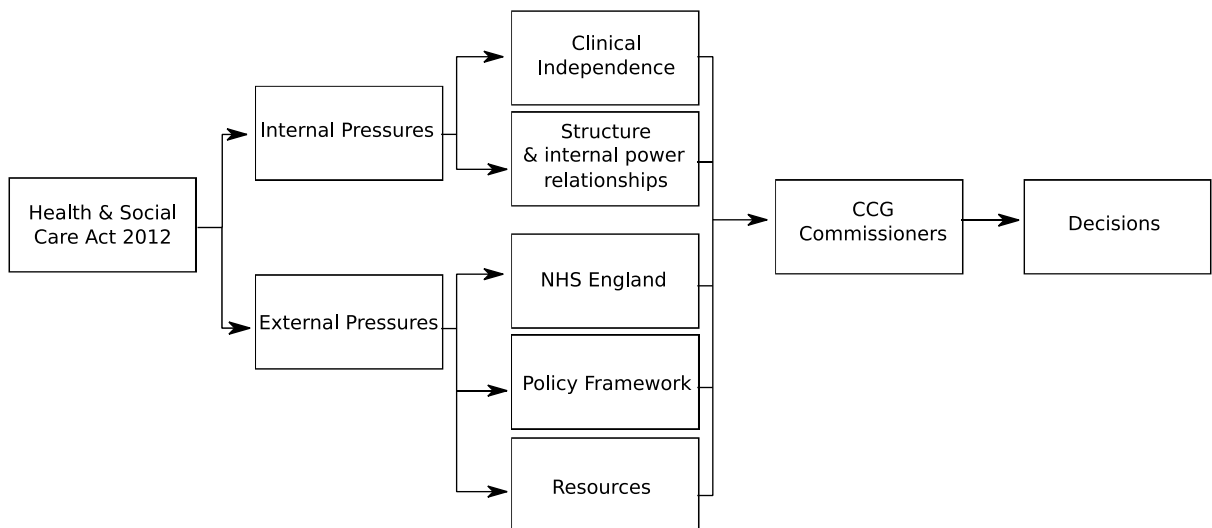


Figure 6 –Internal/External Conceptual Framework

The external regulatory pressures relate to the framework that was outlined above, with NHS England, Monitor and other enforcement bodies forming the Policy Framework. The organisations which comprise the regulatory framework ensure compliance with the Health and Social Care Act (2012) and with the competition and choice laws that now apply to the NHS.

Both external and internal pressures could have the effect of restricting the choices available to commissioners when selecting providers. Theoretically, commissioners have the power to select public, private or third sector providers either through utilising procurement processes or through expanding the scope of existing contracts. As previously mentioned, in old primary care-led arrangements, GPs favoured local health service providers (Flynn *et al.*, 1996) and the early evidence from the exploration of clinical commissioners suggests that this may be the case again (Checkland *et al.*, 2012). From early CCG research, there is a great deal of variation in the structure of CCGs which may also affect their commissioning processes (Ibid, 2012). The third sector providers do not possess the same understanding of the area as public i.e., NHS providers or private providers, both of which have delivered services over a more extended period of time. Consequently, did not have developed relationships with them to the same extent as they did with other providers (Baines *et al.*, 2010).

The empirical work will explore if the autonomy of the commissioners in the selection of providers is affected by the external and internal pressures and how they might change the public/private balance within the health service.

Shaping Strategic Change: Further analysis

In addition to adopting and exploring change from the perspective of context, content and process, from their empirical work Pettigrew *et al.*, (1992) devised a model with eight interrelated factors which can assist in understanding what may lead some organisations to successfully adapt to change (see figure 4). This model assists in understanding how change occurs, the role of top-down or bottom-factors which can account for the pace of change within organisations. These factors according to Pettigrew *et al.*, (1992) assist in creating a receptive context for change. The authors explicitly state that these eight factors are not a "shopping list" (Pettigrew *et al.*, 1992, p 31). Rather, these eight elements represent factors which may constrain or enable policy change (Ibid, 1992). They argue that in their work, NHS bodies (district health authorities) which exhibited these factors were more likely to be successful in implementing change.

These factors highlight that policy change does not simply occur when policy makers institute it, but that a variety of local factors and national policy elements can combine to affect the likelihood that change takes place. The eight factors that form the model demonstrate this. The model highlights the characteristics that are internal to an organisation in order for it to be able to adapt to change and 'move forward' (Pettigrew *et al.*, 1992, p 267). Within these characteristics, emphasis is placed on key actors within the organisation, the role of policy and how individuals working alongside others to affect change. Therefore, the culture of the relevant organisations plays a large role in whether or not reforms will be successful. The way in which commissioners operate will dictate to what extent the reforms are successful in the research sites. It also illustrates the important role that the culture of the organisation may be important in understanding the actions of individuals. These factors will be explored in the discussion chapter in light of the empirical evidence from the study.

In addition to the considerations of internal elements, the external policy context is also important, as highlighted by the conceptual model presented earlier in the chapter. The policy context can limit the ability of actors to shape policy change. It is the combination of the internal cultural and relational elements which interact with the external policy context to allow actors to affect policy change, or limit their ability to do so.

To be able to understand whether or not the Health and Social Care Act (2012) has been successful in its aims, the empirical data was analysed with regards to these eight contexts. All of the eight characteristics were at least somewhat relevant to the study. However, some bore more relevance to the findings of this work. These factors help to shape the discussion in the final chapter, which also includes a full discussion of the power of the explanatory framework.

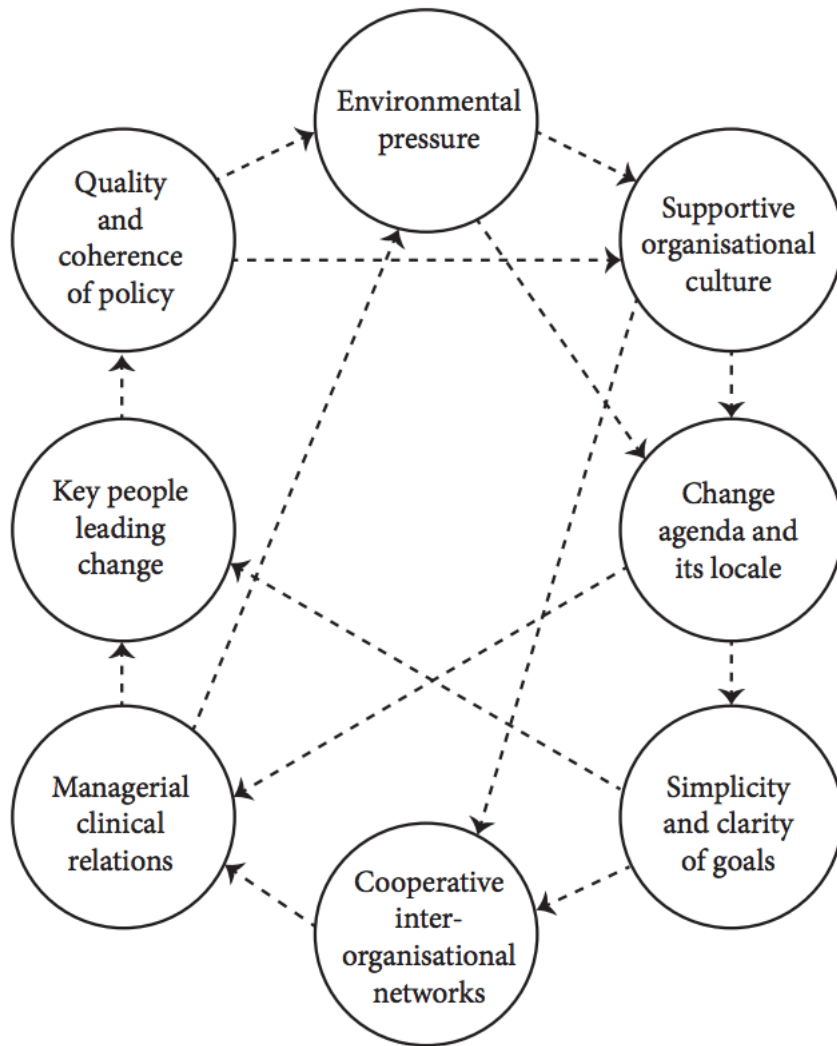


Figure 7 - Pettigrew et al., 's eight contexts for receptive change

(Source: Pettigrew et al., 1992)

Privatisation/Marketisation

As outlined in the previous chapter, privatisation in its most basic form can be described as the transfer of assets from the public into the private sector (Saltman 2003). In Salman's taxonomy (2003) there are several elements of both the private and public sectors (two subsections of the public and two of the private). Privatisation only occurs when there is a transfer of assets from the public to the private, and not if it just moves from one element of the public to another. Saltman (2003) also argues that there is a distinction between privatisation and marketisation, despite not providing a precise definition of the differences. Drakeford (2000) however, is more explicit in that regard and argues that marketisation is the insertion of market ideas and principles into a public sector service. Clearly, this is different from privatisation. However, the two concepts are linked, and it has been argued that marketisation can lead to privatisation.

As discussed in chapter two, privatisation in this thesis will be characterised by a transfer of assets in the funding or provision of a service. If a service was to move from being funded or provided by the NHS to the hands of a private provider, that would represent direct privatisation. This would remain the case if any particular service were to be provided by the private sector but funded by the public sector, or if the third sector replaced the role of the public sector. In most instances in the NHS, organisational changes have been accompanied by changes in the management structure in an attempt to replicate the private sector as much as possible, to reduce inefficiencies and enhance the positive elements of competitions (Propper *et al.*, 2004, Greener *et al.*, 2014).

Marketisation is the process by which there are attempts to change behaviour within existing systems to replicate the free market. In this context, this would mean developing private sector management practices and/or having public providers compete with one another for contracts and work.

Using this approach, it will be possible to identify and define both processes (marketisation/privatisation) and the degree to which they occur within the new NHS. This distinction is important to allow for more detailed analysis of the two processes, and of whether the boundaries between the two have become blurred (Mohan 2009).

Summary

The purpose of this chapter was to outline the commissioning processes that have taken place in the NHS since the election of the first Conservative Government (1979-83), which introduced the first batch of market-orientated reforms into the NHS. The introduction of the quasi-market in 1990 introduced the purchaser/provider split into the NHS, inserting competition as an operating principle into the health service for the first time. The introduction of competition did not initially involve the private sector, instead it aimed to create competition amongst public providers only. Therefore, it was a 'closed system'. This was followed by the development of GPFH and other primary care-led commissioning, with a mixture of clinicians and managers commissioning services (Miller *et al.*, 2016). The contracting of private providers became more common during the 2000s to meet waiting list targets. While this was met with limited success, these changes, both primary care-led commissioning and the usage of private providers, were only adopted on a relatively small scale.

The development of PCGs and PCTs further entrenched the combination of managers and clinicians working together to commission services and to ensure the most effective allocation of resources. There was a further growth of private providers' participation in the system and the utilisation of choice and competition within the NHS, but also a 'blurring' of the boundaries between the two sectors as Mohan (2009) stated. The PCTs marked a period in which managers were given greater powers than those of the clinicians.

The Health and Social Care Act (2012), represents the culmination of previous health policy relating to commissioning. Responsibility for the commissioning process entrusted to primary physicians who were also given greater scope in their choice of the selection of providers than in previous reforms. However, a question remains as to whether the commissioners can genuinely affect all of these new powers in the context of pressures from the external regulatory framework in combination with their accountability to local populations while the service overall is facing unprecedented financial pressures and decreasing funds. The conceptual framework developed in this chapter will assist in a detailed exploration of the actual ability of commissioners to select providers, as opposed to the latitude they have formally been given by the Health and Social Care Act (2012).

Chapter 4 – Methodology

Introduction

This chapter will outline the methodology of this study. It will begin with an outline of the research questions, before discussing the epistemological approach and research methodology adopted.

This thesis aims to explore how the CCG's make decisions concerning the selection of providers. The previous chapter laid out a loose conceptual framework for explaining the influences on the decision-making processes, built up from the previous theoretical and empirical literature. This chapter will outline the research methods used in the study to address this aim and how the different elements of the framework were explored in the empirical research. It will firstly state the research questions, then elaborate upon the research design and the criteria for the selection of two sites (CCGs). The description of the epistemological approach used will be outlined, and this chapter will be concluded with a discussion of practical and ethical considerations.

Research Questions

The implementation of the new reforms and the selection of certain types of provider was the focus of the study. While the reforms have changed a significant element of the service, they continue to evolve and capturing this process will be critical to this thesis. This was an exploratory study and focused on examining and explaining the decision-making processes adopted by clinical commissioners. The research questions focused on the NHS in England because the Scottish and to a lesser degree, the Welsh system, have not been subject to the same reforms due to devolution. The definitions of privatisation and marketisation that have been used in this thesis are outlined in the previous chapter. The research questions are as follows:

1. What influences the decisions of commissioners in/during the commissioning process?
2. Why do commissioners select certain providers over others?
3. How has this affected the private/public balance in the NHS?

These questions cover many of the critical elements of the new reforms while retaining a focus on the commissioning process and the associated inputs and outcomes. This includes the CCGs and the regulatory framework. In this sense, the first question is related to the initial contact made at the both of the research sites, which explored the decision making structures and understanding how the CCGs reach decisions about service selection. By exploring the structures of the CCGs, it further allowed the researcher to gain a rich understanding of where the power within these organisations was concentrated. It also allowed the researcher to explore the power and scope of the various committees and boards which form the decision making sections of the two CCGs. The subsequent question then explored

the interactions between different actors and the boards which comprised the CCGs. The third question explored the data analysis stage. The focus was on the key themes to develop an understanding of how commissioning takes place over the two sites, as well as the effect of those decisions on the number of private providers in the NHS.

The questions were designed to allow the examination of the role of the regulatory framework and the impact of those bodies, including NHS England, in parallel to an exploration of privatisation and marketisation. The Commissioning Support Units (CSUs) were planned subject to research as their role in the reforms was unclear. However, it was apparent that the CSUs were not in use by either of the two selected sites and that their role, in general, was somewhat limited (NHS England 2017).

This study adopted a broad interpretivist underpinning to the empirical work. It draws on the long history of phenomenology and hermeneutics (Crabtree and Miller 1999, Schwandt 1998). The researcher believes that reality is largely socially constructed. The ontological position of this research paradigm can best be described as one that: *“recognizes the importance of the subjective human creation of meaning, but doesn’t reject outright some notion of objectivity. Pluralism, not relativism, is stressed with focus on the circular dynamic tension of subject and object”* (Crabtree and Miller 1999, p10). In this work, it seeks to find a balance between social realism and true constructivism, understanding that there is some objective reality (Hammersley 1992). From this perspective, the relationship between the researcher and the reach subjects is one in which the subjects construct their own understanding of reality and it: *“assumes that we cannot separate ourselves from what we know. The investigator and the object of investigation are linked such that who we are and how we understand the world is a central part of how we understand ourselves, others and the world”* (Lincoln, Lynham and Guba 2011, p104). The purpose here is to understand the approach of the researcher when they designed their research methods. This may be best termed moderate constructivism (Järveensivu and Törnroos 2010). This ontological and epistemological position led to the adoption of a symbolic interactionism framework, which helped to further inform the research design and analysis.

This research sought to gain a fuller understanding of the decision-making process in the newly created CCGs. The research approach was based on a loose form of symbolic interactionism with a focus on the social interaction between key decision makers. This theoretical frame has a rich history in sociology, drawing on the work of George Mead and first developed in the middle of the 20th Century (Blumer 1969). The approach emerged as a response to the dominance of research that was focused on the macro-level institutions and the view that society was organised from the top-down (Carter and Fueller 2015). The basic premise of the approach is that: *“human beings act toward things on the basis of the meanings that the things have for them; (2) the meaning of things is derived from, or arises out of, the social interaction that one has with others; (3) meanings are handled in, and modified through, an interpretive process used by a person in dealing with the things they*

encounter” (Blumer 1969, p2). The aim of symbolic interactionism is an immersive understanding of the world from the perspective of the individual. In the context of this study, the researcher wanted to gain a deeper understanding of the commissioning environment from the perspective of the commissioners to understand how they view their roles and work within the new CCGs. This complemented the internal context of the conceptual framework as it explored the culture of the decision making spaces in the CCGs which were studied. It also allowed the researcher to explore how the commissioners developed their views of their spaces, i.e., areas of responsibility, and roles.

In the context of this thesis: “[In] *Blumer’s methodological approach, an understanding of social life requires an understanding of the processes individuals use to interpret situations and experiences, and how they construct their actions among other individuals in society*” (Carter and Fueller 2015, p3). Using this perspective when observing a social phenomenon, the focus is on the interaction amongst individuals which for this study allows for an examination from the perspective of commissioners. This entailed close observation of the day-to-day working of the CCGs and especially the boards which were responsible for final decisions. Although this approach is predominantly a micro-level analysis, it was also influenced by the context in which these meanings were created, and as such structural factors were also taken into account (Stryker 2008).

The ultimate aim of this epistemological approach is to understand the social interactions at the micro level of the decision making process within the CCGs that were studied. In addition, it also sought to understand how the decision-making process was shaped by the broader social-political process within the organisation, again fitting in with the internal contexts which are focused on by the conceptual framework. The nature of the approach requires that the researcher: “*see the situation as it is seen by the actor, observing what the actor takes into account, observing how he interprets what is taken into account*” (Blumer 1969, p56). This process assisted in developing a fuller understanding of the CCGs as commissioning organisations and of the participants and how they understand their roles.

The majority of other research in the field utilises symbolic interactionism in order to explore illness and the relationship between doctors and patients with regards to sickness and understanding the perception of illness or within nursing studies (see Brown 1995, Charmaz 1983, Lewis 2006, Kelly and Field 1996). This approach can also be adapted to exploring clinical commissioning. There is no existing research which uses a symbolic interactionist approach when exploring the work of health service commissioners; however, it complements the conceptual framework.

There are however some weaknesses of adopting this approach. The primary issue is that the symbolic interactionist approach is viewed as being one which is restricted to exploring micro aspects of social organisation, even if some disagree with this analysis (Dennis and Martin 2005). Thus, this approach would be unsuitable to exploring the broader context of the reforms and how they may affect the decisions of commissioners. In order to be able to utilise it, the researcher

combined the loose symbolic interactionist framework with the Pettigrew *et al.*, (1992) conceptual framework. Combining these two approaches allowed the researcher to delve in-depth into the internal context of decision making, i.e., the structures and spaces of the CCG, while the Pettigrew *et al.*, (1992) framework allowed for exploring how the external policy context would affect the subject CCGs.

This chapter outlines how the researcher explored the motivations of the commissioners, in parallel to understanding the decision making process and what drove it. Another aspect of the observations was to understand the interactions between various actors. This assisted in generating a deeper understanding of the commissioner's priorities and the autonomy with which they decide upon them.

Research Design and methods of data collection

Ethnographic Design: The thesis aimed to study the decision-making process of CCGs and to do so it employed a qualitative ethnography which aims to explore the rules and meanings used by commissioners as stated by previous researchers: "*its role being to illuminate, understand and ultimately interpret and present a range of perspectives – patients', carers', practitioners' and commissioners*" (Sharkey and Larsen, p 186).

A qualitative ethnography approach enabled the researcher to gain a detailed insight into the rationale behind decision making and the context in which those decisions are made, hence it was considered an appropriate approach to answer the research questions. This method includes a variety of techniques including documentary analysis, in-depth interviews and observation. The key element is observation which is employed to "[non]-participant observation, to explore complex clinical and organisational issues." (Savage 2006). Commissioning in the NHS is a complex organisational issue. Ethnography is a method which allowed the researcher to be flexible and to adapt to rapidly changing circumstances and to utilise a broad range of data collection methods.

An ethnographic approach also suited the approach of the researcher. It allowed them to explore, in depth, the nature of the CCGs and the relationships between key actors. It also allowed for the researcher to explore the effects of the broader policy context on these CCGs.

Methods of data collection: The core data collection method employed was a non-participant observation of decision-making meetings of key boards at two CCGs. The researcher was 'embedded' in both of the CCGs, which had the advantage that the gathered data could be described as 'rich' (Lewis and Russell 2011). 'Rich' data refers to data which goes beyond simply describing phenomenon but to interpretation and illustrating patterns to demonstrate a deeper understanding (Nowell *et al.*, 2017). While the focus was on clinical decision making, there was also tracking of non-clinical commissioners and meetings (who did affect the commissioning process). When examining the CCGs, which had variation in their

internal governance structures, ethnography proved to be useful as it allowed for the in-depth study of two decision-making systems within broadly similar contexts. It highlighted the differences in how decisions were reached and provided a basis for interview questions throughout the ethnography to further enhance the understanding of the commissioning process.

The data from the observations was collected in field notes. Each meeting which was observed had its own set of notes which were kept and analysed throughout the data collection period. The purpose of the field notes was to provide information about the way in which the CCG decision making processes worked. Observation allowed the researcher to note discussions of participants, their interactions and make notes about the CCG papers which were available. These were organised around a topic guide (see Appendix). The topic guide was constructed to be able to collect multiple forms of data, addressing the three fundamental considerations of field notes, what, how and when (Crabtree and Miller 1998). Initially the topic guide was written to be able to record descriptions of what occurred in key CCG meetings. This was done in order to be able to understand the dynamics of the CCG and the key actors involved. This encouraged the collection of "rich field notes" (Bogdan and Biklen 1982). Data which was collected included descriptive data of the meetings, quotes and discussions between commissioners and also information from the CCG papers present. The field notes were collected in situ, as researcher did not affect the behaviour of any participants by doing so. Along the descriptive notes, the researcher recorded impressions and their own understanding of the events which occurred. Having completed an observation, the researcher reflected on their notes. This reflection was used to plan focuses of future observations as well as, to plan the questions for the interviews. In addition, there was a further period of reflection before beginning research at site two.

By the end of the data collection period, there had been over 150 hours of observation across the two separate sites. This included different meetings which had been identified by the researcher through initial contact with gatekeepers and further meetings identified through interviews.

The other key data collection approach employed as part of the ethnography was that of semi-structured qualitative interviews with key decision makers within the CCGs. This covered their roles and perception of the commissioning process, and aided the researcher by providing an additional data source with which to triangulate conclusions. It also assisted in eliminating confusion, meaning that incorrect assumptions of the researcher were corrected. The flexibility of the approach allowed for new avenues of inquiry to be explored as new information became available to the researcher. It also assisted the researcher to gain a better understanding of other important meetings in the CCG, and whether exploring those would prove a useful source of additional information. Some of this information only became available as the research progressed. The interviews, combined with the interview data, also assisted in providing the researcher with information about the commissioning process that could be fed back to the

participant CCGs. The topic guide for these can also be found in the appendix section. It allowed the researcher the ability to retain flexibility and explore key areas as the participant opened up.

While ethnographies can vary and the methodology itself does not signify a unified research method, it does represent an approach for the study of everyday social settings, such as CCGs (Atkinson and Pugsley 2005). The very nature of what constitutes an ethnography can be contested (Hammersley 2006) despite characteristics which are common to most ethnographies. These common characteristics include (non-)participant observation and lengthy embedding within a chosen organisation/group (Hammersley 2006, Pope 2005). In addition, ethnographies usually involve a high degree of reflexivity – a critical analysis of observed relationships and power balances – which will be expanded on in greater depth later in this chapter. There is agreement about the role of interviews, document analysis and non-participant observation and how it assists in the triangulation of data streams (Hammersley 2006).

Ethnographies have proved to be a popular method with health policy researchers and have often been used to study commissioning organisations in the NHS, including CCGs (Checkland *et al.*, 2013a and Checkland *et al.*, 2013b). From the perspective of symbolic interactionism, it enables the researcher to embed themselves in the setting in which the participants work. This would enable the researcher to explore the CCG from the perspective of the commissioners and understand how they view themselves and their ability to make decisions concerning service selection. The process can be explained as:

"Through the nature and range of methods it can adapt, ethnography can provide a nuanced understanding of an organisation and allow comparison between what people say and what they do. It can, for instance, help to identify the ways that an organisation's formal structure (its rules and decision-making hierarchies) are influenced by an informal system created by individuals or groups within the organisation or indicate how professional knowledge is locally produced in particular settings" (Savage, 2000a, p1402)

Ethnographic research is a popular research methodology amongst those who study primary care-led commissioning. There are examples of prior ethnographic approaches being carried out on CCGs to gain a better understanding of their accountability structures (Checkland *et al.*, 2013), the way in which they utilise evidence, (Swan *et al.*, 2017) and their commissioning support arrangements (Petsoulas *et al.*, 2014). These have been successful, and the general approach undertaken here has sought to replicate elements from these prior pieces of research. The essential elements which have been borrowed by this work include the use of multiple sites/data streams and utilisation of a qualitative approach. None of these studies did utilise a symbolic interactionist approach.

The methodology emphasises the role of the researcher as an active participant (Savage 2000b, Atkinson and Pugsley 2005). However, in the case of the CCGs, due

to their size and complexity, the researcher for this thesis will adopt a more passive role or non-participator role, while still being in a position to observe the workings of the CCG as it occurs. Being a passive participant mimics the approaches of other researchers in the field and might allow the researcher to be accepted by the participants.

The design also adopted a multiple site approach. The quality of the research methodology was tested by the criteria set by Hammersley (1990). The foremost of these criteria are; the claims made by the researcher will be based on the empirical data; that care will be paid to maintain the credibility of the findings; the transferability of the data will be examined; and the influence of the researcher will be limited.

The approach that was adopted can be summarised as a: "*small-scale social research that is carried out in everyday settings; uses several methods; evolves in design throughout the study; and focuses on the meanings of individuals' actions and explanations, rather than their quantification*" (Savage 2000a, p1400). The ability to be adaptable and reflexive was vital in this approach (Pope 2005). It provided a framework for exploring the question while permitting follow-up empirical work as new information emerged from the early stages of data collection, i.e., it enabled an iterative approach to data collection and analysis.

The research design used was a case study method. It was a single case study across multiple (two) sites tracking how commissioners selected specific types of provider. The units of analysis, as defined by Miles *et al.*, (2014), were the decisions that were reached by the CCGs about the type of provider that they selected as a result of their commissioning processes. A combination of research methods allowed the researcher to explore the effects of the internal and external pressures on the commissioners. The observations allowed the researcher to observe the commissioning process and make basic deductions of what affected them. It was vital in helping the researcher develop an understanding of the internal dynamics of the CCGs, as well as the key actors, the way in which they worked, and provided an overview of the commissioning process. The observational data was key in developing a full understanding of the internal context and how the CCG operated, as well as highlighting some the external issues which may affect the decision making of commissioners. The interviews were key in developing the understanding of the process, being more effective at eliciting details of the decision making processes, and allowing the researcher to gain an understanding of the internal and external pressures on decision making. Combining the two processes, and complementing the findings with limited documentary analysis, allowed the researcher to explore whether internal or external factors influenced the commissioners.

The research was exploratory, and it aimed to understand the rationale and other influences that shaped the commissioner's decisions. This also provided data on the potential effects on the public/private mix in the NHS as a consequence of the commissioner's decisions. Case study research is believed to be useful in this

context as it can: "*uncover the complex influences that impinge on public bodies and the context-bound, event-driven nature of policy decisions*" (Marinetto 2012, p21). Utilising a case study method allowed for the in-depth study of one phenomenon. As decision-making is an identifiable process, with discernible outcomes (which services are commissioned), it was able to be studied using this method. In theory, this method allowed for the comparison of a single phenomenon across more than one site. In practice and for this thesis, it allowed for the comparison of decision making across two sites.

One of the strengths of this approach was that it was conducted at two sites, this would mean that there would be multiple sources of evidence to more easily enable transferability (Guba and Lincoln 1985). The commissioning process was reviewed at each of the two sites, for a compelling examination of separate commissioning processes. The focus of the study which included interviews with key stakeholders and some limited documentary analysis was on the motivations and broader influences of decision makers. The observations were also used to gain an understanding of the process and functioning of the CCG. The interviews were used to triangulate and provide additional context to the decisions of the identified decision makers. Further but limited documentary analysis of papers at the board meetings was used to complement the interviews and observations. These papers consisted of CCG board papers that were issued to members of the respective committees. They were related to the topics and subjects which were being discussed by the commissioners. The researcher utilised them to complement the field notes, by providing a context to the discussions that were taking place. Due to the confidentiality agreements that the researcher signed, these papers were not taken from the meetings but returned to the participants. This provided an additional data stream to help triangulation and ensured the research came to credible conclusions (Hammersley 1990).

Criteria for site selection

The underlying rationale for selecting the two sites was that they were similar as to allow for credible comparisons, as commissioners would be functioning in similar environments, i.e., the comparison of sites will be 'like for like'. In the context of qualitative data, rather than focusing on reliability, the researcher focused on the dependability of data (Golafshani 2003, Guba and Lincoln 1994). Researching two sites should, therefore, increase the level of dependability of the gathered data and suggest that it could be replicated. Significantly, no two CCGs are identical, and they seem to have a considerable degree of discretion in arranging their internal governance (McDermott *et al.*, 2017).

One of the aims of the research was to ensure that all the collected data at the two separate sites was relevant to the decision making process. Initially, it was important that any differences that emerged in the data from the two sites could be explained primarily by the workings of the CCGs and not from the context in which they operated. The collected data enabled the direct examination/analysis of the new commissioning arrangements and how they affected which services were selected (i.e., the data should not have been skewed by differing needs of CCGs but

rather by the nature of the new arrangements). This allowed for the conclusions to be transferred to similar sites – ‘transferability’ as termed by Guba and Lincoln (1985). Rather than merely focusing on commissioning in general at both sites, there was a focus on the commissioning processes in two different specific services, all of which have a history of being delivered by more than one provider.

The first criterion for site selection related to the number of service providers at each site. Commissioners at both sites had access to multiple types of provider (i.e., private/public/third sector) thus attempting to keep the supply side as similar as possible. The services that were examined were all provided by the new CCGs. This was informed through preliminary research about the CCGs and their locations. The sites had similar access to providers, having been selected as comparable areas. Both sites that were selected were of similar sizes which ensured that the contracts that they dealt with were of similar economic values when targeting these providers.

The second criterion addresses the socio-demographic profile of the sites which is related to the demand for services at both sites. The sites that were selected covered areas of similar geographic size. This helped to ensure that the populations of the different sites would use services at a similar level and would have comparable budgets, thus allowing commissioners to target similarly sized providers. They were both in concentrated urban areas, and as previously mentioned had access to multiple providers. While it was impossible to account for all needs in this way, keeping critical aspects as similar as possible helped to ensure that there was consistency across the CCGs and that data could be transferable and accurate comparisons made. Having the population at roughly the same size also allowed for the CCGs to be in the market for providers of a similar capacity. Evidence suggested that there are a limited number of private providers and that they operate in similar environments (Allen 2009). If the CCGs were unable to compete for similar types of providers’ comparisons and conclusions would have been more difficult.

The third criterion for selection of the CCG sites was the size of their catchment area (i.e., the population that they covered). In part, population levels needed to be similar so that commissioners at both sites were choosing amongst providers with similar capacity to provide services in respect of numbers, needs, and available resources. These similarities, once established, helped ensure that any differences are a consequence of the commissioning process itself, and not of any other context. It is important to note that the selected CCGs served a population that was very close to the average population that CCGs across the country serve (circa 250,000) (NHS Clinical Commissioners 2014).

The purpose of using two different CCGs, while keeping characteristics as similar as possible, is that commissioners were faced with other challenges regarding the services they select. The reasons why they are chosen can be very different, yet the comparisons drawn by this research were based on elements which were held constant, to allow the transferability of results.

The research also examined the extent to which private providers operated in their local areas (supply). Insights gained were used to shed light on commissioning from the perspective of the providers including their treatment during the procurement process, what is expected of them, as well as their perception of the actions and decisions of the CCG. This also provided an understanding of the future direction private providers might take based on their first experience of working within the new commissioning framework.

Selection of specialist services and the private/public mix

In order to be able to fully understand the commissioning process, the researcher selected specialist services to track at the two CCGs. This allowed the researcher to focus the study, limiting the scope from all services and also to be able to compare the findings from the two sites. Further, this allowed the researcher the ability to utilise multiple data sources, exploring the specialist services (Baxter and Jack 2008). The way in which these were selected is expanded on in this section.

Both of the services that were selected fall under the remit of CCG commissioners and not of NHS England. They are secondary care services that specialise in care which require a referral from a GP. The services must have had some private sector involvement in the past so that commissioners have the option to choose between private or third sector providers with a proven track record and the public sector.

At site one, the first service which was examined were elective procedures. The monthly average of elective procedures in the NHS is 700,000 (NHS England 2017). Such a high frequency of use illustrates the demand for electives and their resulting importance in the commissioning landscape. There is a mixture of both public and private providers in this area of service provision, and at the beginning of the empirical study over 340,000 elective procedures were being carried out by private providers in the NHS. This would suggest the existence of a relatively mature marketplace of competing providers (NHS Digital 2012). This may represent a small percentage of total NHS activity, around 4.3% (Hawkes 2012). This was partly due to previous Government policy of encouraging the use of private providers to reduce waiting times in the NHS. The number of elective procedures being carried out by private providers paid for by the NHS has continued to grow. However, the majority of the procedures are still carried out by the public sector, so commissioners have the option of pursuing either form of provider, or even a mixture of providers to deliver the service.

The second service examined across both sites was mental health. This included both general mental health services and more specific ones (i.e. Child and Adolescent Mental Health Services). While the use of mental health services was not as frequent as elective procedures, they have grown in importance in recent years. There is a mixture of providers available to commissioners, and there may be a slightly more significant number of non-state/third sector providers of mental health services than private providers (Peck and Hills 2000). This has allowed for the examination of a slightly less developed service (as evidenced by the low levels of spending on them at the outset of the research (Campbell 2014)) in the NHS, which

commissioners may have approached differently and with a different set of incentives than when dealing with elective procedures. The introduction of the NHS Parity of Esteem guidelines brought with it a higher priority being given to mental health (McShane 2013). Under the guidelines, commissioners were obliged to match spending on new mental health and physical health services (Ibid 2013). During the data collection, there was an onus on commissioners to secure additional mental health services.

As the researcher is utilising an iterative approach, there was a period that allowed for the data to be analysed before moving from site one to site two. The benefit of this approach is that it allowed the researcher to explore new avenues of inquiry as data became more available. It also provided time and space for the researcher to analyse data from site one before beginning work on site two. One key result of this approach was the change of service which was explored between sites one and two.

At site two, mental health was retained as a service because of the rich data it generated at site one. However, at site two elective procedures were not explored but was replaced with musculoskeletal services (MSK) with a particular focus on physiotherapy services (which fall under this stream). This was partly because of the difficulties in obtaining data about elective procedures and its quality in comparison to data from mental health. At site one, the electives were provided by the local NHS Trusts and were part of large contracts, with these services being provided by one provider and as such did offer any greater detail in the data. This was further compounded by the fact that at site one, the CCG was not the lead contractor for electives so much of the commissioning for them took place elsewhere.

MSK services have a history of a mixture of provision (Walumbe *et al.*, 2016) and were as such recommended by key decision makers at site one as a potentially rich field of inquiry. Since CCGs have begun operating, there have been reports of commissioners carrying out MSK procurements which have been awarded to the private sector (Allen *et al.*, 2017). The value of contracts which CCGs have given to non-NHS providers has previously exceeded £120 million (Ibid 2017), which may represent a value significant lower than that which is spend on elective procedures, but one which would provide more information to the researcher. There are mixtures of providers in both areas and thus, commissioners do have the option of utilising public, private or third sector providers. In this sense, changing the specialist service which was being explored was key in exploring the decision-making of commissioners in a service area where they have multiple choice of providers.

Exploring the provider's perspective

To supplement the primary study data, additional interviews were carried out with a third sector and private provider. This further strengthened the study as it provided an additional source of data. It allowed for the researcher to further triangulate some of the findings from the commissioners and to ensure that there

was data convergence and to fully understand the case (Baxter and Jack 2008). They were carried out at both sites, with providers that had existing contracts with the CCGs. At site one this included an interview with the Chair of a 3rd sector mental health provider. At site two, there was an interview with the directors of a provider of MSK services. This yielded information about the procurement process and the challenges were faced by the providers under the new commissioning framework. The gathered data provided a complete picture of the commissioning process at both of the sites. GP commissioners facilitated access at the two CCGs.

These additional interviews allowed the researcher to gain further perspective on the process and helped to improve the credibility of the data as it meant that it no longer relied solely on the data generated from the CCGs alone. It helped to triangulate the conclusions drawn from the supply side.

Feasibility: The selected sites were both in the South East of England and were chosen by criteria listed earlier in the chapter. The two sites were similar as they were both in urban areas and had access to similar types and sizes of providers. Both of the CCGs served similar populations in size and budgets. As mentioned before, this was to allow for a comparative analysis of the data. From a practical perspective, it also allowed the researcher to attend meetings and interviews frequently and helped in securing a large number of observations.

Gaining access to the two sites

The sampling method that was used was typical case purposive sampling. This technique was selected as it allowed for the study of: *“particular settings, persons, or events are deliberately selected for the important information they can provide that cannot be gotten as well from other choices”* (Maxwell 2008, p87). The samples were to be kept as similar as possible to examine the commissioning processes. Initially, access was difficult to arrange and how it was negotiated is outlined below.

Prior to beginning research, ethical approval was sought from the Research Ethics Committee (REC). This process involved outlining the aims, objectives and, methods that the researcher intended to utilise. Approval was granted at which point the researcher began to seek sites which matched the criteria.

Site one was identified as meeting the requirements of the researcher. Contact details were secured through the supervisory team. This assisted the researcher to establish contact and begin to establish a rapport with participants. This process took place over several weeks and there were meetings with the CCG Chair and the Head of Governance. After their consent was given, the researcher was granted access and began to attend commissioning meetings. Over the course of the data collection, the researcher was present in the CCG for over twelve months.

Gaining access to a suitable second site presented some difficulties, the second identified site initially identified withdrew from the process due to concerns about their ability to commit to time to the research. With the assistance of key decision makers at site one, the researcher contacted other similar CCGs to negotiate access

to that given at site one. This resulted in the selection of a similar CCG. As at site one, the researcher was present over the next twelve months. As the new CCG matched the required characteristics for a comparison with data gathered at site two, the sample remained a purposive sample.

The meetings and information needed for this research were not accessible publicly and as such the researcher had to access private commissioning meetings, including having access to sensitive documents. For this to be achieved, governance approval from each of the CCGs that were selected was obtained. This included signing confidentiality agreements with both CCGs and providing them with evidence of the completed University REC forms (more on this is available in the appendix). There was no direct need to pursue NHS ethical approval as the research did not encounter patients/use them as research subjects outside of comments that may have been sent in by the public at open meetings. Governance approval is different from 'standard' NHS ethical approval. The individuals in charge of governance requested a range of documentation in order to verify the researcher's credentials. This explains why the researcher had to agree access to the CCGs separately. Heads of Governance at both CCGs only gave their agreement when they were confident that the research was to be conducted properly.

Data collection: Site One

The study involved three stages of data collection. The first stage was the initial conversations, or informal interviews, with key stakeholder members of the CCG. At site one, the Chair was provided with information about the research before a meeting, including an information sheet (see Appendix). This was followed by the researcher attending a Governing Body meeting and gaining agreement from the key decision makers, as well as the Head of Governance. The relationship with the Chair and the Head of Governance proved vital as they enabled continued access to the workings of the CCG. Both of these actors also set expectations regarding interviews and time that members of staff could dedicate to the research.

These initial meetings also assisted in gaining a fuller understanding of the governance structures of the CCG (i.e., understanding the formal decision-making process). This identified key informants to be interviewed and the key commissioning meetings to be observed. At this point the researcher began to collect field notes of the observations which took place. These would help to inform the questions asked at the interviews at this site. Through these early meetings and observations, the researcher began to develop an understanding of the decision-making process at the site. Finally, these early contacts assisted in building a rapport with the key informants. During this period, the topic guides were refined after the early insights about the structure and interaction between principal actors at the CCG. These were then used during the observations and a separate topic guide for interviews was developed.

The second phase of data collection was an observation of the decision-making process. Observing the key actors, the researcher then identified key board meetings which included the Clinical board; the Finance and Performance meeting

and the Governing Body. It was through non-participant observation of these meetings that the researcher became familiarised with the processes at site one and how decision making took place. Data was collected in the form of field notes in situ. This early data collection process lasted approximately six months, at a rate of two meetings attended each month. The benefit of attending these additional meetings was identifying other key decision makers in the CCG, as well as, the services that were to be tracked.

The first interviews took place after six months of observation. Having identified the key decision makers, the researcher formally requested interviews with them. The interviews took place over the following eight months during which the researcher continued attending CCG meetings, so to further inform their topic guide for the interviews. The topic guide ensured that basic questions were asked of all of the participants. It allowed the researcher to be flexible in exploring new themes identified during observation and other interviews. Amongst those interviewed, were lead commissioners and other members of the CCG. The interviews were recorded and then transcribed. Once transcribed, they were coded and analysed and used to inform subsequent interviews and observations.

Throughout this process, the researcher continued to analyse data from the observations and interviews using it to inform subsequent rounds of data collection. The researcher used the observations to explore the decision making process and then clarified and explored other avenues of inquiry in the interviews. This iterative approach provided the flexibility to continue to explore new data streams while ensuring that the researcher remained mindful of the original questions. This analysis allowed the researcher to explore these new themes/data streams, and thoroughly explore other emerging data regarding the original questions.

At the conclusion of all data collection at site one, there had been thirteen interviews (n=13). This included the Chair, Vice-Chair, Managing Director, Lead Clinical Commissioners, Deputy Managing Director, Assistant Directors of Commissioning, as well as other key managers and clinicians. This comprised the majority of the membership of the clinical board, where decisions about which provider to select were taken, and also shared membership with the governing body, the decision-making body which made all formal decisions of the CCG. These actors were identified as key in determining the commissioning strategy of the CCG. Apart from the interviews, there were 100 hours of observational data gathered across three key decision making meetings, including the Governing Body and Clinical Board.

The observation at site one was conducted to the point of data saturation at which new interactions/processes no longer contributed to new streams of data and triangulation. This took place as many of the same discussions started taking place and no new interactions were being found by the observations. As both interview and observational data was being collected, it was continually being analysed, with key themes identified and explored with the assistance of Nvivo. The emerging

themes were explored in subsequent meetings and raised in interviews with relevant individuals. This was complemented by documentary analysis of commissioning texts during the meetings, with key information being recorded in the field notes.

During the observation, it was clear to both participants and the researcher that the relationship would remain non-participatory. The researcher could not contribute to the workings of such a highly specialised professional organisation, and did not wish to influence the decision-making process of the CCG. The presence of the researcher was limited to ensure that they did not influence the discussions at the meetings. The task of the researcher was complicated by the sensitive nature of the information being discussed, including financial information, and meant that some information was withheld/and documents were not disclosed to the researcher. This also raised specific ethical implications about the introduction of the researcher to outside groups who may have been making their presentations to the CCG. As was the case in other research, the researcher was introduced to the relevant groups to attempt to minimise this issue (Pope 2005).

The third and final phase was the follow-up stage. Its purpose was to collect data to allow further triangulation of earlier collected data. The aim of this was to minimise the possibility of misinterpreting the motivations of the commissioners and minimise the possibility of incorrect interpretations by the researcher. This helped to make the data more reliable. It also allowed the researcher to refine the data with the regards to the third question, the public/private balance. These concluding observations and interviews with the key informants were generally conducted face to face, while a few were conducted over the telephone. Figure 5 illustrates the data collection stages at site one. The researcher attempted to replicate the process at site two, although there were some differences in the exploration of the CCG structure as the sites were not identical.

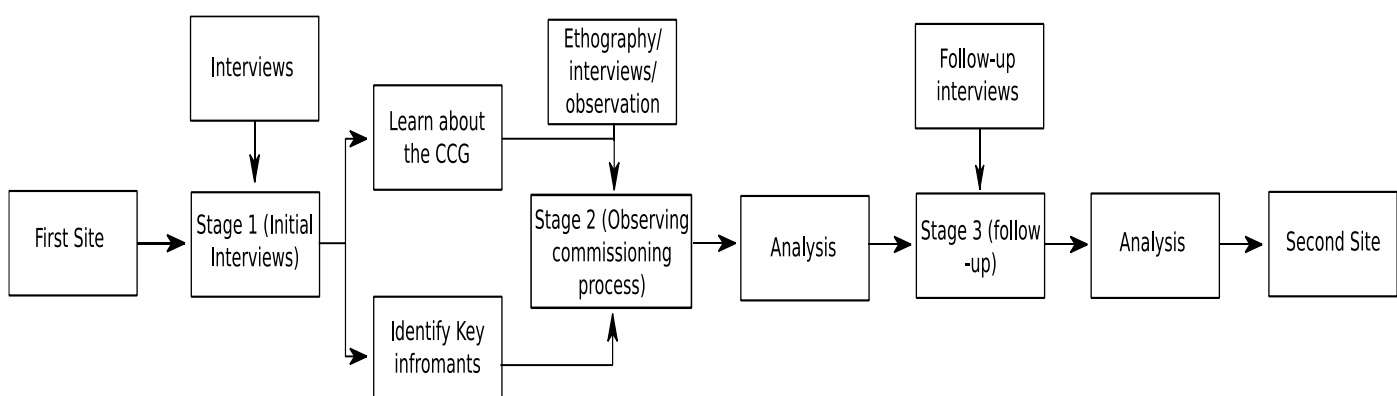


Figure 8 - Data collection stages

One of the aims of the data collection was to identify the principal actors of the commissioning process in the CCG. This data was collected both from members of

the CCG and the providers, with the ultimate aim of comparing the commissioning process before the Act and at the completion of data collection.

Iterative approach – an analysis of data from site one

The research utilised a method of inductive thematic analysis using constant comparison (Guest *et al.*, 2011). Site one yielded rich information about how the CCG reaches its decisions regarding which new providers may be selected. It provided the researcher with information about the structure of the CCG and which meetings are essential in the process. By identifying and attending the key meetings, the researcher gained the trust of key informants. This included non-clinical commissioners who also influenced the decision-making process, a greater number than expected at the onset of the study. The following are the key elements that emerged from the pause in data collection between sites one and two.

The selection of new services followed a consistent pattern. By attending meetings, the researcher identified this pattern and gained agreement to attend further meetings, building a rapport with the staff of the CCG.

The field notes which were taken proved to be invaluable in gaining an understanding of the CCG, the dynamics between key actors and following the commissioning process as it took place. The interviews complemented that and provided data which would support/correct the assumptions of the researchers and provide additional areas of study.

The collected data from site one provide to be an excellent context in which to test the explanatory power of the conceptual framework. It allowed the researcher to update the topic guide for the interviews and more significantly it further helped to improve the understanding of the role of external bodies.

The data from site one also provided some insights and understanding of the interaction of the commissioners with other bodies in the regulatory framework, as well as those from within the local health economy. It further underlined the influential role of the regulatory framework as manifested by its regulation of funding and financial incentives.

Observation of site one gave an insight into the full commissioning process of a new provider, from its initial stages through to completion. This highlighted the complex organisation of a CCG and the multitude of dynamics that can exist when various CCG boards interact when reaching decisions about the type of provider they want to select.

Data collection: Site Two

Observation at site two was influenced by the experiences at site one. One difference was the way in which access was gained to the CCG. After initially being refused by several CCGs that matched the necessary criteria, access was obtained to a chosen CCG with assistance and support from commissioners at site one. The selected CCG was in keeping with the criteria of size, finance and ability to contract similarly sized providers.

After meetings with the Chair of site two, the researcher presented a paper at the Governing Body – as at site one. The Head of Governance acted as the key gatekeeper, and after ensuring the signing of a confidentiality agreement, provided additional guidance to the researcher. A fundamental difference at this point of data collection was that the governance structure of site two was different than at site one; for example, some decisions about the selection of providers could be made in one board at site one. At site two, a similar decision would be spread across several boards. As at site one, field notes were kept of the meetings and these were analysed and themes drawn out. At both sites, the conceptual framework was useful in examining the manner in which internal/external pressures affected the motivations of commissioners when selecting providers. There were also relationships which were unexpected, and these will be outlined in the subsequent chapters which present the findings from the study.

Mental health commissioning provided data at both sites one and two. There was a lack of data about electives at site one, so this was not explored at site two. Instead, on the recommendation of practitioners at site one, the observations focused on MSK services, as they had a history of private and third sector involvement (Propper 2000).

Despite the two sites being similar and in line with the selection criteria, there were some differences. These differences related to the financial pressures and the role of the regulatory framework at the two sites. How this affected the commissioning process will be explored in later chapters. Both CCGs had access to a multitude of different public, private and third sector providers for both of the selected services.

Over the course of data collection at site two, the researcher had regular access to key commissioning meetings, including the Finance and Performance committee, Transformation and Redesign group, and the Governing Body and associated seminars. At the end of the data collection period, this totalled over 65 hours of observation across the different meetings. The observational data was also collected via field notes in situ. At site two, the same topic guide was used as it had proved to be valuable at site one. The committees only met once a month, with the Governing Body meeting once every two months. The Governing Body also had a seminar every other month. Similar to site one the Governing Body was the official decision-making body. These observations and interviews were conducted over a 12-month period.

The number of complete interviews that took place at site two was eight (n=8) attempting to mirror the number of interviews at site one. However, due to the smaller number of committee members at site two, and some non-responses, which included two commissioners who declined to be interviewed, the overall number of interviews at site two was smaller. The key decision makers, such as the Chair, Vice-Chair, the lead commissioners, Head of Finance, Head of the Transformation Group and the Deputy Managing Director were interviewed at site two. All of the interviewees were members of the Governing Body as well as some of the other Boards which comprised part of the decision making structure at site two. This was important to draw comparisons across the two sites.

Relationship with providers

The commissioning processes at the two sites also shed further light on the manner in which contracts are monitored. From the research, it was clear that the majority of the budget was spent on the local providers and large contracts, both fixed term annual contracts and Payment by Result contracts. This helped to highlight how data collection needed to take place - by focusing on the work of the lead commissioners and the commissioning managers (key decision makers for the selected services).

Regarding mental health, the data was rich and provided insights into the commissioning process as a whole. Throughout the time the researcher was present a new service was commissioned allowing service provision to be tracked from start to finish.

	Site One	Site Two
Interviews	12 Interviews (Chair, Vice-Chair, Deputy Managing Director, Lead Service Commissioners, GP commissioners, Assistant Directors of Commissioning)	8 Interviews (Chair, Vice-Chair, Deputy Managing Director, GP Commissioners and managers)
Observations	150 hours (Clinical Board, Governing Body and Finance and Performance Committee)	65 hours (Governing Body, Finance subcommittee and Transformation and Redesign Group)

Table 4 - Decision makers interviewed and meetings observed

Data analysis- Analytical frame – sites one and two

The research utilised the same method of analysis as at site one. Nvivo was used to help identify themes within the data and to inform other parts of data collection, approaching this process by exploring the interactions of various actors. It drew on both the observational and interview data. These themes were compared against the conceptual framework that was created in the previous chapter. This analysis was used to create a narrative with which to understand how commissioning decisions were reached and whether or not commissioners preferred to use public/private/third sector providers. As at site one, the observational data was useful in understanding the internal CCG dynamics and the interview data clarified issues, as well as providing additional data about the commissioning process. Once themes were identified, they were explored in more depth at the sites through further observation and interviews. This process was repeated with the data from site two. The differences and similarities between these two sites were then contrasted before answering the overarching questions of this thesis. The purpose of using this approach was to strengthen the ability to compare results from more than one site and/or one source (Guba and Lincoln 1985).

The field notes assisted in generating a more complete picture of the commissioning process. They were used to record the impressions and understanding of the researcher. The interviews were deployed to test these assumptions and to explore new avenues of inquiry. This contributed to the data that was collected being the researcher's impressions, but ones which were tested against other research subjects.

Assessing the quality of the research

To assess the quality of the research and to ensure that the methodology did address the research questions, its trustworthiness as defined by Guba and Lincoln (1985) was established. This is relevant as the research adopts a similar ontological and epistemological position as Guba and Lincoln (1985).

The first indicator is the credibility of the study. This relates to the 'truth' of the study, or how accurate the findings are (Guba and Lincoln 1985). To establish credibility there are multiple techniques which are recommended (ibid 1985). The first is 'prolonged engagement', where Guba and Lincoln (1985) argue that a researcher needs to spend sufficient time to understand the culture of the group being studied. The researcher spent over twelve months at each of the sites, building rapport and dedicating time to understanding the nature of the CCGs being studied. The second technique is 'persistent observation'. To do this, the researcher should be open to multiple different influences from actors and other influences (ibid 1985). In this study, the researcher spent time observing the working of the CCG and observed various actors across different environments and their ability to influence the decision making processes. This assisted in uncovering other actors to interview and the exploration of new areas of enquiry. The third technique is triangulation of data. In this instance the researcher used the observational data

and the interviews to combine to provide a rich account of the commissioning process. These use of these techniques illustrates that the data produced by the study is credible.

The second indicator is transferability, which concerns demonstrating that the findings have applicability in other contexts (Guba and Lincoln 1985). If a study has described the process being studied in enough detail, then there is scope to evaluate whether or not those same conclusions are transferable to other cases. The technique to ensure that there is enough detail is 'thick description' (Ibid 1985). The use of both observational and interview data collected over an extended period of time, delve into the structure and culture of the two CCGs means that this study does provide thick description.

The third indicator is dependability, which illustrates that the findings are consistent and could be repeated (Ibid 1985). To ensure dependability, the researcher kept notes on the observations, the interviews, supervision meetings and the data analysis. The reflective notes after observations also aided with this. These should allow for a researcher to replicate the methods used and draw their own conclusions about the process.

The last indicator is confirmability, that there is some degree of neutrality between the researcher and the subjects, so far that the conclusions are shaped not by the biases of the researcher (Ibid 1985). The first technique to ensure confirmability is an audit trail. All of the files which have been collected during the course of the study have been kept and an outline of the process has been found in this chapter. The second technique is reflexivity. In this context, in all of the field notes, the researcher kept notes about methodological choices and which avenues of inquiry to pursue. Finally, triangulation also assists with this, and as outlined earlier, the multiple data streams aid with this.

Other possible criteria can be used to judge the effectiveness of an ethnography. One of them which will be considered is credibility (Hammersley 2000). This entails checking how credible the account that is provided by the researcher is to those who have been the object of the study. This was achieved by the researcher going back to the CCGs and providing them with short policy briefings/summaries of the relevant findings.

One key issue with transferability relates to the differences in the service and site selection. The researcher was unable to gain access to a CCG which was as similar to site one as initially planned. The issue with access meant that there was a compromise on some criteria for site selection. The financial situation was clearly different and this was something which is illustrated in the data. However, site two did have similar access to a diverse set of providers and did have similar catchment areas, and served similar sized populations. In addition, tracking mental health commissioning across both of the sites did assist in ensuring that there was an ability to compare commissioning of a specific services across the two sites. The selection of MSK services to be compared at site two allows the researcher to

explore commissioning in an area where there is a history of private provision, and an area which commissioners spend relatively similar amounts of money at both sites. Ultimately the ability of commissioners to select the provider, in areas where there is a certain amount of market penetration still ensures that there is some transferability of data. This is further explored in chapter 7.

Timeline

The research took around twelve months to complete at site one. Further observations were carried out afterwards to provide additional triangulation of the data. There was a brief pause between data collection at sites one and two, which allowed the researcher to analyse the data, rework the topic guides and explore new avenues of inquiry.

At site two there was a similar time frame, with a period of several months being used to build rapport with the commissioners and key decision makers within the CCG. The fact that the research was undertaken in two separate time blocks, rather than simultaneously at both sites, aided the researcher both in practicalities and in the time available for continuous building analysis of data.

Ethical Implications

Ethical approval for the research was first sought from the School of Social Policy, Sociology and Social Research (SSPSSR) Research Ethics Committee (REC). The researcher completed the necessary documentation outlining the aims of the research and the safeguards that were necessary to protect participants. This referred to issues such as data protection and anonymisation of names and dates during the research – within interviews, observations and any of the documents that were to be used in the analysis.

At site one, the researcher worked with the Head of Governance to arrange access to meetings and to provide more information about the nature of the research, after presenting a short paper in the CCG's key meeting and gaining approval at Governing Body level (which was similar to that provided via the information sheet). This was considered to be enough for observation access. For the interviews, informed consent was sought from each individual, and the anonymisation of their names and information was also confirmed. Each participant signed a consent form and was made aware of their rights to withdraw/not answer any questions if they chose. They were also provided with information sheets with the contact details of the supervisory team and University REC (see Appendix). All of the participants were debriefed after their interviews and given the opportunity to ask the researcher any questions that they may have.

When dealing with changing circumstances at meetings at both sites, where external groups came into the meetings, the commissioners introduced the researcher and ensured that they were happy for field notes to be taken during the process.

The research collected valuable information about the commissioning process. As this was the case, specific sensitive information such as names of providers or commissioners was redacted from the write up to ensure anonymity. That included financial information and documents which related to patient confidentiality as well.

At site two there was also an initial conversation with the CCG Chair and the Managing Director. They agreed to support the research, and this was then brought to a Governing Body meeting. Once approval had been gained, the researcher made contact with the Head of Governance who arranged for a confidentiality agreement to be signed by the researcher. They acted as the main points of contact and arranged interviews and papers for meetings that were observed. Clerical staff handled additional facilitation of interviews instead through direct contact between the researcher and the subjects. The interviews also followed a similar process to those at site one, with written consent being obtained by the researcher and a debrief undertaken after the interview. There was a further meeting with the Head of Governance to ensure that no sensitive data was left within the data set.

In summary, this thesis explored the process of decision making and how it affected the use of private providers in the NHS. It involved the study of two CCGs and specialist services at two sites. All of the services which were examined had been delivered by a combination of public and private providers. The epistemological approach which was employed was symbolic interactionism. This approach was used to analyse the interaction between actors who comprised the CCG boards through immersing the researcher in their day-to-day workings. The empirical study consisted of over 150 hours of observation of relevant board meetings at the two sites and 21 interviews with key decision makers, including providers at both of the respective sites. The themes and findings will be explored in the subsequent chapters.

The following two chapters present the findings from the ethnography of the decision making processes and contains data from both the observation and the interviews with key actors. The first of these chapters focuses on the data elicited from the first CCG site and explores how commissioners made their decisions and how that decision-making process influenced the selection of provider.

Chapter 5: Understanding the commissioning process – Evidence from CCG One

Introduction

The purpose of this chapter is to present the themes that emerge from the analysis of the first case study site, a CCG in a large urban setting in Southern England. The general aim is to gain a better understanding of the manner in which decisions are reached in the new Commissioning Groups. This chapter will begin by providing a description of the structure of the CCG and how decisions are reached within these structures. This discussion will be followed by an exploration of the how the CCG made decisions about the selection of providers, using evidence from the ethnography. There will also be a discussion of how these themes relate to the conceptual framework and how they help to answer the questions posed in this thesis. It will be concluded with a summary of the key findings and what is to be explored at site two.

The analysis will focus on the following questions:

1. What influences the decisions of commissioners in /during the commissioning process?
2. Why do commissioners select certain providers over others?
3. How has this affected the private/public balance in the NHS?

As stated, the purpose is to gain an understanding of the manner in which the commissioners select a particular type of provider over any other type and what influences their decisions. The analysis will address the critical influences over decision makers; and if and how decision making fits within the internal/external pressure framework created in the previous chapters. It will explore whether commissioners are restricted, or enabled by, the policy framework to exercise their decision-making ability.

The first part of this chapter will outline the general governance/decision-making process in the CCG, with an aim to understand decisions within the broader context in which the CCG operates. The precise structure helps to highlight the goals of the CCG and how they function in a new commissioning space. This is key to addressing the first research question. Without establishing the context in which commissioners' work, it would be difficult to fully understand their decisions and the process by which they are reached.

The informants interviewed as part of the ethnography from site one were interpretive and reflective. Being part of the loose symbolic interactionist framework that was used, this meant that the data they provided was part of a narrative of how they viewed their own roles within the CCG. This was confirmed as

the observational data was used to explore the workings of the CCG and to understand the roles of the participants, through the immersion of the researcher in the research site. Thus the interviews allowed participants to express their own views and relationship with other actors, both internal and external to the CCG. The first part of this chapter will explore the structure of the CCG and the power relationships amongst the actors, before further exploring the commissioning process with respect to key services.

Site one: the characteristics of the CCG

The first site chosen for the research is in a large urban area. The CCG in question has an annual budget of just under £300m and commissions services for a population of approximately 300,000 people. It is slightly larger than the median CCG in terms of population (ONS 2012, NHS CC 2015). The budget allocation for the CCG is average for the country. The CCG consists of over 50 GP practices and employs a locality structure where groups of practices have a GP chair and vice-chair with the aim to involve as many GPs in the CCG. These GPs do not sit on the CCG boards, but relay feedback of GPs to the Clinical Board – the main clinical decision-making body - as a way for the CCG to communicate with the constituent practices. This is not standard practice across all CCGs, although it is used in CCGs with a large number of practices – circa 70% (Checkland *et al.*, 2012).

Being in a large urban area means that the CCG is more likely to have access to a mixture of public, private and third sector providers. It has been suggested that a significant part of the private provision is located in large urban areas (The King's Fund 2014). Therefore commissioners were able to choose providers from what can be characterised as an active 'marketplace,' i.e., they can select different types of providers for the same service.

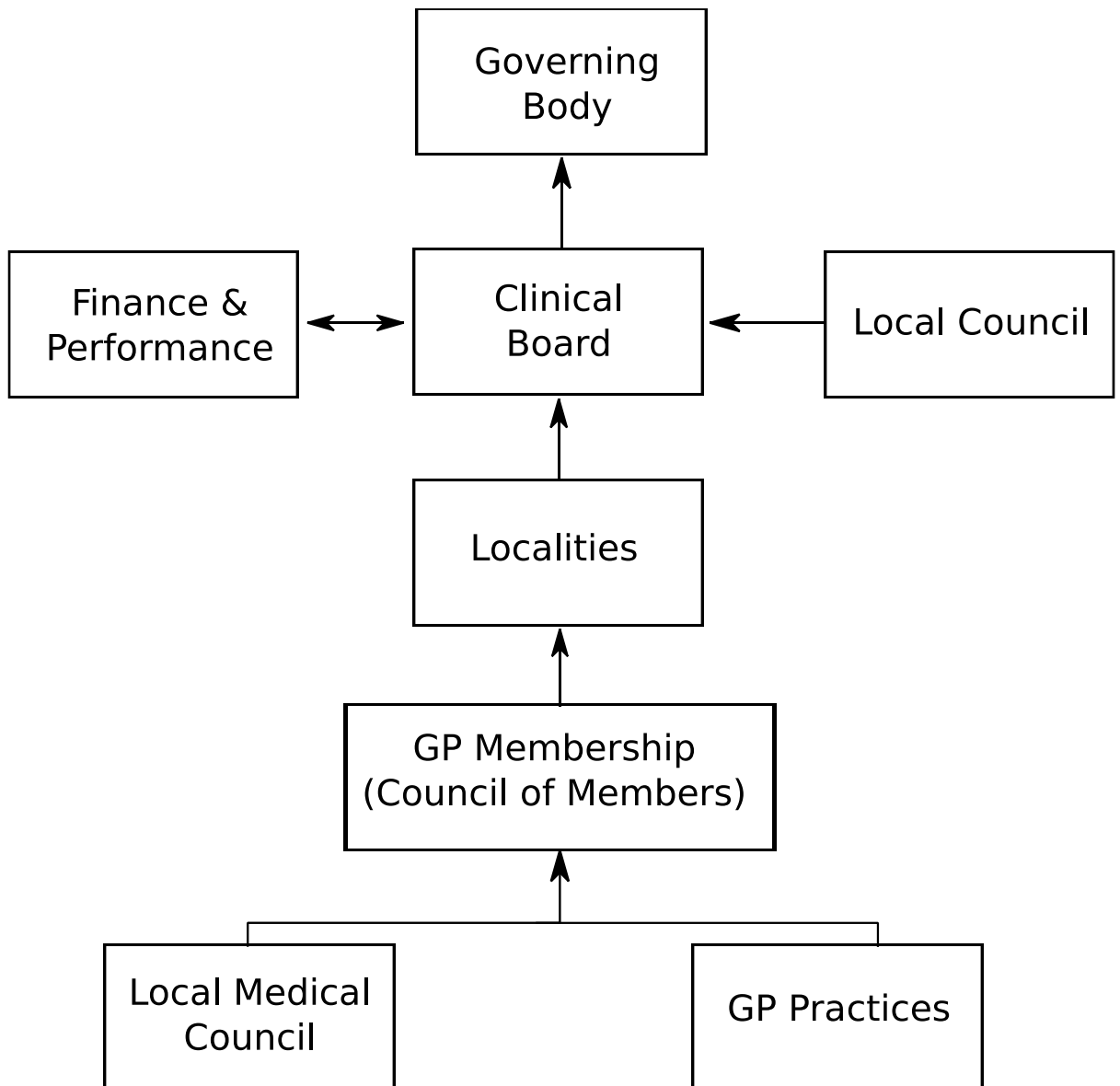


Figure 9 - Decision-making structures of CCG one

Understanding the structure of the CCG and the role of the commissioners aided the researcher in exploring the culture of the organisation and the roles of key actors. It further assisted in understanding the decision-making process from the perspective of the commissioners, with an emphasis on embedding of the researcher in the CCG.

The Structure of the CCG: implications for decision-making

The purpose of this section is to outline basic governance structure of the CCG and to elaborate on how commissioners select providers. The basic decision-making structure can be seen in Figure 6.

All CCGs are required to have a Governing Body (GB) in which all decisions are reached (NHS England 2016). The CCG has several different layers that feed into the

GB (see figure 6). The research found that the GB served to authorise the decisions of other bodies within the CCG. The GB consists of the elected Chair of the CCG (who is always a GP), the Vice Chair, the Managing Director (MD), elected commissioning leads (local GPs elected by the CCG membership), lay members, Chief Officer, Managing Director, Chief Finance Officer and several other managers who work within the CCG and the local council. The GP Chair and Vice-Chair had recently been re-elected to lead the CCG on a platform of being fiscally responsible and continuing to expand services in certain areas. The meetings consist of two sections, one in which the public is allowed to attend and a second section in which the GB discusses issues in private. This research identified that the most important body regarding the selection of providers was the Clinical Board (CB). This was after initial observations in which all decisions would appear to have been taken by this body, and with other board referring their own decisions to be ratified there.

The decisions regarding which services are commissioned occurs at the CB, which is also where existing services are periodically reviewed. The membership consists of the commissioning GP leads and several key managers, such as the Managing Director (MD), the Accountability Officer, Assistant Director of Commissioning and the Compliance Officer amongst several other managers, with the CCG Chair in charge. There is a large overlap between the GB and CB. Also present are commissioners from the local council with a public health remit. The CB meets once a month, with meetings lasting for approximately five hours. Noted in all of the observations, the CB has a horseshoe seating format and welcome groups/other commissioners/Trust representatives whom they invite to provide services, or who request funds from the CCG. These groups attend CB meetings at the invitation of the commissioners, usually after identifying a need through a Joint Strategic Needs Assessment (JSNA) with the local Council. This process can be adversarial in certain situations where representatives/CCG Board Members were unhappy with certain elements of proposals. After the relevant parties have made their presentation or laid out their intentions and plans, the members of the Board reach a decision about the service in question. Once the external representatives have left the meeting, commissioners discuss the issues before deciding whether or not to approve a plan or return it for amendments. From the observed meetings, the majority of the decisions appeared to be made on the basis of clinical outcomes, not on financial ones. This includes the weighting of the procurements that the CCG carries out, as a local provider told the researcher: "*[Site one] often does 90% quality, 10% price, which is unbelievable, you know?*" (3rd Sector Provider, Interview). This suggests that there is a perception amongst provider that the local commissioners did still focus on quality aspects and clinical need than solely financial issues. The other task the CB addressed is the review/auditing of services, providers and business cases of new services. Before any of the decisions that are made in the CB go to the GB, they have to pass through a specific sub-committee, Finance and Performance (FP).

The FP sub-committee consists of a Chair (a GP commissioner who is also a member of the CB, but not the CCG Chair) a second GP commissioner (the Vice Chair of the CB) and several managers, such as the Managing Director, Head of Finance,

Assistant Director of Commissioning and a lay member. While the membership is considerably smaller, the meetings are only slightly shorter than that of the CB. The central role of the sub-committee is to see if the decisions reached by the CB are viable within the budgetary constraints of the CCG. The FP looks at business cases put before it and either approve them or send them back to the relevant body with a series of questions or revisions. Other GP commissioners may also be invited to the meeting to answer questions and/or to assist in the process.

GP practices and individual members do have the ability to express views to the CCG leadership through one of the several ways. The first is through their organised localities that link into the CB. As mentioned previously, GP practices in the CCG are organised into localities (CCG information 2015). These localities have an elected Chair and Vice-Chair who feed back concerns and issues to the CB. In turn, they are required to ensure that constituent practices are implementing and following strategic objectives. The second is through the Council of Members (CoM) where GPs can ask members of the CB questions about what has been agreed, or nominate themselves to stand for election. Finally, there is the Local Medical Committee (LMC) which has some interaction with the CCG leadership. The public can interact via the GB or the Health and Wellbeing Board (HWB). The purpose of the HWB is to have a body formed of local representatives that feeds into the decision-making of the local CCG (The King's Fund 2016). However, their input at site one was negligible. Throughout the observations, there is no evidence of the HWB being given serious consideration during CB discussions, being absent from any observations. Further to this, during the observation of the GB, only three questions were allowed from the public per meeting, which had to be submitted in advance. There was an antagonistic atmosphere between the CCG leadership and members of the public during the AGM, in which the question period was extended to deal with the demands of the audience, and there were even outbursts from members of the public and local councillors (AGM Observation, July 2015).

From the first observation in December 2014 to the one in April 2015, the members of the CB always sat in the same pattern, as illustrated by the researcher's field notes:

Chair and Vice-Chair at the head of the table, discussions centre on them, Role of Managing Director and Assistant Managing Director also important, second after Chair (CB First Observation, December 2014, field notes)

The same people were present and in a similar format, with the Chair and Vice Chair at one end of the table - there was a more evident divide with commissioners around one end of the table and managers around the other (CB Fourth Observation, April 2015, field notes)

This consistent structure helps us to understand the manner in which decisions are reached in the CCG. It suggests that the structure gives greater weight to the decision-making power of the managers and the key clinicians, all of whom sit on the CB.

The decision-making power is concentrated in the Clinical Board. Here the key decisions are taken and while they can be altered by other boards, this did not happen often. Within the CB, all of the key decision-makers are also situated, both clinicians (GPs) and managerial staff (Managing Directors, Assistant Directors of Commissioning, Directors of Finance). As CCGs are allowed to develop their own structures, this situation does not necessarily represent a standard structure adopted by all other CCGs. As such, these key decisions are negotiated in this committee between the various powerful key actors, which are explored in the subsequent section.

Commissioners decision-making: two types of actor

This section will expand on the difference between the two types of actors found at site one. This will assist in understanding the role of the Clinical Commissioners (GPs) and Managers (non-clinical commissioners, henceforth managers). Throughout the study, key actors from both groups were identified. The GP Chair and the Managing Director (MD) were the two most powerful actors involved in the decision-making process. This manifested in two ways. First, the agenda of each CB meeting was set by both actors in advance. This would suggest that they are able to exert greater power, as they dictate the items and discussions that take place. Second, the final decisions reached by the CB are directed by these two actors. This is expanded on in this section.

In order to explore the relationship between the key actors in more depth, there is an outline of the differing roles of the actors and the types of discussion that take place. As already stated there are clinical and non-clinical commissioners. The clinical commissioners have more power than their managerial counterparts. In part this is due to the nature of the discussions within the CB. They tend to be more clinically focused and as such, there is less that the managerial staff can contribute. However, there is also a general deference to the clinical staff due to the agenda and focus of the CB. It appears that the focus of the meetings matched those of the Chair, with a focus on improving clinical outcomes and as a result, the contributions made by clinical commissioners were considered to be more valuable. This is outlined below.

There were two key types of debate around decisions that were observed during the course of the study. These further highlighted the distinction between GP commissioners and managers. The first type of discussion was about clinical objectives/results. These discussions focused on the effectiveness of a new proposed service or how it would address a gap in existing provisions. In these discussions, it was the GP commissioners who dominated the conversation. Commissioners perceive themselves as being best placed to have a critical but fair relationship to the CCG and have discussions in a particular manner, as noted in the approach by one commissioner:

“but, you’ve got to do it in a sort of critical friend type, with reasonable and proper oversight” (GP Commissioner 1). The GP commissioners view their own roles as being important and their high level of knowledge of the subject matter reinforces

this. Within clinical discussions, these commissioners lead the debates. Managers can become involved, independently of being asked, when there needs to be input relating to a non-clinical issue, such as whether or not a proposed new service needs to utilise a specific facility, or statutory obligations which may exist with regards to a specific service. This was observed several times:

There were several options presented to the CB about how they wished to proceed with co-commissioning and how the CCG would work with the others in the local cluster. Managers ruled out one of the options as soon as the debate started as being unworkable in practice. (CB Second Observation, February 2015, field notes)

Similar practices were observed at another CB:

The MD brought up how the CoM (Council of Members) would need to be consulted about a new care pathway, 'A conversation needs to be had with General Practice,' agreement came from other Board members. (CB Fifth Observation, June 2015, field notes)

The Managing Director had to intervene to ensure that the statutory regulations were followed and that the CoM was consulted about a change in working pattern.

The second form of debate observed within the CB related to issues connected to the broader policy framework. This type of discussion related to whether or not commissioning a new service is possible and how it would be implemented. With these discussions, it was managers who controlled the debate, with some input from the GP commissioners on issues that have a clinical and administrative overlap. This generally relates to how a new service or procurement would fit within the rules and regulations laid out by the compliance bodies within the system, namely NHS England. In the July 2015 CB, the Chair and several managers argued over practicalities with the implementation of a new service. The managers were concerned about how the service would be monitored. This was observed in the meeting and in the field notes (CB Sixth Observation, July 2015, field notes). As previously explained, in these discussions the managers' knowledge of the regulations may allow them to have more decision-making power. However as observed in the ethnography, the managers made efforts to ensure that clinical decisions were to be delivered within the regulatory framework.

While discussion relating to the broader policy framework is the most prominent (in the form of discussion about NHS E), there are other important debates with which the managers are involved. There is a clear divide between the GP commissioners and managers and their respective remits. Moreover, this did not appear to be an impediment to reaching decisions on service provision. The two different groupings complemented one another and assisted in ensuring the CB reaches decisions that are both clinically effective and practically possible. In both forms of discussion, final decisions appeared to be reached via consensus, with little dissent except on rare occasions. The CCG Chair had their own views:

"If you talk to managers one of the things you will probably find they say is if you have clinicians in the room it changes the content of conversations completely. Now, I can't see that, So, if you put clinicians in the room, normally clinicians can come up with a

solution, and if you can then get some competent managers to enact the solution you can usually work it out, that is your best way".

There are times when we haven't [agreed], so we haven't ended up with an agreement with the [consultants at local trust] [...], so [service] is an inefficient, autocratic place, but with other places like [service 1], [service 2] and [service 3] [all elective services] we have put the clinicians [secondary care doctors] and GPs [CCG commissioners] together and we normally thrash something out that will work for patients and be cost-effective for the health service (CCG Chair, Interview)

This is an example of how the two different groups, despite having different approaches, views or remits, can find mutually acceptable solutions within an agenda that had been set by the Chair. Part of the reason that decisions do appear to be reached is that there is embedded power within the CB, as the Chair is able to set the agenda, with the co-operation of the MD. This suggests that the discussions take place in the way they do because the chair utilises the second face of power – agenda setting - to ensure that discussions take place the way that they want them to.

This general notion of consensus decision-making is further reinforced by the lack of voting. Instead, principal actors (Chair and MD) seek consensus by alleviating the concerns or making concessions to members of the board. There was minimal confrontation between members throughout the study. This was repeatedly recorded in the field notes: *'Decisions appear to be reached by consensus, unanimous agreement, votes did not take place at the Board'* (CB Second Observation, February 2015, field notes). A similar observation was made in April: *"voting' has been very informal, again it appears to be more along the lines of consensus, unanimous agreement'* (CB Fourth observation, April 2015, field notes). This would fit in with the perception that decisions are reached by consensus with minimum disagreement as both the Chair and MD seek to forge consensus.

This is also apparent in the interviews, with clinical commissioners also viewing decisions as being reached through consensus:

"We'll nearly always come to a consensus decision. We've never really had voting. Voting is very rare on issues because I think we are a reasonably good team, gelling and challenging to one another and there are certain contracts, or certain tenders, which have gone back, and we have re-done and looked at it again. [...] I was working on a funding proposal which took almost a year to come to change or whatever and that was the traumatic brain injury one [...], but again it was refining it and working together and seeing what the sort of continuing cost to the CCGs would be, rather than set-up costs. And that's the kind of thing you need to take a look at because, you've got the [...] thing of the CCG, that it needs to be reasonably in the budget, or you know, you [sic.] got to set a budget which is realistic." (GP Commissioner, Interview 2)

This extract highlights how there appears to be an acceptance of this consensus model, with a lack of pressure for voting in any formal sense. However it is clear that this consensus is developed by the key actors, as the Chair and MD tend to steer the discussions and influence when concessions need to be made to another actor or commissioner. Power is situated with these key actors. As already mentioned, they set the agenda and the strategic direction of the CCG. Their power

is further illustrated by the ability to develop a consensus position, which appears always to follow the interests of the Chair and MD.

On infrequent occasions in which a member is persistent in their opposition, and remains unconvinced, their views are noted, and the CB proceeds with the majority decision while noting the views of that person:

"Because we don't actually vote, oh and also wanting to have sight of how each member of [...] each elected board member has voted on each particular issue. Actually, the number of votes that I have been part of in the last year, I can't even think of one. It's been a capturing of expressions of support, or occasionally there's been [...] a strong opinion of somebody, and we made sure that that strong opinion against the consensus was recorded in minutes." (GP Commissioner, 5)

However, this decision does not take place before a clinical commissioner, Chair, or the Managing Director attempts to find some consensus position, which would still see the proposal be adopted. This highlights the power of the key actors within the CB, even within a broad consensus decision-making process. This may take place by providing more time for discussion, as seen in the researcher's field notes:

"[the] Chair makes decisions related to how much time each agenda item has. In rare circumstances, commissioners or managers can push for extra time if they feel that consensus has not been reached." (March 2015 Clinical Board, field notes).

These types of situations remain rare, in that strong dissent has rarely been observed in the Clinical Boards. These situations clearly demonstrate the ability of the Chair to exert power through control of the agenda. The items on the agenda fit their strategic objectives and ensure that the items under discussion fit the broader agenda.

Decisions about commissioning new services tend to have a set, procedural structure. Once a need has been identified, relevant groups will be contacted and outline an initial case. These groups are either existing providers or potential new providers or partners. Their proposal is then debated and approved or approved with some revisions. There have been some cases where the proposal has been rejected, but in the majority of observed cases it was sent back to the provider who carried out amendments. The provider would work on a business case with managers, which would result in a budgeted business plan with a timeframe for implementation. This would again be debated at the CB. When approved, it is sent to the FP sub-committee. In the case of mental health services at the CCG, it followed a similar pattern as outlined above, with the need being identified, and there being regulations and availability of resources. The Chair highlighted the various different actors that the CCG has worked with in order to commission mental health services:

"For [site 1] we've been stone broke for eight to ten years, so that would be completely atypical. [...]. Everything's different in commissioning because you can be commissioning little bits and pieces of mental health, but mental health has so changed over the last three years, because if you were doing it five/six years ago, you would have done a block contract to the mental health trust, whereas now you're

saying we don't want it to go to the mental health trust; we want to employ more voluntary and lay people, so the whole thing just cycles on." (CCG Chair, Interview)

Again, there was an identified need (mental health services) and the ability to provide the necessary resources to make sure that the service could be funded. What was also observed was the acceptance and use of third sector providers for the provision of services. This included the contracting of a charity to work in providing care for the homeless, including mental health care, rather than changing the existing contract with the local Mental Health Trust (CB Observation, January 2016, Field notes). Rather than simply seeking new providers, commissioners based some of their plans on the capacity of existing providers to take on additional patients or services. There was also the issue of the availability of staff with the expertise to ensure the service has a good business plan, as noted by the Chair:

"Because actually [mental health commissioner] is particularly good and I don't have to worry about mental health because I know it's in safe hands [...]. So we knew some of the holes anyway like we knew CAMHS [Child and Adolescent Mental Health Services] was really weak, but there's been some quite interesting debate."

This was further supported by a local third sector provider which believed that the presence of immersed commissioners at site one aided the process of bringing in other providers and working collaboratively:

"the real positive thing is the GP MH leads ... so I actually think that what the major change or big changes has been actually something that was explicit in its design which was about putting GPs really where they need to be, in terms of influence and commissioning intentions, and I have seen very strong evidence of that actually happening, across the entire [Local Borough], [Site one Borough] and [Local Borough] patch, it does mean that you need, the weakness in the system is that you need, is that it relies on leadership skills for things to work properly, so I am lucky to have a great GP MH Lead in this borough, and [Mental Health GP lead] is very good in [Site one]" (3rd Sector Mental Health Provider, Interview)

Working alongside commissioners who are deemed to be engaged assists in forging consensus, not only at the Board level but also with providers in the system. This further allows the key actors to help influence the decision-making process. The commissioning lead GPs tend to be in role as they have similar views to that of the Chair and other key actors. In this sense, when these commissioners are involved in the process, it helps remove potential issues. As these commissioners share the views of the Chair, they arguably reflect the power which the Chair possess, having allies on the board, who also work with other actors in the system. It reduced the need of the Chair to overtly exercise their power, as the CB generally is favourable to their plans. Again, this highlights the overwhelming presence of the second face of power: control of the agenda. This is carried out by the general agenda of the Chair and the MD.

Once the CB has reached a decision on a service, it is sent to the FP sub-committee. The primary focus here is on the business case - not on clinical considerations but on the value for money case that has been put forward by the CB, as well as general quality control of the contracting element. Discussions tend to be focused on

practicalities, i.e. working out the care pathway that a third sector provider may fit into, utilising existing arrangements (CB Observation, January 2016, field notes). The GP commissioners can help with providing answers about the clinical cases for services (i.e. checking the clinical evidence/data/research) but they tend to take a backseat during the discussion, as managers work out and decide on how to best fund and approve a new service. There is scope for oversight here, with the FP working as a check on the power of the Clinical Board. A lay member (elected to the CCG from a pool of interested persons) participates in the discussions of the FB while there is no such representative in the CB. The purpose of the lay members is to represent the local population; however, they have limited power. Debates at the FP tend to be shorter and more concise, but one where there is some disagreement. Business cases can be sent back to the proposing body (i.e. the CB or the relevant commissioner) for further work if the members are not satisfied. For example, the continence (elective) service business case was sent back to the responsible party for further refinement (FP observation 2, field notes). FP functions as a balance, to ensure that the funding of proposed services by the clinical case is possible. The budgetary effects are dealt with at the FP, but they are also considered in the CB. Once approved, business cases are sent to the GB.

There was a discussion about some of the decisions that have been reached. However the GB seemed unable to override decisions or send them back to one of the other bodies - at least not during any observation. The following exchange between the Chair, Chief Officer, and Lay member is an example of this:

Lay Member: Paper [about ambulance services] doesn't give me great assurance it will solve the problem, my perception was that the issue was around recruitment, how does the paper resolve it? Q2, what about ambulances sitting in front of A&E?

Chief Officer: Very detailed questions. I may not be able to answer them but will circulate the larger paper that we have. But there has been the successful recruitment of 400 Australians to help ease the problem.

Chair: Also, money was not utilised well. We are losing staff to the periphery, due to their higher salaries, lower workload. We as commissioners haven't done a good job commissioning it and they haven't retained staff. Old ambulance stock doesn't help either, does that assure you?"

Lay Member: Same question, I am not assured. (CCG GB First Observation, May 2015, field notes)

The GB does not seem to change or influence the decisions that are made in other parts of the CCG in a significant manner, although it is the only meeting open to the public (attendance is minimal). Once this final approval has taken place, the cases go to their relevant managers and an implementation plan is put into operation. It is supervised by the CB and put into practice.

Within the CCG, the CB is the body in which the key decisions are reached about the selection of new providers. This decision-making approach is one of seeking a consensus, due to the role of the Chair and MD. They are able to exert power through controlling the agenda of the CB ensuring that decisions are reached in the way in which they want them to be. This is an example of the second face of power being used within site one. There is limited evidence that the third face of power is also being used, as many clinical commissioners and managers are members of the

board as they share similar views to that of the Chair. As such, while there is a general consensus model of decision-making, there are embedded power relations within, where the Chair is able to exert power on other actors. The subsequent section will explore the roles of actors and how they interact in more depth.

Decision making by commissioners

The role and influence of Clinicians

This section outlines the roles of the clinical commissioners and managers in more depth, and how they may influence the decision-making process. The clinical commissioners focus on clinical outcomes of services. They appear to be the most influential actors in the context of decision-making.

The most critical actors regarding setting the agenda of the CCG are the Chair and Vice-Chair. The Chair has long experience of working in commissioning, having been in post since 2012, also serving as Chair when the site was a pathfinder CCG. The role of the Chair is to set the agenda at the Clinical Board (CB) and the Governing Body (GB) and to guide the manner in which discussion takes place.

The Chair, through agenda setting, can dictate the flow of discussion in the CB and the GB. This means that the manner in which commissioning takes place tends to have more of a clinical focus, rather than on regulatory or financial issues. While the final decisions about the provision of new services is carried out via consensus, the clinical staff tend to have more influence on the outcomes than managerial staff. The Chair has utilised their power to set the agenda which illustrates the second face of power. While the CCG seems to work on the basis of (broad) consensus, this only happens due to the power of the Chair and the clinical staff.

The Chair and Vice-Chair set the strategic direction of the CCG, having been elected on a specific platform. Part of their role is to administer part of the CCG budget: “[Chair], and I cannot have a cheque to write out for whatever we liked, I think we can only absolutely and completely control, probably 25% of that [total CCG Budget], you know.” (Vice-Chair, Interview). This may not appear to be a large amount, but with the majority of CCG funds allocated to the local Trusts, this represents a considerable amount. It further represents the power given to the medical profession (Harrison *et al.*, 1992), as the Chair and Vice-Chair have control of a large part of the budget and are trusted with it.

The Chair and Vice-Chair also assist in creating compromises between different actors who sit on the Boards, to ensure that the board reaches decisions with regards to services. This is made more effective due to their own commissioning experience, with both having been involved with PCTs. Their experience, coupled with their election, allows the Chair and Vice-Chair to set the agenda and control the discussion of certain topics at the CCG.

The above impressions have been borne out by the data, in which the commissioners appear to defer to Chair:

"[The Chair was] there previously with the PCT anyway, and I think that [...] you have to give credit to them and the previous interim chief exec. of the PCT where they made changes looking at commissioning and getting GPs on board, whereas you may look back and go back about seven/eight years where [Site 1] was the poor counterpart of the eight in [the area] and now I think it's on a par." (Commissioner, interview 1)

The Chair's importance has also been noted in the researcher's observations, such as

'[The] discussion is ended by the Chair, after agreeing with other members of the Board that most had no significant reservations' (Clinical Board March 2015, field notes).

This demonstrates that debate is controlled by the Chair, so they control what aspects of a discussion receive more or less time and what input may be permitted from other staff members. The Chair's method of managing the meeting was seen at further CBs by the researcher, for example, '*Clinical debate starting with the commissioner in question and Chair and being opened up to other members of the Board.*' (Clinical Board April 2015, field notes). While the system does not rely on these individuals, having such a powerful individual means that decisions are reached.

Lead commissioners play a significant role as they decide on where additional services are purchased or lead the procurement process. They are elected from the general pool of GPs who form the CCG. The lead commissioners at site one all have similar views to the Chair and as they influence the selection of providers, so it can be argued that the Chair exert indirect control. They have the accepted 'best judgement' for suggesting initial plans and decisions about which provider may be best suited for any particular service. This is then refined at the CB. While there were no observed incidents in which the CB refused the suggestion of a lead commissioner, there were cases in which they made amendments to initial business cases and plans. While these commissioners may have a degree of discretion to choose providers and parts of the service, their decisions still need approval from the CB and GB. In addition, they only have this freedom in specific fields and are not exempt from oversight, which is why, while having a significant role in the selection of services and contribution to discussions, this latitude ultimately remains limited.

In the case of the CAMHS service, it was the mental health lead commissioner who guided the package from start to finish – being the member of the CCG responsible for the delivery of the service. This included convincing other members of both the FP, CB and GB that proceeding with the service was the right thing to do. It also included working with managers to make sure that the package abided by the rules as set out by NHSE and the CCG constitution and that at various points it was presented in the appropriate manner (i.e. business case, business plan and the implementation plan).

Role of Managers – Dominance of the Managing Director

The managers are the staff who are not clinical commissioners, but rather managers or non-clinical commissioners. This includes members such as the Chief Officer, the Managing Director (MD), Deputy Managing Director (DMD) and Assistant Directors of Commissioning (ADCs). The role of these managers is to ensure that the CCG is fulfilling its obligations and that it is following rules as set out by bodies such as NHSE.

The role of the MD is to assist in providing strategic direction to the CCG and to aid in the implementation of services. While the Chair controls the majority of the discussion and debate, the MD and DMD are the actors who bridge the gap between the GP commissioners and the managers. The MDs are the actors who can bring the relevant people into the discussion if a particular person is unsure about whether or not they should participate. The MDs also ensure that the appropriate people attend the meetings and that discussion remains relevant to the topic. They also help to set the agenda prior to the meeting with the Chair.

The MDs at times also appear to provide a counter to the Chair. The MDs seem to be the committee members who disagree most openly with the Chair, as has been observed, e.g. *'There was a disagreement between the Chair and MD early on in the meeting over implications of a service for the care pathway.'* (Clinical Board April 2015 – Field notes). This highlights how important the role of the MDs is, as they challenge the Chair. For example,

'[the] Managing Director appears to be the most influential of the managers in some agenda items by dictating the terms of the discussion' (Clinical Board March 2015 – Field notes).

Therefore, the role of the MD is vital in understanding how decisions are reached, as they function as another key actor, who focuses on different concerns to the Chair.

In the CB, debate flows through these two actors, with other GP commissioners and managers taking the lead from them. Other commissioners or managers may have essential roles within agenda issues or a particular item. However, both the Chair and MD remain key in every debate. This is made apparent by the fact that both the Chair and MD also shape the agenda, not only by formally deciding it, but also by circumventing the formal process through deciding which items can be 'taken out of the meeting' to a more informal space. While rare, this has been observed, *'After a disagreement about how a specific service may be implemented by the CCG, the MD and Chair agreed that the MD could discuss the issue with relevant parties outside of the meeting to avoid the issue being brought back to the CB'* (Clinical Board April 2015 – Field Notes). This would further suggest that these actors have more power than other members of the CB. It further reflects the second face of power, with the MD not only controlling what is on the agenda, but what can be taken out of the formal decision-making process.

The other important role of the managerial staff is to negotiate and navigate the decisions of the clinical commissioners through relevant meetings to completion, in the form of implementation plans. They can exert some influence in the process of reaching decisions, with the ability to look at contracts from a different perspective:

“we've got lots of small contracts as well, historically, that's where it is and you've always got the acutes [local NHS Trust], the community and Mental Health Service and substance misuse and they've had their historical budgets, but if you are shifting activity there are lots of other smaller contracts that have money put in them.” (Deputy Managing Director, Interview).

This helps to highlight how managers approach the commissioning budget in a more creative way, looking to shift activity in line with the broader strategic agenda of the CCG. The agenda is set by the key actors, such as the Chair and MD, with the managers constantly working to those ends. This suggests that even if key actors are not exerting overt power, many of the other staff in the CCG are still working to the same aims.

Selection of service provider: key influences

To contextualise the decision-making process, the majority of the budget that the CCG spends annually is committed to large contracts with several local Trusts, which roll over each year. This includes both NHS Trusts and Community Trusts, with the CCG committing over two thirds of their annual budget in this fashion. Some of these contracts have site one as the lead contractor, and others are administered in partnership with other local CCGs. This means that the majority of new services are commissioned on the periphery of these much larger Trust contracts. In terms of the specialist services that were tracked, mental health amounted to around 10% of the CCG's annual budget. During the study, there was an investment into CAMHS of £3m. This increase represents a total outlay of approximately 1.5% of the CCG's annual budget.

The commissioning of new services was only possible because the CCG was generating an annual surplus. This was helped by the fact that part of the Chair's mandate was to ensure fiscal responsibility. In addition, the CCG was part of a large local CCG Collaborative, in which certain financial risks were shared. Through this collaboration, the commissioners could draw on reserves and procurement specialists for support if needed.

Following the conceptual framework, the next section will look at how internal and external influences affect the decisions of key actors by using examples that were observed and which emerged from the interviews. The purpose is to understand how the actors and their own roles are affected by the internal and external influences which exist.

Internal pressures

Regarding the internal pressures, the impression gained particularly from the observational data was that the most important issue that dictated new service commissioning was the clinical needs of the local population. The CCGs stable financial situation allowed the commissioners to focus on the clinical issues. The decision on which new provider to utilise would be made by a combination of what resources are available and what target could be met with that resource. New services are considered more suitable if they also fit within the CCG's broader agenda of moving services into the community: *"on the strategic level it's about taking people from acute services, so my job is about stopping us spending so much on acute services and moving them into planned care and looking after people in the community"* (Assistant Director of Commissioning, Interview). Thus, the CCG's financial surplus allows the commissioners to explore which providers they think are best suited to their situation, rather than allowing the financial situation to limit their options.

Using data such as hospital admissions and provider information data, commissioners and managers would identify clinical concerns and those areas where the CCG was not performing to targets. This was done through carrying out a Joint Strategic Needs Assessment (JSNA). These would then be discussed at meetings of the CB, at which possible options to deal with the identified issues would be considered. After identifying the potential resources to address the need, commissioners would discuss whether or not they could proceed with 'transformation' or if they would have to use procurement to meet the need. Transformation is the terminology used by commissioners to signify that they intend to purchase additional services from an existing provider, 'transforming' the existing contract. Procurement is when commissioners write a tender document and invite potential providers to bid for the contract, in line with general procurement law. The ability to appoint new providers is only possible because the CCG was in a relatively stable financial state, which allows it to commit resources to new services. Interview data supported this conclusion:

"when you are commissioning a new service, you've got to look at the options, does the service need to go through procurement process, to follow procurement law, or can we do service redesign and whichever it is, it's the same commissioning process [once procurement has delivered the winning provider], so you've got to know what service you want to commission, you have to develop the service specification, stakeholder engagement, stakeholder analysis, look at what the service costs now, where do we want to get to, and then we have to do a full business case to see its value for money, and viable and following on from that business case we have to decide can we do a service redesign or do we have to go through a full procurement process." (Deputy Managing Director, Interview)

This pattern was fairly consistent and was typified by the process of a Child and Adolescent Mental Health Service (CAMHS) contract that followed this path. The following outlines the way in which the CAMHS package was commissioned.

The initial discussions about the new service delivery were held at a meeting of the CB in which the CCG Chair said there was inadequate provision of CAMHS. This assertion was then further supported by the CAMHS lead GP commissioner, who produced a variety of papers outlining the issues with existing provision (CB Observation 5, May 2015, Field Notes). The clinical need was clearly an internal consideration, as was the financial management of the CCG. This new service was also something that the Chair had identified as a key need, which suggests that it was one of their objectives. This was first observed in the Clinical Board in April 2015, with need being identified as the key driver for service expansion because *"arguments were made that the new Mental Health Provision being commissioned would help generate savings, and relieve pressure on the local Trust which has a deficit"* (Clinical Board, Observation, April 2015, Field Notes). This also highlights how some considerations can align, as this decision was also driven by financial considerations. When interviewed, the GP Mental Health lead confirmed that there was an availability of resources and that additional services could be purchased from existing contracts, rather than seeking a full procurement:

"it just seems that you know what you want, and if it's just there, why not just get it? If it's more of what's already there and you're happy with the service, why do you need to procure? In this particular ... well because the money involved at each different level, for particularly the CAMHS thing, there were lots of them, but they were quite small that it wouldn't have justified a procurement, so we didn't get any pressure, no" (GP Mental Health Lead Commissioner, Interview)

Other commissioners further supported this. The contract was commissioned by utilising local arrangements with the existing Mental Health Trust:

"so if you look at CAMHS, so [local Mental Health Trust a] do most of the CAMHS service already, if you want to put another £100k into CAMHS, the most sensible place is to put into that service, or into that existing provider". (Commissioner 5, Interview)

When commissioning a new service, commissioners tend to utilise existing providers if they have the capacity to expand existing provision. This situation appeared to be the default choice as it avoided the procurement process, which was considered to be an additional transaction cost that commissioners wanted to avoid. This also ensured that a public provider was used, as a new private provider could only become involved through the procurement process. In addition to the financial aspect, the CCG would have to wait a further six to nine month wait for the procurement process to conclude before they could have a provider working. In this sense, the aims of the CCG leadership were best suited to using a local existing provider. Despite this, in the FP meeting, there were some initial disagreements about the funding of services. The funding was agreed after a vote and sent to the Governing Body for final approval, but only after a tense debate between board members about how the case should have been brought forward to the meeting, i.e. the timing of presenting the package to allow for greater scrutiny. As the following quote from the finance lay member highlights:

"I'm not questioning the services on outcomes, but surely it's better to get a lower clinical outcome at a good price, then a great outcome at an extortionate price ..."

we're not able to make a value for money judgement on the cases we have seen ... we're here to challenge and agree what comes here, otherwise, what's the point?"
(Lay member, F&P Observation, May 2015, Field notes)

The lay member agreed to the plan only after the vote at the FP meeting. Other Board members could not alleviate their concerns. The same member commented about how the decision had been reached by the CB and had only come to the FP meeting as a sort of rubber-stamping/box-checking exercise. Another member commented that "*significant details [relating to business cases] are missing [...] we have one [business case] and accepted it, as has the CB [...] we need to move on to finances*" (FP Member, FP First Observation, May 2015- Field Notes). There seemed to be agreement about making sure that all of the cases were brought forward at the next meeting. This shows there can be friction between the different Board members which has been a theme in some of the financial aspects of commissioning. The Chair appears to be challenged by those who do not share the same agenda. These concerns of the lay members tend to be conceded to in some way, but the Chair or the MD have also needed to use their power to move past some issues, which also occurs with other members of staff. In this sense, there are some examples of the use of the first face of power, where the Chair or MD explain that the discussions which create these concerns are of a clinical nature or have been approved by key managers and thus must be allowed to pass.

When it comes to pursuing procurement, one of the critical new processes of the new reforms, commissioners seem to prefer avoid using it if they have the option of purchasing services from an existing contract to meet their needs. There are several reasons for this. At site one, commissioners have had negative experiences of using procurement:

"I mean you take community dermatology, I don't know if you've heard about dermatology at [Local Foundation Trust]? So you've got [Local Foundation Trust] right, run a dermatology department for years, very good dermatology department, and then along came the CCG, a while ago, and say well look, this is all very interesting, but in the new world, what we would like you to do is something different, upskill GPs, get them into your clinics, dermatology isn't rocket science, you know psoriasis, eczema, acne whatever, all the cancer stuff can still stay in the hospital, but it's ripe for the plucking, low-risk speciality to hive off the state money, so what do you want to do? Do you want to spend half a mill on a dermatology department or half a million on wheelchairs, this was at a time that [Site 1] didn't quite have the money that we have at the moment, so we decommissioned it, and put in ... put in a procurement and [Local Foundation Trust] applied for it... and they got it back" (Vice-Chair, Interview)

The commissioners at site one wanted to move local care away from the local Trust, but the procurement process and rules meant that the Trust which was decommissioned, was awarded the contract again, thus defeating the aim of the exercise. This represented a decommissioning failure. This reflects a broader trend where more care is now being delivered out of hospital settings (Robertson *et al.*, 2014). The commissioners have no power to affect the outcome of a procurement process but they do have the ability to choose whether or not they work with existing providers to meet clinical needs, rather than turning to the market via

procurement. This was further supported by the GP Mental Health lead who also felt that the process of procurement would be too costly and labour intensive to deliver the outcomes that they would need:

“there was a lot of discussion about would we go out to procurement to allow anybody to provide that, or because it was a pilot and small and because we want it very much to blend with our primary care MH service it makes sense for it to be hosted by the Trust, as you want to get on and do it, but we did have interesting discussions about you know, if we did go out to procurement, it is such a tiny amount of money [laughter] you know, the cost of actually doing the procurement and people's time, was it a good use of public resources as well?” (GP Mental Health lead, Interview)

There appear to be considerable disincentives to seek to use procurement; not because commissioners appear to be opposed to the use of private providers, rather the time taken to complete the process and have a provider start delivering care was considered to be too long. They were afraid of the transaction costs associated with the process. In addition to the lengthy process, procurement also requires a new provider to adapt and ‘bed’ in:

“procurement is lengthy, and it takes another 18 months once you have a service in to get service implementation up and running to what your vision and your dream is, so it's not easy, as you lose your staff, you've got GPs, so if you can do it by other ways, if by law that's right, then potentially that's a better way to do it” (Deputy Managing Director, Interview)

The aims of the commissioners at site one are to have providers working as quickly as possible. The financial management of the CCG has meant that clinical considerations, which have emerged from the Chair are the primary concern. Commissioners seek to implement new services as quickly as possible and in the majority of cases, this involves working alongside existing providers and purchasing additional services, rather than using procurement. It brings shades of what Le Grand stated, “the constraints are too great and the incentives too weak” (Le Grand *et al.*, 1998), the commissioners have little incentive to turn to new providers. The aims of the key actors are on the development of the CCG to meet local medical needs. As such, the mechanism which they appear to favour is one which enables commissioners and managers to develop services as quickly as possible (i.e. “transformation”). This does mean that they are limited to exploring how they can work with local providers, if they want to avoid procurement.

There is some conflict between the CCG leadership (i.e. CB) and the general GP membership (the CoM and the LMC). According to some of the commissioners, there is a minority of GPs who are unhappy about the NHS reforms and are vocal in their opposition and wish to be continuously consulted about changes to their workload and role:

[A]t the Council of Members there are a number of GPs who are not representative, but by the volume of their voice and the length of [...] meeting time that they occupied, [...] are very disproportionate to the actual representation, but not many members, in fact, I don't think you'll ever see a general member who is

not on the CCG board who will speak out at the Council of Members to basically say "shut up!" (GP Commissioner 2, Interview)

It is unclear how widespread the issue is, but it is a good illustration of the different dynamics within the CCG itself, as there are differing internal opinions about how it is meant to function. It also highlights the type of GPs who are decision-makers.

This seems to create a degree of an 'us versus them' mentality in some instances when the CoM and LMC are brought up, with a conflict between the leadership of the CCG and the local groups being a recurring theme. While this may not effect commissioning directly, it could be said that there is a particular type of GP that chooses to become actively involved in the new commissioning arrangements. This was possibly a significant internal dynamic and should be explored further in any subsequent research.

External pressures: Interaction with other bodies

The main bodies the CCG interact with (outside of Trusts) are the other local CCGs that form part of the local co-commissioning cluster and NHS England. This interaction aims to ensure that the services falling under co-commissioning are appropriately commissioned and comply with NHS England rules. This is to help share the risk and work alongside the Trusts, which tend to be much larger organisations than the CCGs. NHS England also forms part of the external network created by the 2012 reforms. Out of all of the bodies which form the external network, they are the only one which is explicitly mentioned by commissioners and managers in the meetings. The other bodies which form part of the system seem to be seen as forming part of the background, but not really being mentioned explicitly.

NHS England (NHSE) seems to be very unpopular with both commissioners and managers, who are unclear about its role: *"Again it looks like NHS England don't know what they're doing"* (Board member, CB Third Observation, March 2015, Field notes). This theme remained constant throughout the observations.

When asked about the role of NHSE while being interviewed one commissioner responded, *"I don't know. I think it's yet to be worked out, isn't it? Because I think it's like with a big re-organisation, NHSE is sorting itself out as well"* (GP Commissioner 1, Interview).

This helps to highlight how there is some confusion among commissioners with regards to the role of NHSE within the broader framework. This is shared in the meetings as when the Chair noted that *"Targets that are set by NHS England are concerned with the broader framework and not clinical goals"* (Commissioner, Clinical Board Observation 2, February 2015, Field notes).

There seems to be an implicit agreement that the targets set by external bodies are not always in the best clinical interests, as they tend to be focused on national

rather than local targets. During the study there was little direct conflict between the CCG and the local NHSE team, but part of this is due to the surplus which was generated by the CCG. So even with an apparent general dislike or mistrust of NHSE, there was little issue with them. This could explain why the relationship between NHSE and commissioners at site two was so different to site one. The fiscal context is key to this relationship.

External pressures: The Health and Social Care Act (2012): A changing balance from public to private?

In the interviews with key informants, more direct questions were asked about what commissioners thought about privatisation occurring in the NHS since the introduction of the Health and Social Care Act (2012) - a trend that has been alleged by many (BBC News 2015, Peedell 2011). The broad consensus is that it has not taken place to a large degree. Some stated outright privatisation was not taking place, such as GP Commissioner 1 who responded, *“Who is going to privatise the major mental health, long-term, you know conditions and look after them? Right [nodding], so there you’ve got it, isn’t it?”*

There is a belief that private providers have little appetite to deal with complex services and a perception that the majority of commissioner spend should be given to NHS bodies:

“Well the experience will be is that[sic] if we're all committed, and I think a lot of reasonable people are committed to providing good care, and better care, and improving the care and whatever mechanism you can do that with, that's fine, and I said part of the problem that we have is that you see that who is going to then privatise chronic renal failure services? ... I think that we need to be quite sure that the vast majority of the expenditure on the NHS is going to the NHS and I think what we've got to do is look at working collaboratively on how we can take out the massive changes that take place every time that cause a lot of disruption. And then you try and settle in, and then you get other changes coming in, so that's part of the problem and partly I think that the concern that I have is that where you are so-called competition and trusts trying to be totally autonomous, is the professional flow of information and the professional dialogue on contact but we need professionals themselves. (Commissioner, Interview 1)

This was borne from the manner in which the majority of commissioning took place on the periphery of the large Trust contracts. This was observed in a CB meeting, where there was a discussion about the provision of pilot care programmes for specialist patients, with managers stating that there was no appetite in the market for such a low-value contract (CB Observation, January 2016, Field notes). In the observations, the value of new contracts was not large and as such there was a general perception that private providers were not interested in them. The largest contract which was given out by commissioners was the £3m CAMHS contract. Commissioners shared this view: *“Since 2012 there has been a slight increase in the private provider aspect, but from what I have seen with my*

commissioning/procurement experience, it's in a well-controlled and balanced way, it's not just allowing them to cherry pick the good things and leave all the bad things." (GP commissioner 7, Interview).

The commissioners did not have any ideological opposition to the use of private providers, but rather their priority was that care remained free at the point of use: *"So, why is the health service in England so important? It's because it is free at the point of use, we all get confused, so to be free at the point of access is really important"* (Commissioner Interview 6).

Commissioners did not have a preference as to whether a service was provided by the public, third or private sector. Their primary concern was that any new provider should be able to provide adequate care. Competition was generally seen as a positive, giving commissioners more choice about which provider to choose in specific contexts (this is discussed in more detail in the subsequent section). This was evident in other interviews. For example, the Chair commented:

"I don't care, as long as they can do a good service for the population at a reasonable price that's fine by me, because actually when it comes to the NHS, and people, it's usually - assuming this is patient-facing services - it's normally how the people react with the patients they're seeing, and what goes on in the admin and the HR and the parent company, doesn't matter to me [...] I don't think trying to hold a private company to account is any more different."

There was a view that the reputation of providers would mean that they would adhere to specific standards and that they would not endanger their positive image by behaving in an 'underhand' manner.

The scope for privatisation seems to be quite limited, although this was not always the case:

"This was 3 years ago when [Large national charity] was being ignored, and people were lining their own pockets like there was no tomorrow. Another one, the front page of the Guardian about two years ago, Harmony, David Lloyd made £49m out of Harmony by selling it to Care UK." (Manager Interview 4).

This extract suggests that there were more opportunities for private providers in the system. However, the private sector seems to remain limited to some specialist services, as the contracts which were commissioned at site one did not appear to offer a substantial profit for providers. They seem to be restricted to what types of work they are willing to take on, focusing on shorter-term more profitable work. This may not remain the case indefinitely and may change in the future. However, despite these limitations, commissioners seem to be willing to engage with private providers, and as such, there appears to be scope for growth in the future.

Apart from the NHSE, there was also a generally ambivalent attitude towards the local Trusts. As already mentioned, the majority of the CCG's resource is spent on the large local NHS Trusts. Commissioners are limited in what approaches they can take to reducing or improving the contract value, the Trusts are much larger

(regarding finance), and this is reflected by the CCG commissioning a Trust as a collaborative rather than an individual organisation. The balance of power in the NHS remains on the provider side, due to their size. As stated previously, the CCG had to decommission services that had gone out to procurement and were won by the Trust, as they did not match the objectives of the commissioners who wanted more services to be provided in community providers. The research highlighted how commissioners feel restricted by the Trusts:

"we can't re-procure another hospital to provide the same services as [large local NHS Trust], it's something we can't do, but we can tinker with say MSK, diabetes, ophthalmology ... what else can we do?" (Vice-Chair, Interview).

Commissioners believed that they should not destabilise the local Trusts and that they would have to keep working with them, as there is a mutual dependency, as they were also reliant on them; hence limiting potential achievements. However currently, the stable financial situation means that the commissioners are not actively looking to reduce the amount of activity that goes to the local Trusts. Thus they can afford to maintain their contractual relationships and seek to generate savings in other areas of care.

Why do commissioners select certain providers over others?

The second research question is why commissioners may choose one type of provider over another. Commissioners have two key tools at their disposal. They can either turn to the market and pursue a full procurement, or they can seek to purchase additional services from existing providers to fit new needs (i.e. transformation). The choice commissioners make, either to utilise procurement or purchase additional services is their most important choice when it comes to selecting a provider for a service. They can either choose to utilise existing contracts or go through the procurement process, which could mean using a new provider or still having an existing provider win the contract.

Commissioners and managers differed slightly in why they may choose one path over another. At the majority of the CBs that were observed, purchasing additional services was the preferred option of the Board. As stated previously, the primary reason is that procurement is seen as costly, both in terms of financial and human resources.

The majority of the commissioners also did not express any real preference of provider even when they were given a choice:

"We're quite open, we're not really worried what sort of provider it is, I mean the private providers are quite good, with all the glossy brochures and death by PowerPoint, talking the talk, and depending on what their track record is, [um] they clearly aren't delivering what they say they're delivering, the NHS providers ... aren't very good at doing business plans and this that and the other, but do have a certain level of expertise, clinically, and

this is completely unjustified, and you could probably argue in your own mind that, they perhaps weren't ... driven so much by money” (GP Commissioner 5, Interview)

However, as the quote above illustrates, there is a perception that the public providers are still more focused on the clinical outcomes and that the aims of the private providers are not always as clear. While there was some appetite for the use of third sector providers there was strong support for their local NHS Trusts that commissioners wanted to maintain.

What may appear to be contradictory was that commissioners and managers repeatedly expressed support for ‘using the market.’, as long as it suited their objectives. Many commissioners and managers were not critical of the use of new commissioning tools. In fact, many believe that their use would be beneficial:

“is competition a bad thing? And I think that's a different question or discussion. The critics of it being, I don't understand what their worry is, unless your argument is everything public is brilliant, and everything private is dreadful, and many public organizations have no accountability because they're left in a world of their own, so if it is competition through the back door, is it a bad thing?” (GP Commissioner, Interview 6)

While opposing the idea of privatisation, as reported earlier, commissioners were open to the idea of competition and utilising the market even if it could be argued that these views are incompatible. It would not be possible to have both competition and choice without the use of private providers to some extent and hence the presence of marketisation. Commissioners tend to focus very much on what they perceive to be best for their patients, as the system was intended under the Health and Social Care Act (2012). There is evidence of this, with many public providers also ‘winning’ procurements, hence even when turning to the market, there is limited privatisation as the assets remain with the public sector.

One GP commissioner went into detail about the effect he thought marketisation was having on the health service stating:

“it puts war into the middle of health services, which will have [...] repercussions and it causes flak [sic] [...] there's a lot of duplicate work happening on both sides of this thing, now, potentially because the business, you know a hospital is now a business, and it's got to survive and do all this sort of thing, it could bring/introduce efficiencies, but whether those efficiencies are worth the cost.” (Commissioner, Interview 2).

This extract highlights how commissioners view some of the more recent NHS changes as adversarial. These comments were indicative of the view held by both managers and commissioners in the CCG. They were frustrated further by the lack of a developed private sector (i.e., supply-side failure to keep up with the reforms) which limited the options of commissioners:

“[T]here's generally a limited number of providers, and that's the overriding impression that I got, even when you're talking about something like PTS [patient transport service], there's only really sort of maybe two or three providers, maybe four if you're counting the ones which predominantly work out of Birmingham or

sort of up North, and they want to expand down South, and as such there's a, as I said, a limited number of providers in the marketplace. Makes it easier to some extent, for the people who are running the tender process, makes it more difficult in that [...] you might not always get the number of providers you need to be able to create the best marketplace if you see what I mean. Regarding supply and demand, if you've only got one supplier for a service they can pretty much - but they don't- name their price, whereas if you've got ten suppliers, then there's a bit of competition.” (Manager 3, Interview)

The managers and commissioners were keen to avoid the procurement process, being seen to be overly time- and resource-intensive concerning transaction costs (the average tender takes nine months to complete) rather than it faced them with a choice between public or private providers. This was a key finding. This was further compounded by the fear of the procurement being challenged. For example, when the researcher asked whether many tender decisions get challenged the response was:

“The last two procurements that I've been involved in, there's been a challenge, not always formal, and not always unfriendly, but if a provider thinks that they've been unfairly treated there will be [...] They're' quite quick to want to know the reason why they lost out [...] had the assurance that they wanted, that they had lost out fair and square, and they didn't want to take it any further.[...] But if you can prove quite early on that you followed the correct procedure, then those kinds of things usually die a pretty quick death. Like I say, I've been through both of those, and it's not fun going through the one where you have to go to court. The amount of preparation that you need to do in order to go to court is just absolutely horrendous, and the solicitor's bills are thousands, hundreds of thousands of pounds. [...]” (Manager 2, Interview)

This highlights the extent to which the system can lead to conflicting perceptions of the procurement process. There is general approval of using private providers in the correct context, but a dislike of the process. There is also a perception that there are few providers and little money for commissioners to 'play' with, despite the annual surplus, so it is not difficult to understand why tendering is not seen as being a useful, or even fair, tool:

“I think that partly, we're not able to enable, you know? Commissioners also need to understand the provider's difficulties that they may well have, especially, if with these big Trusts, you have fixed costs you can't do much about anyway, so that's an issue, private providers may not have that. A lot of the training and approved jobs and whatever, with the Royal colleges and whatever, you know? Private providers don't have that, is it really a level playing field?” (Manager 1, Interview)

In the CB meetings, there were discussions about how the process had been arranged to avoid procuring some contracts, and both managers and commissioners appeared to be happy with this outcome. Even though this type of intervention was rare, there was a fear of intervention from outside groups, in case managers and commissioners were 'found out'. Again this is to do with high costs of the procurement process and that in some cases the clinical case meant that intervention needed to be swift. The commissioners were not actively seeking to break the rules, but to find solutions which were most advantageous for the CCG.

There is also a lack of debate in the meetings about the types of provider that are chosen to deliver a service. There seems to be more of a focus on the manner in which clinical outcomes can be improved in a climate in which savings seem to be the number one priority. As papers in a CB illustrated, there is evidence that commissioners prefer to work alongside public or third sector providers that they have experience with, rather than use the market, when additional funding was provided to a local Mental Health Trust (CB Observation, January 2016 – Field Notes). This is, in part, due to the agenda of the Chair, which seems to have been accepted by all of the commissioners at the CCG. This links back to the consensus decision making, but also the way in which the agenda is set by the Chair, which narrows the opportunity to explore other options during CB meetings.

The ability to invest into CAMHS was gained by the commissioners being able to generate a surplus. Part of the surplus was invested, with a need identified. Once the funds were confirmed, the lead commissioner was given the freedom to help craft a business case which would address this need, and within the context of the available budget, the only provider they could turn to was the local public mental health trusts. As one interviewee put it:

*“So, it depends, there’s commissioning, procurement and purchasing yeah? [...] if commissioning means you do a specification, and you go out to the market, then, and you do a whole procurement, tendering exercise on the whole what [Site 1] do is they have a big contract with [local mental health trust a], a big contract with [community trust] and a big contract with [local foundation trust], and they renegotiate that every year, some would say they re-commission, I would say they re-negotiate it, and then they purchase a few new things, some would say they recommission, but they don’t do a procurement they go to [foundation trust], could we give you this amount of money to do this, and then I think your question is so if you asked a [foundation trust] to do a paediatric assessment unit, why doesn’t another hospital come in, why are you asking them, when we could do it? It’s difficult as it’s all part of the hospital and so no one ever challenges, so I would say the answer to your question is, in our current environment, **no one really knows these things are happening**, [emphasis added]” (Commissioner, Interview 5)*

Even if commissioners appear to want to engage more with a different sector (i.e. private or voluntary) they are able to do so only in a limited manner, due to the resources that are available to them, the real lack of other providers on the supply side who are able to take on more significant roles in the provision of services, as well as the lack of incentive to change the way in which providers are selected. Commissioners tend to adhere to the agenda of the Chair and the other inner/outer pressures. Commissioners are still bound by the resources available in this context and the marketplace they operate in. Combined with the commissioner’s attitudes to competition and use of commissioning tools, it paints a very complex picture. The agenda of powerful local actor has meant that there is a way of doing things and other actors seem to be in agreement. In some cases, this has resulted in a limited increase in marketisation, with a much greater emphasis on value for money but no preference for the type of provider used.

Summary and Conclusion

This chapter set out to explore three interrelated questions at site one:

1. What influences the decisions of commissioners in/during the commissioning process?
2. Why do commissioners select certain providers over others?
3. How has this affected the private/public balance in the NHS?

Addressing the first question, this chapter provided evidence that shed light on how commissioners reach decisions about the type of providers they select for the provision of new services. The CCG has a distinct decision-making process which was clearly shaped by key decision-makers, even if there was a general 'consensus' decision-making process. There are clear restrictions on what the CCG can and cannot do, which stem from the broader policy network (i.e. NHS England and directives, such as those about mental health). However, there is flexibility in commissioning services with parts of the budget that are not used for the contracts with the local NHS Trusts. When a JSNA has been carried out, the CCG has the discretion to attempt to address any issues with the resources that it has at its disposal. The decision-making process at this site follows a model of consensus building and minimising conflict that stems from the agenda-setting power of the Chair and MD. This model is further aided by the relatively resource-rich context in which decisions are reached. The CCG had managed to generate a consistent surplus, having worked to create savings over previous years, so this does not seem to be the determining factor in whether or not the commissioners choose to utilise a procurement or transformation process.

When commissioners want to select a provider they have two basic tools at their disposal. They may choose to purchase additional services from existing provider ("transform") or commissioners may choose to 'turn to the market' and carry out a procurement. Once this key decision has been reached, there will be a selection of a specific provider. This provider may be public, private or third sector. There is not much that can be done by the commissioners after this decision is reached. That is to say that a public provider may have its contract changed and additional services purchased, or a private provider may win the procurement process. There is much work that goes into commissioning for what is, in effect, a space on the periphery of the CCG's total budget. Again, these choices are still made within the objectives of the CCG, which is to find providers who can start to provide care as quickly as possible.

There is a lack of new private providers as a result of the reforms. Commissioners will pursue existing providers (the majority being public providers) as this fulfils the aims of the CCG leadership. It allows commissioners to work with providers that they are familiar with, and ones which will not need a 'bedding in' period. The only exceptions to this are the contracts they are legally obligated to use procurement

for. However, none of these were observed as during the research period the CCG did not utilise a procurement process for any clinical services.

To answer the second question, commissioners do not directly select the type of provider but instead choose the tool which will, by a process, select the provider (regardless of type – public or private) for them. However, the internal and external influences work in conjunction to 'nudge' commissioners in a specific direction. In the instance of site one, the involvement of external regulatory bodies is very limited in the day-to-day work of the CCG though they do exert influence in more implicit ways in ensuring that providers meet specific standards. It is the internal pressures, stemming from the local aims and objectives of powerful actors which seem to have the most potent influence on commissioning decisions. Identifying needs of the population and then moving to tackle these issues was the most significant impetus for change. The resources that were dedicated to the cause came from savings generated by the CCG in previous years. So there is some evidence of interaction between the commissioners and the policy framework that was created.

The role of the external regulatory framework seems to be very limited. It is only in the longer contracts that the external policy framework comes into play. Commissioners also attempt to support their local Trusts by not actively reducing the activity they receive unless they have to. This reveals an interesting dynamic which was further explored at site two.

At site one, power within the CCG is concentrated in a few individuals, even if there is a general consensus approach to decision-making. Rather than exerting direct control or the first face of power, the key actors, namely the Chair and MD, control the agenda of the key body, the CB. They actively control the agenda, and many of the other commissioners and managers that form the CB are, in part, there because they have similar goals as the Chair. The Chair, while being the most powerful individual actor, still relies on the support of the MD in building consensus and developing the agenda of the CB. This is further enhanced with the Vice-Chair, other clinical commissioners and managers working to their aims and objectives. This system of decision-making would suggest that the second face of power is being demonstrated here, with the control of the agenda. The Chair and MD rarely have to take part in overt conflict with other actors. In this sense, agenda control is made easier when many other actors share the same aims. There appeared to be a general consensus model of decision making within set parameters, with certain actors being embedded in the CB.

How has the decision-making process affected the private-public balance in the NHS? There remains a general preference for public providers amongst commissioners, even if this does not inherently mean that they actively 'choose' public providers. Commissioners seem to dislike the idea of privatisation and specific rules such as having to re-commission procured contracts every five years, but they are not opposed to using private providers. There is little evidence to suggest there is significant privatisation or marketisation taking place, both from

the observations of the researcher and the reports from the commissioners. However, there appears to be a modest increase in non-public providers providing services. Private/third-sector providers cannot be stopped from competing for contracts and with the use of procurement has been accompanied with a growth of the number of private providers delivering services. However, these contracts remain on the periphery of the service and make up a small amount of the total budget (approximately 5-7% of the CCGs annual budget).

The type of provider, private or public, does not seem to be a pressing question for commissioners. Rather it is whether or not the service can deliver within the financial constraints they are contracted for. However there seems to be an implicit preference for public providers, as commissioners are more familiar with the public providers rather than through any ideological conviction. There is also a lack of consensus on whether or not GPs are truly satisfied the reforms as evidenced by the conflict that exists internally, even if they enjoy the idea of having been given additional commissioning tools. Marketisation is seen more favourably, as commissioners and managers do not consider competition between providers to be a negativity.

At site one, there was a limited increase in the use of market mechanisms to deliver services. Procurement has been used, and this suggests that market mechanisms play a role in the selection of providers. This did create some competition amongst public providers but its effect on private providers at site one was negligible. The reason that this represents marketisation, rather than privatisation, is that public providers more often than not won these tenders and delivered services at site one.

There is evidence of very limited of privatisation at site one. There has been the use of private provision, but that has not happened *intentionally*, i.e. commissioners are not deciding to use private providers more than might have been the case previously. Instead, the new arrangements make the use of private providers more likely as a result of the procurement process. It has also resulted in the increased use of market mechanisms, and thus further marketisation, with competition between providers becoming more frequent.

The following chapter presents evidence from the analysis collected at site two. The data at site one suggested a need to explore further the reasons why commissioners might choose to pursue a procurement process. The commissioners at site one had also established working relationships with an ensuing high level of familiarity and shared approach to commissioning. There was also a shift in one of the services, with electives being replaced with MSK services to gain richer data. There was further exploration of the relationship between the regulatory framework and the commissioners, which only offered limited data at site one, as the relative financial stability means that bodies such as NHSE did not intervene much in the work of commissioners.

Chapter 6: Understanding the commissioning process – Evidence from CCG Two

Introduction

This chapter will present the themes that emerged from the analysis of the second case study site. The site was a CCG based in Southern England. This chapter will begin by outlining the structure of the decision-making bodies at site two using evidence from the ethnography. Following on from this, there will be an exploration of how different services are commissioned; how the processes differ from site one; and how and why commissioners employ the tools at their disposal.

Data collection took place through an iterative approach, building on what was discovered at site one, changing one of the services that were studied; and focusing more on the relationship between local Trusts and the commissioners at site two. However there were differences in the composition of the CCG and in the challenges it faced. Over the course of twelve months, the researcher carried out over 65 hours of observation and nine interviews with key decision-makers and providers at the CCG.

The questions that were explored here remain the same as in previous chapters:

1. What influences the decisions of commissioners in/during the commissioning process?
2. Why do commissioners select certain providers over others?
3. How has this affected the private/public balance in the NHS?

The first part of this chapter will outline the general governance and decision-making processes in the CCG, with the aim of putting those decisions into context. Without establishing the context in which commissioners work, it would be difficult to fully understand the decisions of the CCG and how they are reached. The chapter will also attempt to identify the similarities and differences of the decision-making processes at the two sites.

Differences in specialist service tracking between sites one and two

The data at site one was particularly illuminating when examining commissioning of mental health services. However, the examination of electives yielded fewer insights as an exemplar and was therefore not tracked further at site two. It was replaced by Muscular Skeletal services (MSK) with a focus on physiotherapy services, as there is a history of private sector involvement (Iacobucci 2013).

Data from site one did not fully delve into the relationship between the commissioners and the local NHS Trusts. At site two, there was much more of a focus on exploring this relationship following from the analysis of data found at site one.

Characterising the CCG at site two

The second site is a medium-sized CCG, serving a population comparable to that of site one. It is also based in a large urban area in Southern England. The population is diverse, with a high employment rate; and it serves a range of older individuals and deprived communities. This suggests that the CCG commissioned a broad range of services, as they would have to cater to a varied population, including the ones that were tracked in the ethnography.

The annual budget of the CCG is in the region of £300m, which excludes additional resource that is accrued through working as part of a CCG collaborative. This is similar to the situation at site one, where the CCG works with other CCGs to consolidate larger contracts with Trusts, in order to share financial risk. Furthermore the CCG has access to a relatively developed marketplace of providers, being based in the South of England. The ability to utilise the private and third sector market was one of the key determinants in selecting the site and in gauging its suitability for the study. This was to ensure that the commissioners would have access to a variety of providers in their selection process. While sites one and two share several similarities (budget, diverse populations, access to provider's market) they differ in their financial situation. Site two is faced with much more severe resource pressures, which appears to have had a considerable effect on commissioning. This will be discussed in more detail later in the chapter.

There were key differences between the manner in which decisions are reached between sites one and two. At site one, there was one large key decision-making meeting in which many conclusions were reached regarding the provision of services. At site two, there were several smaller meetings at which similar conclusions are reached. This meant that the researcher observed a greater number of meetings at site two.

The structure of the decision-making process

Both CCGs operate a committee structure, with groups of decision-makers meeting to deliver recommendations in certain areas before referring these decisions to their respective Governing Bodies. Site one had a very centralised decision-making process, with key decision-makers meeting in one meeting – the Clinical Board, which made recommendations to the Governing Body, which were always accepted and nominally voted through. At site two, there are several different committees which operate in place of the Clinical Board at site one. There is a Governing Body (GB) through which all formal decisions on governance, financial and clinical issues are reached. It remains the group through which the CCG makes all official

decisions. The committees that feed into the Governing body are Finance and Performance (F&P); Quality and Safety; Transformational Redesign Group (TRG); Leadership Executive and the Joint Co-commissioning group. This can be seen in Figure 7, which outlines the decision-making structure and how they feed into one another. The observational data suggested that most clinical decisions about transformation/purchasing or commissioning services were taken in these meetings and nominally voted through in the GB, in a similar arrangement to that at site one.

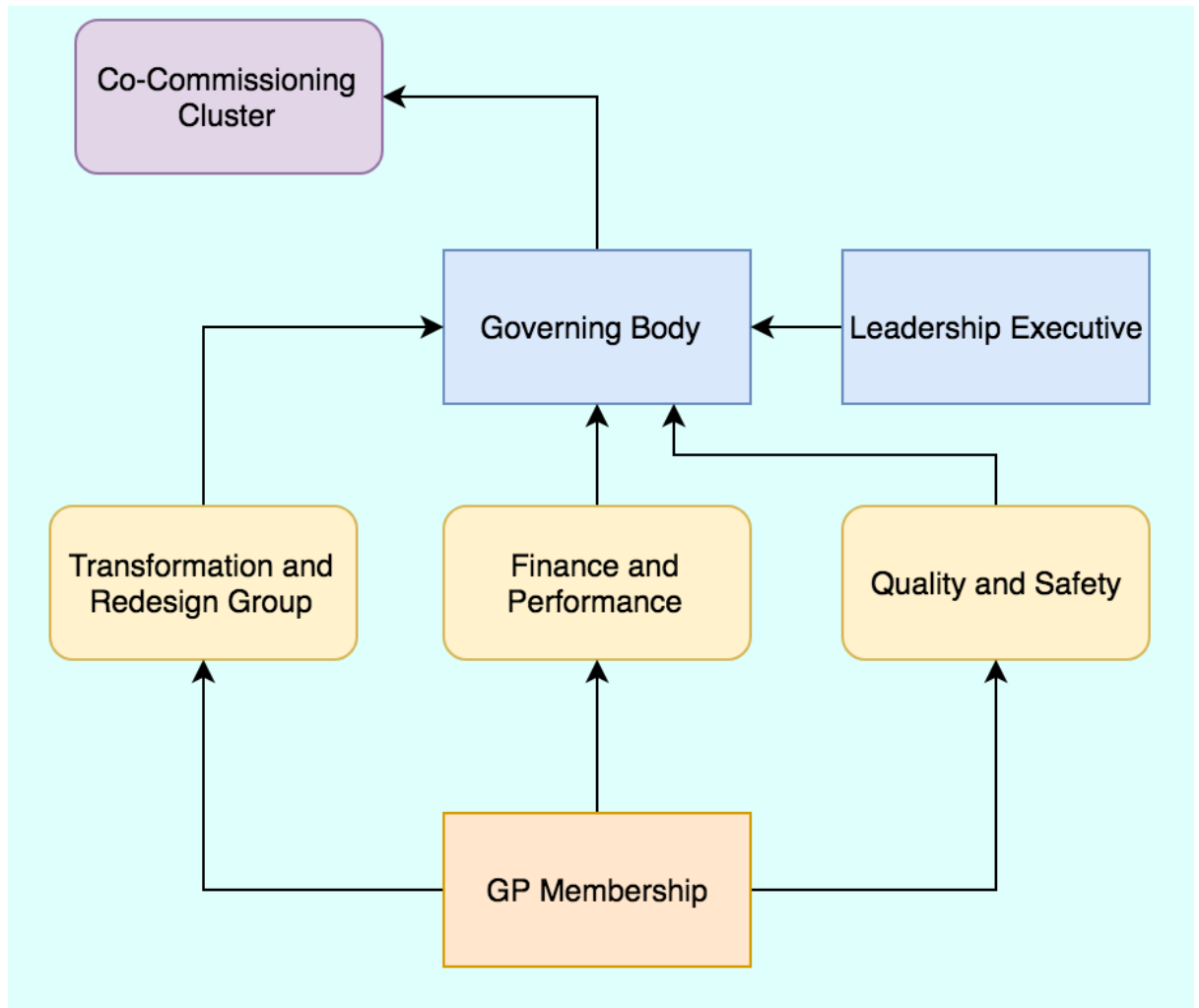


Figure 10 - Decision-making structures at CCG two

Each of these groups have their terms of reference and their work informs the decisions that are reached by the Governing Body. Through providing information and suggested courses of action, the Governing Body tends to concur with their decisions and implements them. It is through the Governing Body that the CCG receives reports on the status of the co-commissioning cluster. The Governing Body is also responsible for communicating its decisions to the membership of the CCG. A fundamental difference however is that the Leadership Executive Committee, consisting of the GP Chair, Vice-Chair and Managing Director, has the ability to reach decisions on its own, outside of the Governing Body in situations in which a

short term response is required. Nevertheless, they have to relay decisions to the Governing Body and are seen as being able to reach decisions at short notice – to provide the CCG with the ability to react to changing situations more effectively than the Governing Body. As stated by the Chair: *“It is more of an executive sort of if you like, making sure that things are getting done, making sure that what we need to do to push something along, and I think it's been quite important with the turnaround situation that we've put ourselves into”* (Chair, Interview). It is part of the decision-making process and assists in the financial improvement of the CCG, which is one of the overarching aims of the commissioners at site two. This reinforces the power of the Chair, as they have been elected to improve the financial situation of the CCG and have latitude to reach decisions, outside of direct oversight, that they think will suit site two. It illustrates how other actors within the CCG agree with the agenda of the Chair and remain willing to work within such a framework. It is a clear demonstration of the second face of power, something that the CCG has in common with site one.

Below the committees are the lead commissioners who work on their portfolios and feed back to the relevant committees or Governing Body, depending on the issue. There are also contract management meetings on both a CCG level and collaborative cluster level. The CCG works directly with the collaborative cluster and relays information to the Governing Body on relevant initiatives.

Compared to site one, there are several other key groups that feed into the Governing Body, rather than just two. The Transformation and Redesign Group (TRG); the Quality and Safety group; and the Leadership and executive committee all deal with clinical decision-making. They explore clinical needs and possible solutions for the CCG. They are complemented by the financial stream which comes from the F&P committee, which focuses on ‘value for money’. Finally, there is the co-commissioning stream, which affects both of these, where the CCG agrees with other groups about what they can commission as a larger collective (i.e., giving them the advantage of acting as a single large provider). This means that there are more inputs from different committees, even if there is overlap between the various memberships.

Ultimately, decisions are reached by the Governing Body using the information and discussions that take place in other committee meetings. The fundamental differences compared with site one are that there are several different committees and the formal role of the Leadership and Executive committee, which can reach decisions alone outside of the Governing Body. This provides added flexibility to the CCG, as it is able to make decisions about services if needed. Again this would highlight the relative power of the Chair and the acceptance of their agenda.

Similarly, as at site one, commissioners have two primary tools when selecting new providers. They can either go through the full procurement process, which is similar to the one at site one (i.e. there is a considerable time and staff cost) or they may purchase additional services from existing (referred to as “transformation” by informants) providers. The other tool available to commissioners is the

decommissioning of services, something that was observed more frequently than at site one.

In this sense, the structure of the CCG means that commissioning decisions go through several meetings before approval at the GB. This is different to what was found at site one. It means that there are multiple sources of scrutiny and there is a clear distinction between managerial and clinical commissioners across the meetings. Decisions about new providers are not made in one meeting, but across several, which allowed different actors to influence the commissioning process differently. The financial pressures at site two were also much more severe than at site one. This is discussed later in this chapter.

Context of decision-making

At site one, the CCG was able to commission new services and demonstrated that it could utilise the commissioning tools at their disposal. At site two, the financial context in which the CCG operates in is different. Over the course of the 12-month period of this ethnography, the CCG had attempted to eliminate a deficit in excess of 6% of its annual budget. Commissioners have attempted to achieve this aim through entering a voluntary 'turnaround' in which they agreed to reduce the deficit. The CCG Chair was elected on a platform of bringing the finances into order:

"Yes, we had to change direction because we were in the ... in a financial hole, and the only way of getting out of that financial hole was too... bring the clinicians in the practices on board, and say look, you are the solution to this, if we go on doing the same, we will be a problem, so how can we do it? I think the previous Chair, probably [um] hadn't got the confidence that... of her peers that she was going to do that:"
(Chair, Interview).

The reduction of this deficit has been the primary concern of the CCG during the ethnography. During the observations, it became clear that this was not the first year in which the CCG faced considerable financial pressures. This was supported by evidence from the field notes:

A new MD was appointed. Old post holder resigned as unhappy with situation of CCG. Justification being that CCG needed more support in reaching financial targets. (F&P, October 2016, Field notes). This turnaround plan has been entered into after there was engagement with NHS England which threatened to intervene with the workings of the CCG. This course of action strengthened the hand of the Chair and meant that many of the staff ultimately believed in their financial agenda, demonstrating the second face of power. The turnaround plan has informed many of the commissioning decisions and is one of the key themes to emerge from the data as it had a significant influence on the remaining themes identified during the observation.

The CCG has access to public, private and third sector providers to a similar degree to site one. This means that comparisons between the two sites can be justifiably made and the influence of the commissioner's choices examined. Both sets of

commissioners were able to exercise choice in comparable settings, with access to a relatively developed marketplace.

Meetings Observed

Over the course of the initial discussions with the Chair and Managing Director, as well as, taking into account the data that was generated from the first ethnography, the decision was reached to observe the Transformational Redesign Group (TRG), the Finance and Performance meeting (F&P) and the Governing Body meetings and private seminars. The researcher was unable to gain access to the Leadership Executive meetings due to the sensitive nature of some of the information. The decisions taken in this meeting were for any action that the CCG would have to take in a short space of time and where there would be no meeting of the relevant body to discuss the relevant action. However, the key outcomes from the meeting were observed through discussion of the results in the GB and other clinical/financial meetings.

The F&P meeting was chosen so that the researcher could stay up to date on the financial situation of the CCG. This proved to be fruitful as the financial situation affected most decisions that were reached by the CCG. It highlighted the importance of resource allocation discussions and how these pressures affected the commissioners. It also provided an insight into how commissioners juggled the competing demands of providing high-quality service and being a sustainable organisation.

Characterising the role of CCG Staff at site two

As at site one, there was an overlap of staff with commissioners and managerial staff comprising the GB and also the membership of other committees.

The deployment of CCG staff was fundamentally different to site one, with less overall cohesion being observed. Cohesion was defined by the amount of staff members who were in the different meetings. At site two there was less overlap of the members and less time working together. In part, the financial situation of the Trust meant that each of the observed meetings had a smaller, specific remit, with the commissioning process being divided, with only the Leadership Executive Committee having oversight of the entire process. There is a general perception that the CCG has too many staff members, and indeed that the NHS as a whole was over-staffed;

“No, we are really in big trouble, I don't mean to be disrespectful, because we have some fantastic people, but we are struggling, I mean if I think about what the 3 CCGs [part of the CCG collaborative] have delivered... because there are so many people involved and the decision-making is so hard, I mean you've sat in a Governing Body, you know they don't make any decisions or talk about anything meaningful, because so much other ridiculousness [sic] is going on, I mean there are all these papers ... I mean I would like to know what all those people sitting out there are doing [gesturing

to CCG staff], and are they realistically affecting patient care and delivering the change that we need? I would probably say no, and I know that" – (Deputy Managing Director 1, Interview)

This further developed into discussions about the efficacy of staff members and the use of information by the CCG to reach decisions about how to best use the limited resources. Again, this is related to the underlying theme of resource pressures, which influences how the CCG functions. Many of the staff members feel that there are many others who are not 'pulling their weight' which contributed to the financial situation of the CCG. However, it also reflects on the changing staff numbers related to the policy framework. It is mandated that the CCG has to determine the number of staff members, which had changed from when the Health and Social Care Act (2012) was first implemented to the present day. Initially, CCGs had to downsize and utilise the Commissioning Support Units (CSUs), which could have represented a form of privatisation, as private providers could bid for those contracts. However, CSU's proved to be ineffective, and the CCG had to re-start hiring staff, as occurred at site one as well.

Staffing issues have been an issue in previous reforms of the NHS. This is a reflection highlighted too other academics (Hunter 1996). In the broader context, the staffing issues in the NHS could be viewed as a political question as the Government realised that some services were too essential to fail due to the potential public opposition. It may make economic sense to decommission services or release staff members to reduce wage bills, with wages representing the most significant single cost to the NHS (NHS Confederation 2017). The NHS still needs to provide the same standard of service, but with reduced resources and increased levels of treatment activity in providers. There is also more pressure on CCG staff to work to tighter deadlines because of the financial situation.

These sorts of financial and framework pressure could potentially limit the ability of private providers to become further involved in the NHS – additional contracts would create more work for CCGs, thus commissioners may be less likely to favour tools such as tendering in favour of working and changing existing contracts (i.e., transformation). This, however, stands in contrast to site one, in which the staff numbers allowed the CCG to devote more time to various contracts and to explore options for commissioning more effectively.

The commissioners at site two did not utilise a CSU and instead utilised support staff from their co-commissioning cluster. As a result, the CCG had all of the necessary support staff to operate on a day-to-day basis. Most of the services that they were meant to provide have been moved back to the CCG, resulting in an increase in staff after the initial cuts in 2012. The CSUs were also heralded as being a potential opportunity for the private sector to get involved in the NHS. However, this was not the case in practice. It appears that throughout the system, commissioners have been reluctant to engage with CSUs (Petsoulas *et al.*, 2014). This attitude towards staff (hiring/firing) could create a situation in could ultimately affect private providers if the delivery of contracting slows due to staffing issues

(i.e., lack of staff). Commissioners at site one enjoyed a financial surplus, meaning that their key consideration when pursuing new providers were clinical issues. The financial issue at site meant that financial considerations were much more prevalent in the decision-making process.

Specialist Services examined

Mental health commissioning yielded data about the commissioning process and as such, was retained and further explored at site two. While mental health services can be commissioned through a variety of providers, the majority of care is commissioned by the CCGs directly. The data at site two was rich, adding to and providing some results which reflect the state of mental health commissioning as found at site one. Both CCGs remain committed to following the 'parity of esteem' (NHS England 2013) model where commissioners are obligated to match funding between mental and physical health services. While there was not as much investment into mental health services at site two, there remained enough for the researcher to explore the commissioning of services.

Key influences on the decisions of commissioners

As described earlier in this chapter, the key factor influencing and limiting the activities of the CCG was the budget deficit of the organisation. The observation at site two focused on this aspect and its effects on the commissioning process using the internal/external pressure conceptual framework and comparison to what was discovered at site one. The financial considerations meant that the key regulatory body, NHS England, was much more involved in the situation of site two and this manifested itself with the financial turnaround plan. This affected the decision-making latitude of commissioners as the plan restricted their ability to commission new providers without first decommissioning others and/or generating savings.

The internal pressures were those that arose from the organisational structure of the CCG and the resulting decision-making process. The others emanated from the use of commissioning tools which had a direct effect on the extent to which privatisation and marketisation occurred as a result of these decision-making processes.

Internal pressures: Financial Pressures

The first and most important theme in understanding the decisions of commissioners is the effect of severe financial pressures they were exposed to at site two. At one of the Governing Body meetings, it became apparent that the deficit that the commissioners needed to address in that financial year was in excess of £10m (Governing Body Observation, January 2017, Field Notes). This issue was the most important one that the CCG was facing, as the current CCG Chair was elected on the basis of tackling the financial deficit (Governing Body Observation, November 2016, Field Notes). This financial agenda accepted by other CCG staff as the threat of external interference in the work of the CCG is viewed as something

more severe than adjusting current behaviours. The implementation stems from the Chair who controls the agenda of the CCG, with a strict focus on reaching the financial targets which have been agreed with NHS England to avoid further sanctions. The CCG committees also follow this agenda and their actions can also best be understood as following the directive of alleviating the financial pressures.

Throughout the data collection, tackling the financial pressures was the dominant theme, occupying both managerial staff and commissioners, being mentioned in every commissioning debate and meeting. In each of the observations at site two, there was a discussion relating to the financial situation of the CCG. Primarily the discussions were focused in the F&P meetings, but other decision-making meetings also discussed the issue, framing it in terms of contract management: *Discussions took place reflecting on the ability of the TRG to manage contracts and generate savings from the start to the end of the financial year* (TRG, April 2017, Field notes). The financial situation facing commissioners at site two was what distinguished them from commissioners at site one.

Through the co-commissioning collaboration, the CCG had been able to offset its losses in the previous financial year. However, these financial issues remained a central pressure when discussing new services. The CCG ceased commissioning new services focusing instead on changing existing contracts and the decommissioning of some services. It also limited the ability of commissioners to explore their commissioning options, focusing instead on generating savings.

An example of decommissioning was at a meeting of the Transformation Group in February of 2017 at which the possibility of decommissioning a service was discussed in light of the financial pressures. The CCG had two months before the end of the financial year to reduce a deficit in excess of £8 million. At one of the TRG meeting, the commissioners agreed that a small podiatry clinic, operated by a local Trust, was to be decommissioned. The service, which provided nail cutting services to older people, was decommissioned to generate an annual saving of £75,000 (TRG, February 2017, Field notes). The commissioners and managers were in general agreement that the service had to be decommissioned to save the CCG money but did not agree to sanction the move unless there were alternative services available. A third sector provider existed in the catchment area but was not in a contractual relationship with the CCG. It did mean that patients would be forced to pay to use this other provider. This was considered enough alternate provision to justify the decommissioning of the podiatry clinic. Thus the commissioners justified their choice and believed that patients would go to the third sector provider of their own volition. This is an example of limited privatisation, with the public sector being replaced with a third sector provider due to resource limitations. It reflects the overarching influence of the financial pressure on the decision-making of commissioners, adhering to the Chair's agenda.

During the discussion about the decommissioning of the podiatry clinic, the patient representative did raise some objections to the removal of services but ultimately was unable to convince the commissioners to not decommission the service (TRG,

February 2017, Field notes). This highlighted a growing shift, from commissioning of services to 'negative' commissioning and the removal of services to meet growing financial pressures, especially with the CCG in financial turnaround. While the service would be cut, the commissioners did state, on record, that they would if possible have kept the service open, understanding its impact on the local community (TRG, February 2017, Field notes). This discussion was a microcosm of the situation that the commissioners at site two faced. Commissioners and managers are being forced to look at decommissioning of services and to reduce existing contracts to ensure financial stability so that the NHS England did not intervene. This is in contrast to the opinion of some staff who express concern that financial considerations could influence clinical outcomes, with a belief that they are best suited to carry them out:

“Those decisions will be taken in a more clinically informed way than they would have been, hopefully, we will not simply have salami style cuts. Hopefully, it will not be a purely financially driven process, but equally, we know that this is the requirement. Otherwise, I would consider leaving” (Commissioner – Head of Finance, Interview)

This also highlights how commissioning at site two also takes place on the periphery, outside of the contracts with the major local Trusts. However the discussion with regards to the podiatry clinic was lengthy and did become heated. As seen in the field notes:

One GP commissioner very unhappy with the head of the TRG arguing that the decommissioning of the clinic in principle represented a serious challenge to the principles of the NHS. Other commissioners' express general agreement (TRG, February 2017, Field notes).

While there was opposition to this course of action, the overriding financial pressure was in the end enough to convince the commissioners to agree to the decommissioning. As was observed later in the same meeting:

The Head of the TRG continued to highlight the need to meet the financial control total. Better to close down the “non-essential” service than other more important ones. Mention of NHSE. Eventual agreement from all the involved commissioners. (TRG, February 2017, Field notes).

The TRG Chair, who is also the Vice-Chair of the CCG, utilised the narrative of financial issues to ensure that other commissioners would eventually agree to the decommissioning process. While this agreement was secured, it was not a simple process which would suggest while the Heads of the relevant committees do have power and acceptance of the overarching agenda, conflict can still occur. In this respect, it is much clearer that the first face of power is being deployed. The Head of the TRG had to convince the other commissioners of the importance of reaching their financial targets reminding them that they could face actions from NHS England.

Decommissioning as a method of reaching financial targets is unpopular with the commissioners, and it seems that they are prepared to remain in post in the belief that they might be able to ameliorate its effects. Some commissioners have said that even this has its limits:

“Yeah because we're failing, you know, even if, when I go into lots of these discussions about efficiencies, and we've been told, you know, make a 9% cut, well now I'm not going to do that, I'll tell you clinically how to make it as efficient as possible, and the savings that you can make from that, but I'm not going to further into cutting things, because I don't want to basically, and the way I see it, is if you present the best thing for our population and you still say that's not good enough, that's when I'll walk, and I'm not even joking, that's when my conscience will kick in when you're being told over and above and you know it'll cause people harm” – (Commissioner 4, Interview)

It emerged from the observations that the voluntary turnaround that the CCG had entered had been influenced by the role of NHS England. This was later confirmed via interview with several commissioners and resulted in the appointing of business consultants to assist in the delivery of savings. It was also found in observations: *Consultants were brought in by the MD. They have a remit to evaluate contracts and to see if they are 'value for money' and to advise the commissioners which contracts they may want to decommission.* (F&P Observation, November 2016, Field notes).

Hence there is clear evidence of the financial pressures having affected the behaviour of commissioners, as they engaged in behaviour that would reduce the financial pressure on the CCG.

Commissioners can generate two types of saving. They can either generate savings over a longer period of time (termed recurrent by informants) or generate one-off savings (termed non-recurrent by informants). The majority of the money that the CCG had been able to save during the ethnography were one-off savings, decommissioning services and reducing services nearing the end of their contracting cycles. The CCG also utilised most of its reserves to tackle the deficit in an attempt to reduce it by the end of the financial year. However, as the deficit was primarily handled by one-off savings, the next financial year could mean cutting of further substantive contracts might be unavoidable. This could have more severe implications for the local Trusts, whose contracts have managed to avoid being changed or reduced over the course of the ethnography. The agenda has become more prominent since the election of the current Chair. Similar to site one, the Chair uses the second face of power in order to control the agenda. The remaining commissioners and managers work to that aim, but unlike at site one, the commissioners are more likely to openly disagree with the leadership. So while power may still be in the hands of key actors, they have to also use the first face of power to ensure co-operation with their agenda.

Another element is that the CCG has engaged business consultants to improve the 'turnaround plan', which is mentioned at every F&P meeting. The consultants had been tasked with delivering a plan assist the CCG in reducing spending to make it

sustainable, something which has been placed on the agenda by the Chair and MD. This was where the suggestion to decommission the podiatry clinic emerged:

“A contract [the podiatry] clinic of little clinical value was cut, that’s not saving or QIPP [Quality, Innovation, Productivity and Prevention scheme, a large scale savings and improvement programme], that’s just good contract management” Business Consultant – (F&P Observation February 2017, Field notes)

This illustrated the acceptance of the overarching agenda that has been implemented by the Chair of the CCG. They are also reviewing all of the CCG's contracts (with Trusts, other providers, and nonclinical contracts), trying to identify other areas for savings.

This contributes to a different theme that commissioners consider when reaching decisions about services - that of the role of the local Trusts, where the bulk of the CCG resource is spent. The commissioners have been exploring their options, believing that part of the reason that they are facing financial pressures is due to the cost of utilising the local Trusts. When exploring commissioning options, they are seeking to use more cost-effective community providers instead of the larger Trusts. There is a consensus amongst the commissioners that the financial pressures are forcing the CCG to look at other providers, including private sector ones, and as a result they are pursuing a greater use of private providers. There is not an ideological dislike of NHS Trusts, but commissioners are seeking to engage in behaviour which would improve the financial situation of the CCG. The data suggests that there exists a perception that private providers (i.e., the supply side) are more responsive to the needs of the CCG and are seen in a favourable light by commissioners. To engage a greater number of private providers' commissioners are more likely to attempt to use procurement to identify the best value provider, almost being forced by their financial situation to turn to procurement, even incurring additional transaction costs, which is different to the attitude of commissioners at site one. This may seem paradoxical in the short term due to the costs associated with procurement, commissioners at site two however believe that private providers would generate savings for them over the long term. This all fits within the Chair's agenda of cutting costs which appears to be accepted by the commissioners and the managers in the CCG. This general approach has been observed:

Commissioners vote to impose fines against local Trust due to not meeting certain targets. Argument that Trust has been warned about failure to meet obligations. (F&P Observation, August 2016, Field notes).

The agenda of the CCG and the internal dynamic with the Chair has led to commissioners prioritising a policy that focuses on reducing their financial pressures rather than thinking of other actors in the system i.e., local NHS Trusts.

External pressures: Role of the local Trusts

The vast majority of the CCG's resources are dedicated to the Trusts, which is a similar situation to that found in site one. This emerged from data of the finance meetings and the documents that were seen in these meetings (F&P Observation, February 2017, Field Notes). This is for several reasons. First, the CCG is obligated to use local providers. It is obliged to as NHS England requires that CCGs provide care for their patients in their local areas (NHS England 2017). Second, working within the co-commissioning collaborative, the CCGs work together to sign larger contracts with the Trusts, allowing some CCGs only to commission the services that they need. Lastly, relationships with the local Trusts have also existed over a much more extended period; there is some institutional knowledge and belief that the CCG needs to support their local Trusts, even if these Trusts are exacerbating financial pressures. While there is a perception that the financial situation is partially due to external bodies, there is still some hesitancy about the movement of treatment away from the Trusts. This is explored in the subsequent section.

While there is a commitment to the Trusts, there still remains an overall negative perception amongst commissioners, as can be evidenced from the deputy managing director. This highlights the tension in the system and the ambivalent attitude that commissioners have to the Trusts.:

“the other thing is that the hospital is being constantly told that they have to meet their targets, they have to see people in 18 weeks, so they suck up all these people in because they need the money to pay, but they can't meet their targets, but we can't reduce the amount of money we pay them or reduce the number of people we let them see, as they'll fall over, it's this conundrum that'll never be fixed and there's not enough money in the world to pump into places like [Large Foundation Trust] to make them sustainable, because every time you pump a load of money in, their costs spiral, because they haven't worked out I don't think, how much it costs them to see people, and they don't have any clue, so they have clinics going on which could cost a fortune and they never have those conversations” – Deputy Managing Director 1, Interview

The Deputy Managing Director (DMD), who is responsible for the contract management, suggests that the local Trusts generate the most substantial financial pressures. The CCG needs to keep funding these arrangements, so that its population can continue receiving health care even if commissioners believe that it is beyond their financial capacity. Commissioners feel that they have a responsibility to support the Trust even if they think that the relationship is not mutually sustainable. This would suggest that the commissioners perceive themselves as having limited scope for action: they cannot utilise other providers and therefore have to find another solution to deal with their financial pressures. Part of the agenda of the Chair is to improve the financial situation of the CCG and part of this is to create an atmosphere where savings are generated wherever possible. There is an attitude that these large contracts are very difficult to influence, but other smaller providers may be more susceptible to change. The main difference between sites one and two is that the better financial situation at

site two means that the financial pressures are not so severe and thus the Chair agenda at site one has a different focus even if power is exerted in a similar fashion.

The view of the system as a whole by some of the actors at site two, is one in which the Trusts represent a threat to the financial stability of the CCG. The significant resources committed on behalf of the Trust further the belief on the part of the CCG staff that the system favours the Trusts but that there is little that can be done to change this. Data from observations confirms this perception amongst the staff with the CCG Vice-Chair citing the following conversation with a Trust director during an F&P meeting:

"You don't need to work so hard for the savings, as when it all crashes, that's when the government will step in" CCG Vice-Chair, F&P Observation January 2017, Field notes

This is a small example of the perception of the relationship between the CCG and the local Trusts. The commissioners view the Trusts as unresponsive organisations, which have a focus on developing their own services, with financial concerns being secondary issues. The inherent competition in the system creates this tension, with the dominance of PbR contracts over fixed annual value contract (referred to as block contracts by informants). They remain a key mechanism that has been used by governments to enhance competition – which was meant to ensure that providers only charged for the care they provided. While the purpose of the contracts may have been to ensure that commissioners only paid for treatments carried out by the Trusts, commissioners instead view it as a major financial challenge that they face. During times of recession the number of treatments carried out by Trusts continue to increase, exacerbating the pressure (Doetter and Gotze, 2011). Providers are expected to compete, but there remain a limited number of large Trusts that can deliver a wide variety of services. As such, commissioners are unable to generate significant savings.

There is also a conflicting pressure that working with several other CCGs in the delivery and use of Trusts, creates additional work;

"There is lots of opportunity, but the thing is in [site two], is that we have lots of different services and you've got several different CCGs working for the same services and it makes decision making difficult, if you are one CCG in one area with one main hospital, you'll get a lot more done, here you have 5 CCGs working together, who can't effectively delegate amongst themselves without leadership in that respect, and you've got all these different hospitals..." (Commissioner 3, Interview)

This is in addition to the resource pressures that arise from the use of the Trusts. There is also a perception amongst commissioners that they have no ability to influence the Trusts, or the other local CCGs, which furthers the supposed disparity within the system. While the benefits of collaborative working relate to commissioning services on a larger scale, generating savings, commissioners believe it also makes contract management more difficult. This highlights the contradiction

between the need to scale care up and make it cost effective and the need to be able to exert control so that local patients can benefit from the new commissioning arrangements. One of the collaborative staff illustrated this perception in a discussion about the best way to generate savings within the local collaborative at a F&P meeting:

“It is impossible to get to the juicy bits of the turnaround unless you work across, 3, 5, or 8 CCGs... We have to put a lot of time working with the other CCGs” – (Collaborative Finance Committee Member – F&P Observation, January 2017, Field notes)

Therefore, generating the needed savings becomes an even more difficult task as the CCG needs to work with the lead contract commissioner (i.e. another CCG) to negotiate changes to existing contracts, thus limiting its independence and the options available to commissioners.

These issues combine to make it more difficult for the commissioners at site two to manage their financial pressures. As highlighted by the Head of Finance:

“particularly those acutes [Hospital Trusts] which have major deficits, and they are very much aware of the sponge cake theory of commissioning, you press down in one area, the cream squidges [sic] off into another area, so if we press down too much on the CCGs then that will transmit deficit pressure further into the acutes [Hospital Trusts], which obviously has consequences ... in the aggregate it is the commissioners who are in the black and the acute providers who are in the red” – (Commissioner 1 – Head of Finance, Interview)

Commissioners feel unfairly treated, as they perceive themselves to have generally been the more ‘efficient’ part of the provider/commissioner split, yet are left to deal with the financial problems. This fits into the agenda of the Chair as it ensures that commissioners and managers are seeking to reduce costs. To some degree this is borne out by statistics in the system, that the underspend by commissioners is £599 million whilst Trusts operate a £2.45 billion deficit (NHS Confederation 2017). The agenda becomes one which is about justifying the actions of the CCG staff as they seek to generate savings from these large Trust contracts. It does appear to be a rationale for the justification of the actions of commissioners within the CCG, especially as they seek to utilise more community providers to lessen the spend on the NHS Trusts.

Two further elements appear to pose difficulties additional challenges for the CCG. The first is that the CCG is bound by Payment by Results (PbR) contracts with the local Trusts. The CCG is unable to seriously affect demand management (limiting treatments in the Trusts). Second, with some of the Trusts, site two is not the contract lead as already mentioned, which further limits their influence on the Trusts. Commissioners need to cooperate with the other CCGs who are part of the larger contracting collaborative and this can present additional difficulties. Instead, the commissioners at site two rely on good working relationships with the CCGs that are the lead contractors to act on their behalf, but this still limits the power of commissioners to change the behaviour of the Trusts. Overall, the contractual

arrangements remain complex and this limits the ability of the commissioners to exert control over Trust treatments.

Commissioners also question the motivation of hospital doctors working in Trusts, believing that they are more concerned about the service they run than the patients and clinical outcomes;

“because the person who runs the dermatology service, that is not what motivates them, they are a dermatology consultant, they are motivated by dermatology, and if they are motivated by running a business they’ll do some private medicine because that’s what consultants do, GPs generally, there’s no ... long story but for me, there is no desire to do private medicine because as a GP, me, but as a consultant, why not? Half a million a year... they can, and they do.” (Commissioner 3, Interview)

This highlights the perception that doctors in the Trusts do not have to deal with the same issues that clinical commissioners do. It further enhances the narrative that the CCG staff are being responsible and focus on the patients and the limits which exist within the system. This perception also highlights the perceived difference between the doctors who work within the same system.

Regarding the issue of PbR - across the NHS, there have been increases in treatment numbers over the past several years (Maguire *et al.*, 2016). Site two is no exception. Under PbR, the CCG is bound to pay the Trusts for any treatment that they carry out, regardless of their ability to do so. While there is an acceptance of the agenda that the CCG needs to make financial savings, many of the commissioners also still feel bound to try and help the Trusts as much as they can and as such keep the PbR contracts. They also trust the NHS providers not to overcharge/oversupply treatments and cases, but that they are doing what is best for the patients. This relates to some public sector ethos and is part of the reason why some staff still need to be convinced to decommission/alter contracts. At site two, the smaller mental health Trusts did show flexibility and changed their contracts to fixed annual ones, which is discussed later in this chapter. This has created resentment amongst some of the staff, who see competition amongst NHS bodies, as being a negative that has come about as a result of the reforms and made the work of commissioners more difficult through added financial pressures;

“So I think modern commissioning is about collaboration, I think the days of commissioner/provider roles are ... or should be over, we are one NHS, and we have one pot of money, and we do not need to make sure that people are delivering and doing the things that they are supposed to be doing, but actually doing them in isolation of providers is madness and of course we’ve got, we spend all the money on then having a whole infrastructure of commissioning and the providers have all the infrastructure of their workforce to train and keep the commissioners happy, and it’s just complete madness.” – (Deputy Managing Director 1, Interview)

The purchaser/provider split, while not a direct result of the HSCA, has been brought into sharp focus by the reforms. It has increased the competition amongst NHS bodies and is making collaborative working more difficult, in a situation in

which resources are limited. It highlights the tension between purchasers and providers in a system which lacks resources. These issues are being used to justify the actions of the commissioners at site two as they seek to reduce their own costs. This has resulted in the staff at the CCG exploring different ways to generate saving, such as commissioning business consultants to assist them with the task. This does not inherently represent marketisation. Instead, it is their suggestion to either decommission services, or to levy fines which would signify the growing role of marketisation. The example of the podiatry clinic is the most explicit example of this.

The issues which the commissioners are exposed to are not unique to CCGs. Indeed, as mentioned previously, many Trusts face deficit positions and some CCGs have been placed under special measures. There is little the Trusts can do to alleviate their own fixed costs and the increased numbers of treatments would be out of the control of clinicians in the Trusts. This illustrates the broader issues within the system, but the commissioners at site two focus on their own financial pressures to alleviate the risk posed by NHS England.

The commissioners at site two would like to see fixed value annual contracts utilised, with some staff even suggesting that PbR is the root cause of many issues in the NHS:

"I mean we have to stop paying every time someone asks for money, it's just madness, that's the biggest, PbR was the biggest failure of the NHS as far as I'm concerned." – (Deputy Managing Director 1, Interview).

The question that arises is whether market reforms that were introduced at a time of plentiful resources are still adequate in present circumstances. The framework developed by the HSCA has created conflicting pressures: on the one hand, there is the demand for savings; and on the other, the need to provide adequate care, whilst retaining the quasi-market and the division between purchasers and providers. This creates a level of tension within the system and means that there are issues with the role of the Trusts, as evidenced above. There is a perception that the only manner in which the local Trusts can continue in their present form is by generating increased activity – for which the CCG cannot pay.

This is not the case for all services. At both of the sites, the majority of the mental health services are delivered by the public sector. There is a difference between the local Trusts, which operate PbR contracts and the mental health trusts. The mental health trusts operate on fixed value annual contracts and have worked with commissioners to find mutually beneficial arrangements (F&P Observation, March 2017, Field notes). The mental health trusts are smaller, and thus the balance of power lies with the CCG and not the trust. This is an illustration, firstly, that these Trusts enjoy a preferential status and secondly, that there is an alternative to the PbR contract, as exemplified by the smaller mental health trusts.

Fixed value annual contracts have become more prevalent due to the more stringent management of contracts, however, only the local mental health trusts were willing to change the contractual relationship with the CCG:

The commissioners discussed what value they should set for the block contract for the local mental health trust. Several figures discussed before settling on specific range and informing Trust of the said range and potential structure of contract (TRG Observation November 2016, Field notes).

Some other providers, including the private MSK provider, have also engaged in discussions to change their contract to a fixed value annual contract, which has further made private providers an attractive option to some commissioners within the financial context of site two. Apart from accepting fixed value annual contracts instead of PbR, some private providers have also engaged in sub-contracting arrangements with a mixture of third sector and other private providers to generate additional savings. They have also explored other ways to generate savings. This has emerged from interviews with staff:

“so [local Mental Health Trust], which is our local mental health Trust, they're going out and looking at providing community services as well as mental health services, because they are not sustainable, they're block mental health and they've always historically been block, and so because they think block and they've been kind of... they've lost money, but they're just a bit behind regarding data and things and are better at mental health” (Interview, Manager)

The mental health service is the only partner with which the CCG has been able to find success in generating savings and maintain the service with no disruption.

The Trusts utilise around 60% of the CCG's resources, which means that there is little room for the commissioners to hire additional public, private or third sector providers. The CCGs use their commissioning tools on the periphery of the large Trust PbR contracts. Commissioners have to maintain the status quo and attempt to limit the cost of PbR contracts. There was some scope for the use of private providers, but the overall value of these contracts was minimal. It was confirmed in one of the observations that there was no private provider contract which exceeded £2 million at site two (F&P, Observation December 2016, Field notes).

In addition, as part of seeking to generate the necessary savings, commissioners at site two sought to move services into the community and wrote several procurements, which included tenders for an Urgent Care Centre (UCC), MSK service and ophthalmology. The local Trusts wrote effective bids and won several contracts as they are allowed to compete for these contracts. It has created dissatisfaction amongst the CCG staff, claiming that they are merely “*feeding the beast*” (Deputy Managing Director 1, Interview), and not achieving the aim of moving care out of hospital settings. This was made clear in the case of the Urgent Care Centre (UCC) tender:

“I was leading on the urgent care centre before I went away and that was a really interesting process, so UCC at [Local Hospital], [Local Foundation Trust] had it, they

actually came to us and said, we don't want to do this anymore, as they were having lots of issues with subcontractors providing GPs for the UCC and they thought they weren't making money on it, so we looked at it, and realised we were paying a lot of money for it compared to other UCCs, we need to be better, so point number 1, we weren't aware how much we were paying, it was just rolling on, number 2, [Local Foundation Trust] realised they were making money and wanted to change their mind, but it was too late, then we had to look at it very carefully, then the joint CCGs had a great idea, of taking the front desk away from Accident and Emergency (A&E) and putting it in the UCC, which meant that patients would be triaged in favour of the UCC which makes sense, as most people walking in do not need to be seen in A&E, and if they do, they can then put them back in, but it meant that [Large Trust] is losing a lot of control over A&E if someone else is triaging their patients" (Commissioner 3, Interview)

This further helps the narrative that the commissioners are facing an increasingly difficult financial challenge and that the local NHS Trusts do not care about the situation of the CCG. There is other evidence that the commissioners have written a procurement and had to decommission the service when it proved that the care was not being delivered as they had intended (Governing Body Observation, November 2016, Field notes). This provides a partial explanation for why commissioners are unhappy with the Trusts – there is a perception that the Trusts focus primarily on their own needs, rather than seeking to work in partnership. The Chair's agenda is one where there is a perception that the CCG is unable to keep paying the PbR contracts. Either the relationship with Trusts will need to change, or it will lead to the commissioners exploring alternative avenues of provision, including private providers. This has manifested itself in some of the decisions of the CCG:

"we cut the easiest bit, so if you're spending £20/30k it's easier to cut that than to go to the acute and take away 30% of outpatient activity, although they are trying, and so I think we should, and there are private providers which are fantastic, and they provide and know how to run a business, and I think we need more" (Manager, Interview).

A clear example of this is the commissioner's decision to award a contract for physiotherapy services to a private provider via procurement. There was a perception that the local Trust attempted to obstruct the private provider from providing the service. Initially, the Trust refused to allow the private provider into the facilities that it owned, thought the provider was ultimately permitted to access the building and provide services. This was discovered through an interview:

"So we go to [Site two] and the example there is when the contract went out to tender, there was an estate that was designated by the CCG that you had to use, so the tender was written up and then off it went, and the award was made, but then it transpired that the estate didn't belong to the CCG and didn't belong to the NHS proper, it belonged to the incumbent [local NHS trust] who are unwilling to release the estate, so we found ourselves in a position where we didn't have the estate, again, we had to do a workaround, go to the GPs, try and get the estate, and we managed it in the end" (Private Provider 2, Interview)

Again, this further went to support the notion that there was a disagreement between the Trusts and the CCG; and that they were blocking the actions of the commissioners. This further enhanced the perception of that specific MSK provider amongst the commissioners, as they continued to provide the service even if they faced substantial challenges from the Trusts.

Internal pressures: Use of commissioning tools/levers

The overarching agenda of the CCG is to generate savings in order to be able to avoid sanction by NHS England. The lack of resources in the CCG means that commissioners were limited, they could not easily select new providers but used their commissioning tools to attempt to improve their financial situation. Part of this was achieved through attempts to improve contract management and part through decommissioning certain providers. In order to extend provision of service, the commissioners would need to generate savings first. This proved to be challenging, and as mentioned previously, the focus was much more on negative commissioning. However, the commissioners at site two were much more positive about using procurement as there was a belief that in the long run this would generate savings if some services could be transferred out of the local Trusts.

Apart from the considerable staff cost in running a procurement from start to finish, just as at site one, there have also been disruptions associated with the commissioning of the particular service. Overall, it appears that procurement as a method of commissioning has not delivered the benefits that might have been expected, at least according to commissioners. The ability of the Trusts to participate in the procurement process it is claimed to be a significant limiting factor in attempts to diversify providers. Commissioners seem to be supportive of a greater plurality of providers, and that seems to be a view shared both by managerial and clinical staff. On the other hand, while expressing discontent, commissioners remain happy that the procurement process should remain 'fair' and open to all;

"so I've seen it from a practical viewpoint the spec has been clear, and I think the guidelines the commissioning teams are clear on the expectations on what the service is aimed at providing, the one that I've seen is objective and fair, and clear and a split marking system." (Commissioner 2, Interview)

Commissioners at site two appear to be more positively inclined towards the procurement process as it presently is and are satisfied with the system in relation to this. At the same time, they are concerned that the Trusts have a significant advantage in that they possess significant experience and knowledge of competing for bids. This also works against the 'direction of travel' of the CCG and its aim to move more services into the community as a method of achieving savings. This is compounded by the financial situation of the Trusts:

There was discussion of a board paper highlighting the cost of the contract with the local Trusts. Overall for the month of December, the Trusts had spent £1m more than commissioners expected. (Financial Paper, F&P Observation, December 2016, Field Notes).

Another concern that appears to be affecting the commissioner's decisions is the fear of legal challenge and their decisions being overturned. Commissioners openly admit that they are concerned with this prospect and that it has made them more reluctant to use the tools at their disposal. However no challenges were lodged during the ethnography. The use of procurement to transfer care out of the local Trusts and to community settings did manage to generate around £450,000 of annual savings (F&P Observation, December 2016 - Documents). This represents a large potential saving for commissioners. It still did not achieve enough for them to pursue new provider, as again, the financial pressures limited this.

While some savings were generated, the financial pressures facing the commissioners at site two remain considerable. The local Trusts continue to use the bulk of the CCG's resources, as at site one. While there may be an appetite for the use of the private providers to help alleviate this pressure, the present set of circumstances means that commissioners at site two are unable to engage them in greater number. In summary, there is evidence of limited privatisation and marketisation, with a modest growth of the use of private providers and growing acceptance of a mixed economy of care. The increased use of procurement would point to increasing marketisation with competition amongst providers encouraged by commissioners to help alleviate their own financial issues.

One example of the use of greater use of private providers is the CCG's use of one to deliver MSK services throughout the catchment area. This has been mentioned several times in interviews;

*“eventually they agreed that they would put this out to tender, with a lot of scepticism on the part of managers. However, an open tender was run, it was won by an excellent, albeit private organisation and within 3 months they had transformed that service into something that people wanted to refer to, patients wanted to go to and to give a real example, at that time I had a chap come to me, who lived rough... used more drugs than was strictly good for him, and had the most stunning deformity of his knee that I had ever seen, and he suggested that he should get some physiotherapy, and began to laugh at the concept that somebody like him would ever get to see a physio, and I was able to draw to myself some forms, put it into his hand and I said, go around these two corners, you would come to [Local Treatment Facility], it'll take you 2 minutes, you show this to the large chap on the door, he will send you 30 yards down the corridor to your left, you will come to another desk, your hand in this form at the desk, you then do not leave that desk until you have received in your hand, the date and time of your appointment, if that appointment is more than 14 days from the present moment, you come and tell me as that's not meant to happen, so said, so done. And that was such a radical transformation of that service, **which it made us all believe**” (Commissioner 1 – Head of Finance, Interview) [emphasis added]*

‘That it made us all believe’ – this statement is crucial to understanding the acceptance of private providers at site two. Having such a strong positive experience made the commissioners at site two feel more comfortable using a private provider. This is further facilitated by the private provider being willing to fix

their annual rates rather than using a PbR contract. While this may reflect the lower operating costs of a small private provider when compared to a NHS Trust, it fits within the agenda of the CCG which enhances their reputation. If commissioners do develop a working relationship with private providers, then their use could further become normalised, especially if other CCGs find themselves in similar financial issues.

The private providers at site two were prominent in the areas where private providers have experience of delivering care. At site two this was physiotherapy, with the local private provider being recognised as one of the best in the country: *"we just won last year for Clinical team and MSK service of the year, nationally, so that's what we can deliver with a good CCG behind us"* (Private Provider 1, Interview).

These private providers are able to operate with lower costs as many of the services they provide do not require specialist doctors or consultants. Rather they require less well trained professionals and less specialised equipment, which means that the associated costs are considerably lower than Trusts. These private providers also do not need to cross-subsidise their business as they only focus on these profitable enterprises. In certain contexts, where there is a perception that there are increasing financial pressures, these types of private providers may become more attractive options for commissioners. Currently, this represents a limited form of privatisation as commissioners are only able to use some private provision for areas such as MSK or ophthalmology.

At site two there has been consistent use of private providers to deliver physiotherapy services (as part of the larger MSK pathway). Not only did they secure the contract via a procurement process, but commissioners view the private provider as delivering the service to a high standard. Several commissioners are so impressed that they say they would like to replicate their efficiency in the CCG;

"Our best provider of the things that we have commissioned is a private organisation, [Name of private provider], physios, is the best provider, they do everything, everyone is happy with them, because they run things with energy, when there is something that is a threat to my practice, we need to be better and provide a better service, provide better care, because of performance reviews and we need to get big, and that's it, and I think like that, and I think that's what's missing, it's a market out there but you can use it to your advantage but you have to be smart, so, the hospitals don't think like that" – (Commissioner 3, Interview)

This experience of working with a private provider seems to have left an impression on the commissioners. Primarily, it seems, because of the quality of the delivery of the service. It also further fits in to the narrative that the commissioners have of the Trusts being inefficient. This is further evidence of limited privatisation, and just as at site one, it came in an area in which the private sector specialises and has dominated for a number of years. Another such area is Ophthalmology;

"we've long believed that it [Ophthalmology] offered real opportunities for clinical benefit and financial efficiency, fundamentally to ophthalmology, you need a chap with a torch,

and a ready supply of patients, because fundamentally, the common single referral into ophthalmology, is the optician has seen something he's not quite sure about at the back of somebody's eye, will somebody who does this for a living have a look, now somebody who does that for a living can have a look whenever you want, you can get 3 clinics in this room, this is the same size room that they have in the [hospital name], and they have 4 SHOs in ophthalmology looking into people's eyes! So it's not a hard thing to provide, so the feeling was that this could be done anywhere, and all you need is the cost of the chap, his torch, and his chair, and if you really want a chair for the patient! [laughter] It is that simple" – (Commissioner 1 – Head of Finance, Interview)

The targeting of services by private providers and the willingness of commissioners to engage them motivated by their need to generate savings seems to be a trend across both sites. The private providers appeared to be more willing to compete on price and move to a fixed value annual contract (or a "block" contract). At site two, this commissioning strategy is much more of a need as a result of the financial pressures faced by commissioners. While this trend has met with little opposition in the present circumstances, it is not certain whether there will be a similar acceptance for greater use of private providers in other services (i.e. outside of MSK services). The kinds of positive experiences that commissioners have had with private providers, in comparison to the public sector Trusts, could gain momentum and lead CCGs to pursue a greater number of private providers. Currently, the private sector has not developed enough to generate profit out of more complex forms of care which require specialist doctors and equipment, which means that most private providers have remained in areas of care where they have prior experience.

This positive perception of private providers is not universal within the CCG. Some commissioners are not satisfied with the idea of further privatisation or use of private providers in order to meet the goals of the Chair. They would much rather support local providers or work with them to reach their aims. Most commissioners are also acutely aware of the context that they are working in, and of previous policy issues:

"I think the major ultimate driver of privatisation is the toxic legacy of PFI, this is not a political point, because governments of both colours have been engaged in that process, but those very large PFI contracts, including some not far from here, I think are major concerns because ultimately that accumulation of deficit must... the only way of resolving that will be some sort of debt to equity transfer which is a very direct form of privatisation, so I think the acutes [Hospital Trusts] are at big risk of that, within General Practice, the stresses are such that a lot of GPs are looking to become private organizations" (Commissioner 1 – Head of Finance, Interview)

The 'toxic' legacy of PFI is the cost associated with the scheme which it is argued has left many NHS trusts facing financial issues (Sweet 2017). These issues have been recognised as placing the NHS at a disadvantage. There is some consternation amongst the commissioners about the use of private providers as they may force public providers to behave in a similar way and to potentially compromise care in order to have a surplus/deal with their own deficit issues. It also highlights the view

of many commissioners that they are wary of giving the private sector free reign but are willing to proceed with a mixed economy of care:

“I'm not against it [the use of private providers], but you have to be tight, you have to look at the outcomes and managed the contract properly, so for example if you look at, and profit does motivate people, the best-run organisations that we see run, are run for profit, so if you look at example our federation, not run for profit, knowing it's the money, they exist to continue their existence, if they ran for profit, and the GPs, or whoever... they might be a bit more... you might get something a bit more commercially involved” – (Commissioner 3, Interview)

There are contradictory views about the use of for-profit providers. In some instances, commissioners are opposed, but in the areas where these types of providers may assist in alleviating their financial pressures they seem much more willing to engage. This could have far-reaching implications for commissioning services in future, there seems to be a growing view amongst commissioners that the provision of services is no longer the sole responsibility of the public sector, but that there is a need for a mixed economy of care, which includes private providers being introduced in a gradual and controlled manner.

Possibly the most significant effect of the above-described circumstances at site two, is the acceptance of private provision as a 'cultural norm'. The evidence confirms an increased level of marketisation and limited privatisation – a trend that could increase in both scenarios: an underfunded NHS searching for savings, and turning to private providers to achieve them and the opposite in which a well-funded NHS could turn to the private sector simply by commissioner's opting for procurement as a method of selecting providers. In the shorter term however, the use of private providers might increase by direct privatisation, and/or 'passive' privatisation in which private providers work alongside public providers in community settings. This was a possibility Rondinelli (1984) described and characterised as privatisation. Simultaneously this trend would increase the level of marketisation, with the introduction of bodies necessary to regulate the system and to enforce competition and choice.

External Pressures: The role of the regulatory framework

NHS England

As at site one, the dominant external regulatory body that interacts with the CCG is NHS England (NHSE) which is tasked with ensuring the financial stability of commissioning organisations. The key relationship here is between the CCG and the NHSE. As stated, the Chair was elected to improve the financial situation of the CCG and coupled with their possible intervention has been able to have other commissioners and managers accept their agenda. The acceptance of agenda has made all other concerns secondary to the commissioners at site two. Having entered voluntary turnaround, the commissioners have continued to remain in

contact with NHSE to ensure that they remain on track to meet their financial targets.

It is worth noting that unlike at site one, NHSE is not viewed as a single monolithic organisation, as the commissioners have had to work with NHSE much more frequently, rather it is seen as being a vast and internally complex organisation;

"I think it's a mistake in the same way that it's a mistake to think of Islam as a single religion, I think it's a mistake to think of NHSE as a single organisation, there are lots and lots of bits of it and they are not always terribly well-coordinated in their approach, so NHSE [Local Region] regional team that commissions general practice isn't in the same building and doesn't always have very clear relationships with the bit of NHSE that authorises CCGs and marks their homework, and similarly, that is a different sort of thing to the NHSE [Regional Centre] Region, that administers strategy for health services within [local City] and takes a much more strategic approach" – (Commissioner – Head of Finance, Interview)

The relations between NHSE and the CCGs are complex. The financial oversight role of NHSE was very present at the site, however, the commissioners had discretion when it came to actually reaching their financial objectives. While NHSE is more present as a powerful regulator, they still allowed the commissioners to control the process and in this sense the role of the Chair, guiding the CCG proved to be important. They could shape how the CCG generated savings alongside other key actors such as the MD and the Vice-Chair who were also placed within key meetings to exert power. Even so, there was still a perception that NHSE were making the commissioners carry out jobs they were not particularly satisfied with:

"it always seems like they're the baddies, I guess in every story you need to have a good baddy right? That's how we work! And they are definitely the baddies as it feels like they are the ones pushing down these, or the DoH, they're the ones pushing down these ... directives on us, and this STP [sustainability and transformation plan] business, a lot of it seems to be unevidenced [sic]" – (Commissioner 4, Interview)

This further highlights the perception amongst the commissioners at site two that the framework created by the HSCA restricts the ability of the commissioners to carry out their remits by giving precedence to considerations other than clinical outcomes, such as financial concerns. Some of the staff at site two felt they had no choice but to enter 'voluntary turnaround' to ensure their independence from NHSE. In this scenario the CCG agrees to focus on reducing its financial deficit. This appears to have had a subsequent effect on the commissioning of services and the decommissioning of some services.

Financially underperforming CCGs can be placed in special measures (NHS England 2016) and halfway through the ethnography, the CCG had to directly tell NHSE that there was no need for this to happen, as was stated:

"we are coming that time when it is really difficult, because we are in a deficit position, fortunately not a recurrent deficit position, we will meet our control total for the year, we will still meet some of our QIPP expectations, and Friday before last, in this very room, we

managed to persuade NHSE that we were still likely to be better at doing this than any likely alternative that is available to them, so I think we are in as good a place as can be, I think” – (Commissioner – Head of Finance, Interview)

This highlights that NHSE appears to be most interested in intervening in the working of a CCG when there are financial issues. The manner in which the commissioners at site two convinced NHSE not to take further actions (outside of the turnaround plan), was by pointing out the advantages of being part of the co-commissioning collaborative (multiple CCGs), which would offset some of their financial losses, and by establishing a turnaround board to explore and implement savings plans. This further strengthened the agenda of the Chair, as the CCG could only remain autonomous if it agreed to generating savings. This is an example of how the actions of a national body did affect the commissioning process. The threat of interference made the commissioners and managers adhere to the Chair’s plan and engage with the national body and many of the actions can be seen as being affected by this. It also further goes to highlight the influence of the clinical commissioners; they are still viewed as being best suited to deliver the financial turnaround. There was a second meeting between NHSE and the CCG at which there was further scrutiny of the CCG’s financial performance. Through reading the financial papers;

The CCG assured NHSE that it would meet its control totals for the 16/17 financial year and has adequate plans in place for 17/18” (Commissioner, F&P Observation January 2017, Field notes).

This also illustrates how an internal pressure (financial situation) can lead an external regulatory body (NHSE) to become involved and affect the commissioning process. The commissioners at site two entered turnaround to maintain their autonomy after a 'soft' nudge by NHSE. The commissioners maintain their autonomy at the cost of having their ability to commission new services/providers limited. Their latitude for decisions in terms of selecting new providers is reduced and are effectively limited to working alongside existing providers or carrying out small procurements. The financial turnaround plan strengthens the agenda and authority of the Chair. The commissioners believe that they are best suited to carry out the turnaround so that in future they can commission in the best interests of their patients again.

In these discussions, there was also talk of how commissioning arrangements will change to allow the CCG to achieve savings. The resulting turnaround plan represented a form of marketisation, as meant that the CCG had agreed to effectively cut expenditure through decommissioning providers and in order to cover the provision gap would run small procurements which could involve private providers. What was not discussed at the meetings with NHSE, was explicitly how the CCG would generate these savings, rather that they would use the tools at their disposal to try meaning that they retained decision making latitude in this sense – they were allowed to pursue their own plans.

There are other mentions of external bodies, such as the National Institute for Health and Care Excellence (NICE) concerning clinical discussions, where the decisions of commissioners are justified using the guidelines laid out by NICE. This is also carried through when discussing how to transform services or to reduce them – such as the decommissioning of the podiatry clinic, using NICE guidelines as justification for decommissioning the service. However, this was in a very limited context.

Decisions at site two are still taken based on primarily clinical considerations. However rather than exploring new services to commission, the staff at site two focus on minimising disruption when decommissioning/altering existing contracts. The relationship between the CCG and the regulatory bodies is also different. Again, this stems from the financial pressures. The CCG has a large amount of autonomy in how they alleviate financial pressures but is restricted in commissioning new providers. This is an example of power relations between the two organisations: the CCG is still given the time and space to carry out its work. This has enabled the Chair to strengthen their agenda and focus staff on achieving financial goals, even if there are some reservations about the process. This interaction between the CCG and NHSE has shaped all other aspects of commissioning and has generated tension within the CCG as commissioners and managers seek to make the necessary savings. They have engaged some private providers in order to enable the generation of savings and this represents some privatisation as these providers appear to be an attractive alternative to the NHS Trusts. These pressures have also led to the increased use of market mechanisms with commissioners seeking to use procurement to generate additional savings.

Summary and conclusion

This final section will briefly address some of the differences between the evidence gained at sites one and two, before discussing the data that directly relates to the research questions. The financial pressures at site two have shaped the approach to all other aspects of commissioning. Having convinced NHS England to allow them to continue, the commissioners at site two have considerable ability to generate the necessary savings how they deem best. The presence of powerful actors, similar to site one, shaped the agenda of the CCG and focused it on addressing the financial deficit. As a result, they had to carry out 'negative' commissioning, i.e. decommissioning services and clinics. This can also be argued to be the withdrawal of public services and fall under the Saltman taxonomy – where the private or third sector replaces the departing public sector which had a reduced role due to the savings which are to be generated under the Health and Social Care Act. This means that there is more evidence of privatisation at site two than at site one. The regulatory framework is much more present at site two, with the financial situation meaning that the commissioners have to adhere to the turnaround plan to remain free from NHS England sanctions. This seems to have been the most significant influence on their decisions in the short term, with commissioners hoping that once they have achieved the relevant savings, they will be able to operate more freely and consider expansion of services.

This had helped to create an atmosphere where the commissioners are more ambivalent towards the Trusts, viewing them as responsible for their own financial issues. They seek to limit the cost of these contracts and aim to reduce the amount of care carried out in the Trusts and want to transfer care to community settings. This has led to the decommissioning of smaller contracts and the greater use of private providers in an attempt to reduce the financial pressures. Many of the decisions at site two were primarily informed by these financial pressures, although clinical considerations were also taken into account. It highlights the dominance of the financial agenda at the CCG. It is in contrast to site one, where the commissioner had more flexibility to commission new providers to address clinical needs.

There are similarities between the two sites and the decisions that they reach. Commissioning generally takes place within the same 'periphery' space, with the majority of decision-making taking place with the resource that is left after securing the contracts with the local Trusts. Marketisation continues to play a role in the manner in which decisions are reached, with private sector practices being important. This also includes private and third sector providers, who still currently only operate in this periphery space.

At both sites, the local Trusts compete for contracts when they are sent to procurement, despite the commissioner's agenda to secure more community services. However at site two there is more open frustration with the Trusts, due to the several negative experiences which commissioners have had. At site two, this has led to frustration amongst commissioners as they believe that the with Trusts which were not fulfilling their obligations.

What influences the decisions of commissioners? Commissioners at site two have the same tools as commissioners have at site one. They can turn to the market and use procurement, or they can purchase additional services from existing providers. However, the adverse financial situation at site two has increased the use of the third tool - decommissioning. The commissioners at site two have directly decommissioned and changed services due to the need to generate savings. This differs from site one, as the CCG generated a surplus. In this sense, the internal financial pressures directly influenced the decisions of commissioners. The commissioners were also more likely to turn to the market to find more financially friendly providers, despite many commissioners having reservations about utilising private providers instead of public providers. The financial situation has also resulted in direct intervention by a body from the external framework, with NHSE becoming directly involved with the workings of the CCG at site two. The result of that intervention concerning the focus of this thesis is that the commissioners at site two entered voluntary turnaround, which increased the level of marketisation through focusing on reducing its deficit, and the amount of privatisation than the at site one. This is most clearly visible through the reduction of providers and the willingness to work with private providers.

In terms of selection of any particular provider, commissioners at site two seem to be led by pressures emanating from their financial difficulties. Commissioners at site two use procurement more often than commissioners at site one due to the perception that this will generate savings over a longer period of time. They are also more likely to decommission providers as well. The observations indicate that the staff at site two remain united in seeking to generate savings. The overall effect is increased use of procurement, more stringent contract management and decommissioning with the priority being financial stability.

As a result of all of the mentioned pressures, there is a growing acceptance of the presence of private providers in the market at site two. The success of the private physiotherapy provider has left a deep impression on some commissioners and is an example of how a perception that the private sector is more 'agile' and responsive to the needs of commissioners could lead to further expansion of private provision. It also illustrates why some commissioners find the private provider more attractive, as it appears to be willing to work with them more than the local Trusts, despite the difference in size and financial issues they face. This could signal the possibility of a broader culture shift in the NHS - that the private sector does have a role in the delivery of services in future. The private providers seem to have found a niche in the market in which they are comfortable and are proving to be successful in the delivery of services.

This negative perception of local Trusts is further compounded by the perceived inability of the commissioners to affect activity levels. The Trusts also have the ability to compete with other providers when there is a procurement, which disrupts the work of the commissioners who want to see more care being provided in the community and is the main objective of them using a procurement process. The private providers (and some mental health trusts) are more willing to accept fixed value contracts, which makes them more attractive to the commissioners in the context of their own financial pressures. In part this could be due to the difficulties of fixing costs to mental health treatment compared to physical illnesses (Mason *et al.*, 2011). There are also fixed costs in the hospital Trusts that the commissioners do not seem to discuss in their own commissioning meetings (Propper *et al.*, 2008) However, decommissioning services provided by the Trust is still a rare event, primarily due to a view shared by commissioners that they have some responsibility to work with the Trusts, as well as the provider market being under developed and incapable of meeting the demands and providing the service of a large hospital.

The public/private balance in the NHS has slightly shifted as private providers have managed to establish their presence in areas where they already have experience. Commissioners at site two select private providers more often than their colleagues at site one. This does not necessarily indicate that the private providers will expand further as many private providers have not expanded into other areas of care. The limited resources available to the CCG at site two, has led to this, with the private provider being willing to change their own contract to ensure continued business with the CCG. However, these private providers remain limited as the value of the

contract with the largest private provider, had a value of £2 million. The tool that commissioners still turn to most often is purchasing/changing of existing contracts.

At site two, the growth of private provision is indirectly assisted by the regulatory framework. NHS England only became directly involved in the work of the CCG, because of financial, not clinical issues. This enabled the Chair to focus the CCG on reducing the financial pressures, exerting the second face of power. This somewhat changed the priorities of the commissioners, who now seem to give a greater level of consideration to financial aspects compared to clinical considerations. The CCG needs to generate savings, while also attempting not to disrupt the work of local Trusts, which is the source of their significant expenditures. This 'push and pull', of seemingly contradictory pressures of providing services while retaining financial stability, seems not to be possible to maintain over the long term. These circumstances have been one of the reasons behind the expanding presence of the private sector in the NHS. At site two financial considerations are growing in importance, and influence on commissioning decisions, which is to a degree the consequence of NHS England's intervention in its workings. At site one, which operates a small budget surplus, commissioners have been more cautious, but are able to consider various commissioning options with a view to the longer term.

Overall the level of marketisation and privatisation has increased, although in a limited way despite the various pressures exerted by the external and internal networks on the CCGs. There appears to be a growing acceptance of the presence of the private sector in the NHS as the new 'normal'.

Chapter 7: Discussion

Introduction

The Health and Social Care Act (2012) has been championed and denigrated in equal measure (The Nuffield Trust, 2015). It has provided commissioners with the ability to select whichever provider they think is best. It has also been argued that it has exposed the NHS to more competition laws with procurement becoming much more important in the context of the NHS (Ibid, 2015). The goal of this thesis is to examine if, and how, commissioners use their newfound powers and how that can affect the selection of providers.

The primary purpose of most, if not all, of the attempts to reform the NHS, was to change the manner in which services are commissioned (Timmins 2012). This thesis explored the decision making processes in two CCGs, tracking different specialist services. This chapter will discuss some of the key findings and illustrate how they might assist in answering the broader questions posed in this thesis. They were:

1. What influences the decisions of commissioners in and during the commissioning process?
2. Why do commissioners select certain providers over others?
3. How has this affected the private/public balance in the NHS?

They focus on the new commissioning arrangements, the process of commissioning itself, as well as the factors and outcomes regarding the providers they selected. They also explored the extent to which commissioners have the autonomy to carry out their role. The innovative aspect of this work is that it tracked two years of in-depth clinical commissioning, focusing on several key specialist services. It also focused on the new organisations and individuals and utilised a conceptual framework based on the work of Pettigrew *et al.* (1992) to understand how various competing internal and external pressures may have affected the decision making of commissioners. This conceptual framework aided the researcher in contextualising the various influences on the commissioners when making decisions on the type of provider that they selected. It also proved useful in exploring how various factors did or did not affect the commissioners in selecting new providers. There is also a discussion about the receptive contexts for change to see if they are relevant and if they assist in creating a better framework for understanding change in the NHS.

At the outset of the project, there was a lack of literature about the way in which the Health and Social Care Act (2012) would affect the NHS. There has been a steady growth of new literature exploring the effects of the reforms, with which this study will be compared. The thesis has discovered a difference between policy and practice, in which the broad formal autonomy of the commissioners is in reality limited by varying influences. The methodological framework which informed the data collection was symbolic interactionism. This allowed for the exploration of the commissioning process from the perspective of the GPs and managers in their environments and how they understand their roles within a changing NHS

landscape. The key was to study the perspective from those who are working in that environment. This approach focuses on individuals rather than institutions as the determinants of outcomes as the focus is on the way in which commissioners interact with each other and the challenges that they face. This should provide an insight into the commissioning process from the standpoint of the commissioners themselves. In effect, this should identify the micro-processes that have arisen between the commissioners in the environment/framework of the Health and Social Care Act (2012).

The first question was explored using the observational and interview data from both sites that characterises the decision-making processes and the way in which they developed. The data illustrates that a combination of direct and indirect influences created by the policy framework affects the commissioners in their functioning. The second question examined the context in which these decisions were made and which services were selected. The third and final question examines the commissioner's personal preferences and the potential for them to exert their influence to ensure the selection of their preferred options.

These questions also encompass the 'why' of the commissioning process, as well as how various influences affected the commissioner's orientation towards any specific type of provider. The influences were described in earlier chapters, but are restated below. The overall aim when answering these questions is to understand the preferences of the commissioners and their significance for the future of private provision in the NHS. The data gathered provides some insights into whether there may be an increase in privatisation in the NHS (Pollock *et al.*, 2012). Quantitative data has allowed for the exploration of trends over longer periods of time and but the use of qualitative data allowed the researcher to explore the how decisions are reached and the implications of those decisions in local environments. The conclusions should be transferable to CCGs with similar characteristics.

Overall, this chapter will explain these processes and how they compare across the two sites, with a focus on the degree to which the new arrangements allow for the expansion of private provision in the NHS. This is followed by a discussion of how this research fits with the broader literature and whether the new legislation has resulted in increased privatisation and/or marketization. Finally, there is a discussion of the explanatory power of the internal and external pressure framework on commissioners.

Summary of evidence from the study

The study has provided sufficient evidence to conclude that the new commissioning arrangements did result in an increase of privatisation, although in a limited sphere when examining the NHS as a whole. It also confirms a growing use of market mechanisms (e.g. procurements) and a lower level of involvement of the regulatory bodies than was initially expected.

The acquired data also identifies questions that were not initially in the scope of the study as the study uncovered a more significant role than expected of the NHS

Trusts, seemingly resistant to the changes introduced by the Health and Social Care Act (2012). This evidence shows that despite the broad powers that commissioners are given by the Act, in reality they have a very limited choice when commissioning. Depending primarily on the financial circumstances, commissioners are, it suggests, more likely to opt for commissioning tools which end with a private provider being selected when faced with budget deficits (external pressure). This is opposed to a situation in which they possess a surplus, allowing them to prioritise quality of care (internal/local demand). The latter is confirmed by the differences in the data gathered at the two CCGs.

The data demonstrates that as a result of the dynamics between the external and internal pressures, the commissioner's autonomy is limited to the 'periphery' of the commissioning process, and when choosing the method to select providers. The research also showed that whether commissioners choose to either utilise procurement, decommissioning, or the purchasing of additional services (i.e., "transform") from an existing provider, is the major determinant of what type of provider is awarded the contract (procurement is the only entrance to the NHS market for a private provider). With regards to privatisation, commissioners are faced with a limited choice of private providers, as on the whole they do not have the capacity, either financially or in expertise, to provide complex care. This in effect puts a limit on the potential privatisation of the NHS.

Key influences on commissioners during the selection process

This section discusses the factors which influence the decision-making of commissioners at both sites. It includes a brief description of the commissioning tools they employ at both sites and will also provide a comparison of the differences between the two sites.

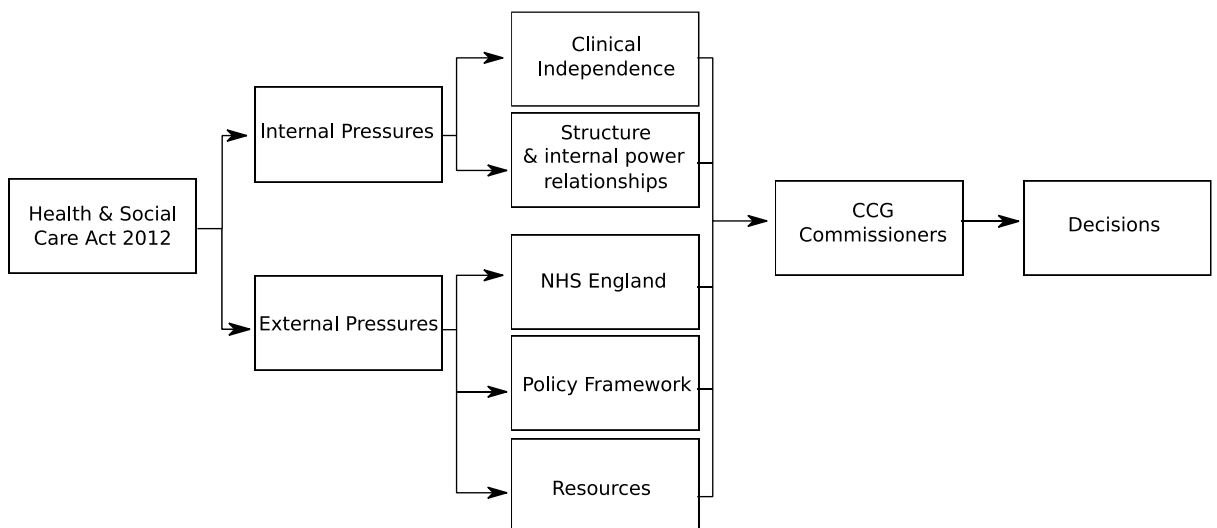


Figure 11 - Internal/External Conceptual Framework

This thesis used an internal/external framework to understand which factor may affect the decision-making process. The basic framework is adapted from the work of Pettigrew et al. (1992) and illustrates the forces which can influence changes within organisations. The internal pressures relate to the structure and internal dynamics of the CCG. This includes the structure, the staff and desires of the CCG members. The external pressures relate to the policy framework, the rules and regulations of central bodies and the resources which are allocated to the CCGs. This study found that CCGs are exposed to sometimes contradicting pressures from the central authorities (i.e. NHS England) on the one hand and local demand and context on the other. This tension is often reflected in the provider selection process (see Figure 8). The framework proves useful in understanding which factors do restrict the ability of commissioners to exercise their autonomy.

The commissioners at both sites have at their disposal three tools by which they can affect commissioning. They are procurement (turning to the market), purchasing additional services from existing providers (also known as 'transformation' or redesign of existing contracts) and decommissioning providers. The motivation of the commissioners varies as to why they choose any particular process or method, and is also affected by the dynamic between the internal/external pressures.

The key influence on the decision making of CCGs is the financial situation of the CCG. Commissioners are in the position of not being in control of either, the funds they are given to disperse from the 'centre', or to fully control the expenditure of their major contractual partners (Trusts). Therefore, commissioners are often operating in financial circumstances which, in practice, are beyond their control. Commissioners faced with a financial deficit seem to be more likely to use tools which have a higher probability of private providers securing the contract when they judge that such an option can relieve the financial pressures. Other research has highlighted the financial pressures that both NHS providers and commissioners face. To illustrate this: over the course of the 17/18 financial year, NHS providers generated a £960 million deficit, even after £1.8 billion of Sustainability and Transformation Plan (STP) savings (The King's Fund 2017). Commissioners face an overspend of £250 million (Ibid 2017). Research also suggests that as a result many CCGs are considering reducing the amount of treatment being carried out in the system (Ibid 2018). However, there is little literature which explores the effects of these financial pressures on how commissioners within CCGs seek to utilise the powers they have been given through the Health and Social Care Act (2012). In this respect this is a unique finding which highlights the effects of these financial pressures and how they affect commissioners.

Internal dynamics of CCGs are affected by the financial situation of the group. Both of the Chairs at the two sites exerted power to address certain issues which faced their CCGs. However, the agendas of the Chairs were different due to the financial situations at each of the sites. At site one, the financial surplus allowed the Chair to seek new providers to address clinical needs within the area of the CCG. There were fewer challenges to their authority and decision making took place in one meeting.

As such there was considerable latitude to select how and when to commission any new provider. With the pressures being perceived as more severe at site two there was some resistance to the overarching aims of the CCG leadership. The decision making process was also spread across several meetings and as such there were more opportunities for this resistance to manifest. However, the Chair also had the ability to take executive decisions which provided them with more ability to carry out actions without consensus within the CCG. This was triggered by interactions with NHS England and their potential intervention. So, while the commissioners had to reduce their financial deficit they had considerable latitude in how they went about this. The internal dynamics of the CCGs were important in understanding how power was distributed in the organisations and how this affected the commissioning processes.

The CCGs are at once tasked with contributing to the development of the provider market, whilst also being constrained by its relative weakness. There are no real alternatives to the NHS Trusts – no other provider can provide adequate care for large numbers of people. In this context, commissioners seek to utilise private providers to relieve their own financial pressures. They are not seeking to develop the market, or use private providers as long term alternatives, but rather to use them to compliment the work of the Trusts.

External pressures, primarily local demands, mean that commissioners show a propensity for risk aversion by generally opting to maintain the status quo, a conclusion shared with other research (Sanderson *et al.*, 2017). Namely, preferring familiar providers with which they have experience in the past, and in which they have the confidence that they will fulfil their obligations. As mentioned previously, commissioners feel that they have a ‘duty’ to NHS providers even if there is a perception that it may not be in their best financial interests. Commissioners do not seek to replace the NHS Trusts on a large scale but attempt to reduce the financial burden they face through the use of smaller private and third sector providers.

The dynamic of these internal and external pressures on the CCGs constrain the choices that commissioners do make when selecting providers, and thereby the potential rate of privatisation of the NHS and its future shape.

With regards to the public/private balance of the NHS, there have been several reviews of the effect of the Health and Social Care Act (2012). Initially, there was widespread concern about the increased role of market mechanisms, private providers and competition (Timmins 2012; Davies 2013). The current literature on the effects of the Health and Social Care Act (2012) suggests that it has not had the impact that many thought in 2012. Ham *et al.*, (2015) argue that the reform has: “*resulted in greater marketisation of the NHS but that claims of mass privatisation are exaggerated*”. Other work has drawn similar conclusions, with the role of competition and the regulatory framework being vague and undefined (Allen *et al.*, 2016, Sanderson *et al.*, 2017). This thesis supports these findings while there are differences between the two sites and the degree to which privatisation has occurred.

Decision making by the CCGs: The similarities

Commissioners at both of the sites are drawn from GPs from member practices, with those elected usually very motivated individuals as has been found in other research (Moran *et al.*, 2017). This reflects a similarity to the type of GPs that were previously GP Fundholders and PBC commissioners (Miller *et al.*, 2012). Also notably is the perception amongst the GPs involved in commissioning that they are the group in the best position to regulate and commission services. This manifests itself at both of the sites, with those GPs who are currently involved having previously held commissioning roles, and with very few commissioners having no past experience. At both of the sites, commissioners did not appear to have much appetite to radically change the providers they utilised. The data suggests that the majority of the commissioners are generally satisfied with existing arrangements. The bulk of the commissioning budget is spent on services from the local NHS Trusts, and any additional commissioning takes place in the 'periphery' space of existing arrangements. In this context, at both sites, over 85% of the annual commissioning budget went to large local Trusts. The remaining resources were spent on other providers (public/private/third sector), and it is here that there was competition over the procurement of contracts. Commissioners feel they have to maintain good working relationships/contracts with the larger Trusts to maintain the provision of existing services. There is little evidence that the commissioners feel they could change the practices of these large providers by adopting a different use of their new tools.

At both sites commissioners focus their work in this periphery space. This approach to working on the edge of these larger contracts has been confirmed by other research (Checkland *et al.*, 2016). This study shared some of these conclusions, that the decision-making space of commissioners is focused on the 'periphery' of these larger Trust contracts. As has been illustrated by the data, commissioners were allowed to explore and use multiple different arrangements within the broader agenda of the CCG. However, their powers are much more limited than initially assumed and their functioning is not as was predicted (Pollock *et al.*, 2011, Hunter 2013). Commissioners at both of the sites felt that they were much more restricted in the delivery of services due to these large contracts. The extent to which these differences manifest was affected by the financial situation at the sites. This also resulted in commissioners focusing more on working with existing providers rather than commissioning new ones, as was the case at both of the CCGs. This further enabled the commissioners to bypass formal decision-making processes and allowed commissioners at both sites to avoid using procurement when the regulatory rules may have required them to do so. Contributing to this is the perceived length, cost and potential complications of a new procurement process meaning that undertaking the task of contracting a new provider is not seen as desirable.

At both sites it appears that the commissioners wanted to continue working with the Trusts, partly due a lack of alternative but also because of a seeming

loyalty/duty to the NHS more broadly. In addition to a general feeling of loyalty to the NHS, commissioners also have experience of working alongside these public providers, and this further strengthens the commissioners' preference for these arrangements. There is evidence which would suggest that commissioners in many CCGs seek to work collaboratively with their local providers (Allen *et al.*, 2016). Also, and similarly, while being able to fine providers who fail in their obligations, commissioners are reluctant to choose that option because of the relatively precarious financial situation of those providers who are part of the NHS. Again this reinforces the notion that commissioners are aware of the financial issues that face the entire system (Allen *et al.*, 2016). There is however, a feeling of tension in the system, with commissioners unhappy with the Trusts seeming inability to reduce their costs. This was common to commissioners at both sites, as was their desire to work cooperatively with Trusts where possible, which they see as being part of the NHS system. From this standpoint, the manner in which the bulk of NHS services are selected and provided has mostly remained unchanged as the CCGs have principally continued to utilise the same providers that the PCTs did. This is true even though they do have a wider choice of providers as the market has somewhat evolved in the intervening period (Hunter 2013).

While there is loyalty to local NHS providers the size of the private market limits the options of commissioners at both sites. While there is a general belief that local Trusts should be supported, there are no real private or third sector providers who would be able to provide the same care that an NHS Trust would. The nature of the latest set of reforms had led to a concentration of private providers and further issues to the development of providers (Sheaff and Allen 2016), something that was also found in this study. In the present circumstances, if commissioners wanted to change provider they would have no alternative but to commission another large Trust. To split these contracts among smaller providers would be impractical due to the numbers of separate contracts that would need managing and the ensuing increased costs associated with this administration. Therefore, even if there is a support for public providers, the lack of an alternative means that commissioners would have to continue working alongside these providers even if there was more appetite for radical change.

The way in which commissioners operate in this periphery space varies, but activity here represents only a fraction of the total expenditure of the CCGs. This is common to both sites and commissioners tend to utilise the tool which best fits within the broader agenda as set by the Chairs. Even here there is some use of existing providers (public or private) as it allows for quicker mobilisation of service provision. General commissioning activity is restricted to this area as the commissioners view themselves as a weaker partner and unable to affect the behaviour of the Trusts. The CCGs have little real ability to affect the clinical treatments with regard to PbR contracts, despite their formal powers to decommission services. This reflects a similar limitation that was found with both PCTs and PbC arrangements, where commissioners were unable to affect the behaviour of providers as was intended by the reforms (Smith *et al.*, 2010). Similar conclusions have been drawn from other research which highlights the issues with

PbR contracts and their inability to reflect the capacity of local commissioners to pay for certain services (Allen and Petsoulas 2016, Allen *et al.*, 2016, Robertson *et al.*, 2017)

The majority of procurements conducted at the two sites are in the previously described 'periphery' space, commissioning in areas in which there is a history of private sector involvement. Where there is evidence of privatisation and marketisation at the two sites, it occurs within this space. Procurements, as mentioned above, are the main entry point for private providers into the NHS. At the same time, commissioners seem to be wary of this process as they perceive it as a lengthy and costly (9+ months), which also carries with it the obligation of "re-procurement" every five years. This further reflects the belief amongst commissioners that procurement guidance from the regulatory bodies is unclear, as commissioners are unsure of how and when they are obligated to carry out procurements. This means in some cases they are actively seeking to utilise local arrangements to avoid the process entirely, a finding reflected in other research (Allen *et al.*, 2017). This lack of guidance afforded the Chairs at both of the sites more latitude in how and when they chose to utilise procurement, and in how it fits within their own agendas.

Purchasing or changing contracts (termed "transformation" by informants) is primarily used in order to secure additional services from existing providers, as it allows commissioners to circumvent full procurement and the associated costs and time. As a result, this method seems to be one of the more popular options available to commissioners. At both sites, commissioners pursue the course which fits within their commissioning priorities as set by the Chair, which vary due to the financial situation at each CCG.

Decommissioning has only been used infrequently at the CCGs, and only in cases in which a provider was judged not to be fulfilling contract specifications. It is viewed as a last resort and during this research was only found to be used on public providers. There was some limited evidence that the commissioners also sought to use decommissioning to assist in moving some care in to community settings. While decommissioning was uncommon at both sites, it was utilised more at site two. Other research also highlights that the focus of decommissioning appears to be to affect either financial aims or to have care moved into community settings (Williams *et al.*, 2017). The use of this did vary somewhat according to the priorities of key decision makers at each CCG and will be explored in more depth in the next section.

At both of the sites, commissioners made use of the tools that were provided by the Health and Social Care Act (2012) which resulted in an increased use of market mechanisms in the selection of providers. The use of procurement has been borrowed from the private sector as a model, and its use reflects the growing acceptance/norm of these processes in the public sector. At both sites, there is evidence of the use of these mechanisms, with commissioners using procurement to select providers rather than setting their terms and conditions. This finding is

supported by other literature; commissioners regard the usage of such mechanisms as 'normal' (Allen *et al.*, 2016). The ability of commissioners to affect the outcome of the process is limited. Rather, they determine how important the financial and clinical elements are to any procurement process. The data from this study demonstrates that even in an environment in which financial pressures are becoming more severe, the focus still remained on quality. However, the use of procurement has been linked to the need to generate savings in some contexts and assists in commissioners being able to remain independent of NHS England. The reasons why commissioners may choose to utilise procurement may differ, as already outlined. The use of procurement is one part of several other processes which highlight the growth of market mechanisms within the NHS. This includes encouraging competition and greater use of subcontracting amongst providers. This represents a change in commissioning with a much greater emphasis on competition, which is in contrast to the more cooperative way in which commissioning previously took place (Glendenning *et al.*, 1998). These examples confirm growing marketisation in the process of selection of providers with the goal of making the services more 'efficient'.

The data from this research also highlights the limited scope of privatisation. Commissioners at both sites were unable, even if they wanted to, to alter/decommission the large contracts that the CCGs have with the Trusts. Those contracts represent a considerable proportion of the total budget and have already been set up; existing contractual methods (i.e. PbR) prove challenging for commissioners financially (Allen and Petsoulas 2016). These financial pressures are only set to increase in the next several years (The Kings' Fund 2018). However, there appears to be a growing use and acceptance of private providers in the 'periphery' space, and as a result, most of the active commissioning occurs in this sphere. The targeting of private providers by commissioners at site two highlights how privatisation is increasing, albeit in a limited fashion. This targeting is aimed at services which have been highlighted internally as key areas for improvement, and while there are competing aims between the two CCGs, they focus on similar areas. As stated previously, private and third sector providers are unable to compete with large NHS Trusts. This leads the commissioners to target specific services (i.e. physiotherapy, MSK) for procurement as the evidence from this study has shown. However, future changes at the political level could mean an expansion of this process and point to the use of private providers on a much larger scale than previously seen within the NHS.

CCGs operate in circumstances which are heavily influenced by their relationship with NHS England which manifests itself differently from site to site. It is the most influential of the new regulatory bodies. The commissioners at both of the researched sites seem to hold in common a negative perception of NHS England which appears to be primarily a result of the contradictions that exist between local needs and the high-level targets set by them. Similar tensions between local and national priorities have existed under previous commissioning arrangements, such as PCTs (Mays *et al.*, 2004). Part of the reason why the new framework was perceived negatively relates to how it was viewed as confusing and at times

contradictory by commissioners in this study. Ham *et al.* (2015) report that “reforms have resulted in top-down reorganisation of the NHS and this has been distracting and damaging” and that the “new systems of governance and accountability resulting from the reforms are complex and confusing ... absence of system leadership is increasingly problematic when the NHS needs to undertake major service changes” (p 8). At both of the sites used in this study commissioners had concerns with the role adopted by NHS England. Again, there is other literature which has drawn similar conclusions about the role of the new regulatory framework (Allen *et al.*, 2016). At site two, this relationship has had a much more tangible effect on the decision making of commissioners and has led the Chair to institute their own agenda to reduce the financial pressures faced by the CCG. This demonstrates the impact of the regulatory framework to affect the decision making of commissioners by helping to set their commissioning agendas. These effects of NHS England directives differ across the two sites and will be explored in the subsequent section.

Decision making by the CCGs: The differences

All commissioners have the same tools available to them with regards to selecting a new provider. However, there were differences in the applications of these at the two sites. The most influential element was the financial concerns of the two CCGs. At site one, the positive financial situation enabled the commissioners to exercise their decision making abilities relatively freely, with little interference from the external regulatory framework. At site two, the severe annual budget deficit has forced commissioners to accept the Chair’s plan to reduce the financial pressures in order to maintain their autonomy, rather than have a plan imposed on them by NHS England. While commissioners at site two were unable to seek many new providers, they were given a large amount of freedom to tackle the deficit as they saw fit. This section will explore how the different pressures affected the choices of commissioners and how this resulted in different commissioning processes.

The financial situation of the CCGs affected the internal dynamics which in turn influenced how commissioners reach their decisions. At both sites the Chairs were powerful actors who exerted their power through setting the agenda and creating general consensus. The data from this study suggests that the majority of GPs tend to not want to be involved in commissioning, and that those who do tend to have personal motivations for doing so. These personal motivations include prior experience of being a commissioner or the belief that they can affect change. The financial situations at the two CCGs led to different internal dynamics and agendas. From the data, it is clear that commissioners value their autonomy and will strive to protect it as best they can. Commissioning allows them a measure of independence in the shaping of services in the manner in which they deem to be the most effective.

The significant difference between the two research sites are the budgetary pressures they face. At site one there is a small annual surplus (approximately £2m+ a year) which gave commissioners more room to examine options for new

services. In effect, this surplus allows the Chair at site one the ability to focus their agenda on commissioning new providers/services in areas where there is a clinical need. Thus commissioners at site one had the ability to utilise the full range of powers available to them within the periphery space. In practice, the surplus allows commissioners more time to pursue different options and also to purchase additional services to address needs. They additionally have the ability to invest in early intervention services which would yield savings in the future. At site one, they sought to purchase additional services from existing providers if it meant that they could do so and avoid the costs of carrying out a full procurement. They would seek to utilise a procurement only in the instances where existing contracts could not provide the necessary services or if they could not be carried out in the manner which suited the commissioning priorities of the CCG. This meant that if they wanted to have a service provided in community settings they would be more likely to utilise a procurement as the majority of existing providers are hospital based. The choice of the process that commissioners use is the most indicative and important part of the commissioning process, and it can be argued that it is more significant than the application of the chosen method, e.g. procurement, or purchasing additional services from existing providers. In conclusion, commissioners at site one can purchase new services due to their stable financial situation. This highlights the way in which an external pressure, the financial situation, affects the internal structure of the CCG. The relatively stable financial situation of the CCG enabled the Chair to enact an agenda which focuses purchasing additional services in order to improve the health of the populace.

There are varying reasons why commissioners carry out a procurement process. In situations where commissioners have selected procurement, they write the specification. However, they have no ability to affect the outcome afterwards. Procurement documents have to be marked anonymously, and commissioners are legally bound to respect the outcome. Arguably this means that the market chooses the best provider, as the commissioners only weight the clinical and financial elements of the process, dictating how important fulfilling the financial obligation is compared to the service itself. Site one has the ability to use a procurement process when they deem it as being the most useful mechanism for selecting a new provider. In general, they seek to avoid the process, but due to their financial surplus, they face less oversight from regulatory bodies and thus are able to use it when they are seeking to appoint a new provider, where commissioners feel that their existing providers may not be best suited. At site one, commissioners are more open to using procurement to attempt to find the 'best' provider as they are under little pressure to focus on generating savings. They also state that they have no preference between private, public or third sector providers winning procurement processes. A contributing factor to this seems to be the possibility that the commissioners at site one can re-procure if necessary, as their budget surplus means they can manage any losses they may incur. There have been occasions where the commissioners at site one have had to re-procure, and this has not been viewed as a severe setback. On the other hand, at site two, commissioners turn to the market primarily to find less expensive providers and do

not possess the ability to absorb financial losses if those providers do not work as intended.

Another tool at the disposal of commissioners is renegotiation and 'transformation' of existing contracts. This occurs when commissioners renegotiate existing contracts with providers. In most cases this results in purchasing additional services predominantly from NHS Trusts where the majority of CCG resource is already committed, but is used with any existing provider. It gives the commissioners more 'direct' control over the providers that they work with, allowing them to select the provider directly. Formally this is not one of the new tools derived from the Health and Social Care Act (2012) but an option the commissioners have in order to alter existing contracts. The drawback of this approach is that it means commissioners are restricted if they are attempting to introduce a new service, as they can only work with their existing providers. Commissioners at site one prefer to redesign contracts as it reduces both time and administrative costs in comparison to procurement and removes the risks associated of working with new and unfamiliar partners. As stated before, it appears that the moment at which commissioners have the most space to exercise choice is when choosing the method by which they will commission any particular service. At site one, this is exhibited by a preference of commissioners to opt for redesign of contracts when a service needs quick improvement or expansion. This enables them to select an existing provider to work with. Procurement is used in cases in which there is less immediate clinical demand and thus commissioners are happy for the process to take place and dictate the 'best' provider. The commissioners at site two have a similar approach to transformation, as it allows them to quickly commission additional services on the one hand but also to renegotiate terms with existing providers when pressed to achieve savings.

Commissioners at site one are in a position to give priority to clinical needs in the commissioning process. The primary consideration is related to how quickly new services can be established and begin delivering care. This ability to engage with the clinical cases stems from the stable financial situation and the agenda of the Chair. There is little consideration of the type of provider that is engaged, but rather a focus on the priorities of the commissioners and the means with which they feel they can best develop new services. While there is a lack of immediate financial pressures, the Chair and the other key actors at site one ensure that there is a focus on maintaining that independence and focus. This represents an example of positive change with greater clinical involvement in commissioning, something which did not always occur under previous primary care-led commissioning (Smith *et al.*, 2010). Hence, it can be said that site one functions in the way that PCTs were intended to operate, with a view to the long-term (Robinson 2004). In the observed cases at site one the benefit of purchasing additional services was seen as yielding clinical results faster, i.e. commissioners did not need to go through a nine-month procurement to appoint a provider. The apparent willingness of providers to accept this type of contract negotiation process has been observed previously under other commissioning arrangements (Allen *et al.*, 2012).

The financial surplus at site one also enables the commissioners to avoid serious interference from NHS England. While they are still subject to sharing information and adhering to general target sets by NHS England, they do not fear intervention in the way in which they commission providers. The Chair enjoys a lot of freedom in developing their agenda and many of the other commissioners' work to that agenda. This large amount of freedom means that the commissioners at site one are able to utilise tools in the way they see fit. To some degree their ability to choose when to use procurement or transformation as they wish means that they set their own agenda, and that the stricter rules laid out in the Health and Social Care Act (2012) are less important than ensuring commissioners can work as they choose too. This freedom from external oversight enabled the commissioners at site one to set their own priorities and methods of working within their local health economy. This is a conclusion which is shared with other research in the field, which found that cooperative working with some use of competition tools was the preferred mechanism of many CCGs (Allen *et al.*, 2016). This approach of the regulatory body was the key difference between sites one and two.

The commissioning situation at site two varies considerably from that at site one. The external financial pressures are much more severe and as a result the threat of intervention by NHS England was much more prevalent. This affected the decision making process of the CCG more than at site one. While other research has pinpointed that the regulatory framework can be vague in the guidance set out for procurement and contracting (Checkland *et al.*, 2017), the effects of financial pressures is more severe. NHS England has had to be dissuaded from placing site two in financial special measures, which has led to the Chair having a much more important role in the strategy of commissioners at site two. This action acts as motivation for commissioners at site two. While they are limited in selecting new providers, they still have a considerable amount of autonomy in how they address their financial pressures. This was revealed through the way in which they used procurement and the 'transformation' of contracts. These other factors proved to be more important in the process than the rules which were created by the Health and Social Care Act (2012).

The primary concern of commissioners at site two is to reduce the financial pressures that they are facing. The decisions of the commissioners are best understood as seeking to reduce the financial burden. The main method chosen for this is more stringent contract management, as well as the use of procurement to target private providers. While there is an associated time and cost element with procurement, it allows commissioners to seek to use less expensive community providers. Commissioners at site two do so by procuring services which they think are more attractive to the private, third sector, or community providers, relieving cost pressures by removing those services from hospital (i.e., NHS Trust) settings. This strategy has not always been successful and remains somewhat limited as it is not feasible for commissioners to seek to replace the large Trusts with multiple other providers. The large local Trusts also have the ability to compete for the same contracts and have done so in the past, which only further complicated the commissioning process from the perspective of the commissioners. Also, despite

such expectations, there is no evidence that providers have competed on price. Rather, if there is competition, it is based on the quality of service. Despite such instances, commissioners at site two remain determined to use procurement processes in this fashion. While they are not inherently predisposed to a more substantial presence of the private sector in the NHS they do see this type of use of procurement processes as a solution to the pressures that they face. This is further shaped by the significant positive experiences that commissioners have had with private providers who provide some services at the CCG. There is evidence in other literature which supports this, with commissioners seeking to use procurement to generate savings through moving care from hospital to community settings (Williams *et al.*, 2017).

In their attempt to reduce costs, commissioners at site two also attempt the change (or transformation) of contracts. Though they use this method sparingly, they do so when they wish to add services to existing arrangements or reduce the cost of the largest contracts, which are the Trust contracts. Commissioners at site two have also attempted to merge smaller contracts into single larger contracts, as well as attempting to encourage providers to adopt fixed value annual contracts, as opposed to PbR contracts. These types of commissioning behaviours are best understood as the commissioners at site two seeking to reduce expenditure. The commissioners at site two are less concerned with the type of provider they engage than by their need to achieve savings. However, many providers do not intend on changing from the PbR contracts, with the notable exception of the private MSK provider at site two, which has shown a willingness to change and thus reinforcing its favourable perception amongst commissioners. The data from this study reinforces the view that providers have little incentive to change their behaviour (i.e. accept fixed value annual contracts instead of PbR contracts) to assist purchasers (Allen and Petsoulas 2016, Smith *et al.*, 2010).

These behaviours are rationalised through the commissioners at site two seeking to avoid being placed in special measures by NHS England. This is an example of how the external regulatory framework can influence the internal commissioning objectives of a CCG. Commissioners are forced to make decisions led by financial considerations as they do not want to be placed under special measures, yet the cost-cutting process is left down to the commissioners. There is evidence to suggest the possibility that other CCGs may come under direct control of NHS England in the future (Hazell 2016). NHS England at both sites appears to be much more concerned with the stable financial running of commissioning organisations rather than issuing firm guidance on how to tackle such issues. To some degree new developments such as the Capped Expenditure Programmes (CEPs) provide more useful guidance on how to control expenditure and the relationship with the external regulatory bodies (The King's Fund 2017). Commissioners have latitude in deciding how and which services are altered to reach their goals. Thus, this role of the financial watchdog affected the decision making of commissioners who focused on generating savings and ensuring their own independence. NHS England maintains both its indirect and direct control over the CCGs. Directly, through the

threat of special measures, and indirectly, by shaping the commissioning agenda, as commissioners need to meet the targets set by NHS England.

One of the more explicit ways in which the regulatory framework should impact the work of commissioners is through the assumption of the use of procurement. While commissioners are expected to make greater use of procurement in specific contexts, commissioners have adapted and used this new tool in situations which suits their own agendas. It is within the limit of the commissioners to determine the size of any contract, and how any particular procurement is written; for example, commissioners can procure a relatively small amount, or restrict the amount of subcontracting that can take place. In so doing, commissioners can incentivise certain types of providers to submit bids and discourage others. At site one this is done to bring in new providers, but at site two this is again conducted in order to relieve the financial pressures. Commissioners have to generate savings in order to be able to invest in new services. This has led to some care being moved in to the community in order to generate savings. In this sense, commissioners are subverting some of the statutory responsibilities as other pressures and issues become more important than their formal obligations. Hence, the CCGs are able to ignore some rules and regulations if it is in their interests and if it demonstrates to NHS England that the commissioners are in a stable financial situation.

While commissioners have a variety of tools at their disposal, the way they have used them has resulted in a situation in which the number of private providers is not as high as might have been expected. At site one there is limited penetration of non-public providers in the local health economy. This is due to the internal focus on delivering care as quickly as possible so local existing providers are favoured. This is reflected in the evidence from this study, and those of other authors who also found that the penetration of private provider is not as marked as may have been imagined (Checkland *et al.*, 2017). However, at site two where there is a relative lack of resources, there has been a greater involvement of private providers as they are one method of relieving the financial pressures faced by the commissioners. Although there is a cost to the procurement process, it enables commissioners to make long term savings and the apparent willingness of the private provider to move to a fixed value annual contract further enhances their attractiveness to the commissioners.

This helps to explain how the financial context that commissioners must operate within plays a significant role in which tools they opt to use. The role of NHS England is one of a regulator which is primarily concerned with financial matters. At site one, the surplus position of the CCG enabled the Chair to pursue selecting new providers using any of the tools at their disposal. Site two was different. NHS England was more involved and threatened the commissioners with special measures. This enabled the Chair to focus the agenda on dealing with the financial pressure. Once NHS England was assured that this would be the priority of the commissioners they were given the freedom to complete the task. Other research has found similar conclusions, that the role of the regulatory bodies was vague but that it was concerned with financial issues (Allen *et al.*, 2016) and that

it had less influence in the day-to-day running of the CCGs (Ham *et al.*, 2015). In this sense, commissioners have less ability to exercise choice, as they rely on the resources that they are given.

There was little evidence to suggest that third sector providers were used in the same fashion at site two. Even with non-NHS providers winning a third of all new contracts which are awarded via procurement (Iacobucci 2014). Private providers were utilised almost exclusively, and third sector organisations were seemingly not considered. There is limited evidence about the role of the third sector in the delivery of care. Of all the care provided by non-NHS providers, 71.3% of contracts are given to the private sector (Lafond *et al.*, 2017). The third sector only received 11% of spending that was given to non-NHS providers. They represent a much smaller proportion of spending and as such, they may not be viewed as viable alternatives – at least not to the level that private providers are. Evidence from third sector providers in the NHS would reinforce this view, with many believing that commissioners are not supporting the third sector as they should under the *NHS Five year forward view* (Baird *et al.*, 2016).

While there may be an expectation that the commissioner's accountability to the public would be important in deciding commissioning priorities, this was not always clear. Early research on CCGs suggested a complex mixture of accountability networks (Checkland *et al.*, 2013). The data gathered confirms that these do exist, but that their influence was limited. The key element of accountability was to NHS England and was generally of a financial nature. This manifests as a perceived obligation of maintaining high standards of fiscal responsibility and management, the alternative to which is the imposition of sanctions. As most commissioners tend to be experienced and motivated individuals, the CCG's loss of independence would likely lead most of them to leave commissioning altogether. They do not feel that managers alone can reach the best decisions, whilst being deeply convinced of the importance of the role of clinical commissioning. Some lay members of boards were vocal in their criticism but they were unable to really affect commissioning decisions. At site one there was more of a focus on delivering the services needed, including those which were deemed important by the public. However, at site two this proved to be less effective due to the financial constraints and the commissioning approach to dealing with it. Oversight from NHS England meant that the commissioners' first priority was satisfying their demands ahead of those of the public.

Summary of similarities and differences at the two sites - Discussion

The rules laid out by the Health and Social Care Act (2012) are undermined by other factors such as the financial pressures which have much more influence over the behaviour of the commissioners. A positive financial situation enables commissioners to seek arrangements which suit their local needs, whereas a negative situation means NHS England shapes commissioner behaviour and leads them to seek cost savings. While there is a lot of independence when it comes to

how these processes take place, it illustrates the power of the regulatory framework as something which drives behaviour of commissioners. The external influences of financial pressure and regulatory bodies dictate the way in which commissioners will behave under the auspices of the Health and Social Care Act (2012). Once there is a clear delineation of the sort of finances a CCG may have access too, the process of selecting providers becomes much clearer. There remains a lot of discretion with how CCGs may do this but, as long as regulatory bodies are satisfied, commissioners do possess some flexibility with regards to selecting new providers.

Both sites' commissioners have access to the same commissioning tools and are faced with similar limitations, having to direct the majority of their resources to local NHS Trusts. Commissioning takes place only on the 'periphery', it is only in this space that the full range of commissioning tools are used. The way in which these tools are used is therefore quite limited, as is the commissioning of new services.

The differences between the two sites emerge when trying to understand what may motivate the commissioners to choose which of the tools mentioned. While both sites rely on powerful Chairs in order to develop the commissioning agenda, the key difference seems to be the financial situation. At site one, the relatively stable financial situation allows commissioners to be more flexible in their choice of methods and how they employ them. They are able to absorb the potential costs of failed procurements and are also in a position to change the contracts of existing providers more frequently to provide additional services when the need arises. The commissioning agenda focuses heavily on the clinical needs and which provider or process may allow them to mobilise as quickly as possible. In essence, commissioners at site one use procurements only as a result of internal pressures (their commissioning agenda) and not due to pressures from the external regulatory framework. Similarly, they utilise the market only when they feel they have the time and scope to pursue new options. Significantly, the data indicates that the level of marketisation and privatisation is lower than that observed at site two which is subject to additional external pressures.

As stated previously, at site two commissioners are more exposed to financial pressures and this becomes the primary concern of the Chair. Commissioning tools are primarily used in this context and in practice are expressed in attempts to move services out of the NHS Trusts, lowering the costs associated with the Trusts. There is evidence to suggest that PbR contracts and the new national tariffs have placed the commissioners under increasing financial pressure (Allen and Petsoulas 2016). This has led commissioners to seek ways in which they can divert care into the community, third sector or private providers, and has increasing the number of services transferred to the private and/or third sector. Procurements were carried out in a planned way to target a greater number of private providers in order to move care to less expensive providers. There is other evidence in the field to suggest that this is not a unique situation (Williams *et al.*, 2017). This is an example of how commissioners attempt to overcome the formalised nature of the commissioning process and use it to their benefit. Commissioners at site two alter

existing contracts as much as they can (“transformation”) in a similar way to commissioners at site one, however their primary goal is to reduce costs by merging or eliminating contracts in contrast to site one where commissioners primarily use transformation when commissioning new services. The most notable example of this was the decommissioning of the podiatry clinic. Accordingly, at site two there is much clearer evidence of privatisation and marketisation than at site one, which indicates that CCGs under financial pressures may be more susceptible to privatisation and marketisation.

A number of elements shape the commissioner's decisions. The decision of which commissioning tool to employ is the key decision which affects the likelihood of any particular type of provider being selected. It is here that commissioners exercise the greatest choice, whether or not to engage with potential new providers or to focus on exploring/improving existing arrangements. This choice itself is shaped primarily by the financial situation of the CCG, and this then has an effect on whether or not the regulatory framework, namely NHS England, does or does not dictate financial rules. Site one was able to resist any serious interference from NHS England and engage with commissioning according to the needs that the Chair deemed most important. They are also able to explore their commissioning options in more depth as they are usually commissioning new services rather than eliminating/limiting existing ones, and the financial surplus allows site one to absorb the cost if the processes fail. Furthermore, commissioners who have a surplus can look for opportunities to commission additional services from providers and to explore the best way of securing the service, i.e., which commissioning tool to use. It is also important to note that the majority of such commissioning takes place beyond the ‘periphery’ space of existing large contracts. The situation at site two was different. With their associated financial pressures, the commissioners were vulnerable to intervention from NHS England and this meant that the Chair focused the CCG on reducing the financial burden. While it restricted the ability of commissioners at site two to seek new providers, they still had considerable ability to address the financial issue using any tools at their disposal. Within the study it became clear that factors such as financial pressures were key determinants of behaviour. As a result, it dictated the behaviour of commissioners and was more important than some of the formal rules to do with commissioning.

These decisions resulted in a limited increase in the amount of private provision at the two sites. The form of privatisation is best described as passive privatisation, following on from the bottom of Saltman’s (2003) taxonomy. Many of the commissioners, notably at site two, have sought to use the private sector so that some elements of care are delivered in the community and outside of hospital settings. Again this is supported by evidence from other research (Williams *et al.*, 2017). This privatisation has taken place in areas in which the private sector has had prior success, such as MSK services. Commissioners seek to make these changes as they are able to influence the private providers who have also shown some flexibility and willingness to adopt fixed value annual contracts. Other research has noted that changes are required to continue the pattern of moving care out of hospital settings (Allen and Petsoulas 2016), but

they have not explored the way in which commissioners would use these specific tools to try and reach their aims. The total value of contracts procured out in this fashion is small and does not represent more than 2-3% of the CCG's annual budget.

Commissioners spend £12.7 billion on non-NHS providers which further highlights that privatisation which is occurring is limited (Lafond *et al.*, 2017). This does represent an upward trend, with there being annual increases in the amount commissioners did spend on non-NHS providers (Ibid 2017). There is also a great difference in the amount that commissioners spend on non-NHS providers, something that is similar to the data from this study. There is little information about how this may manifest in terms of financial pressures but is something which is worth further exploration.

To summarise, this study has found many similarities with previous research in this field. There has been an increased use of market mechanisms and of private provision in the 'periphery' space. There has been a noticeable, if relatively small, uptake of private providers which does represent a form of limited privatisation. The delivery of care has not been fragmented despite data that suggests that there is a certain degree of friction between the public providers and the newly contracted private providers. This is much more visible in services which already have some history of private provision. Another significant factor arising from the perception of relatively loose regulatory framework is the deepening conflicts between public and private providers due to the possibilities of legal challenges and other means of blocking the decisions of the commissioners, something that has also been discovered by others (Sanderson *et al.*, 2017). The external regulatory framework functions more like a blunt tool, rather than exercising discretion as was anticipated when the reforms were announced (Davies 2013). There are other similarities with existing literature; the lack of a developed private market (Sheaff and Allen 2016); the issues arising from the financial power of the Trusts over the CCGs (Allen and Petsoulas 2016); the limited evidence of privatisation (Ham *et al.* 2015); and the limited decision making space of the commissioners (Checkland *et al.*, 2017). In this regard, evidence from other research has come to similar conclusions.

Marketisation has also increased with the commissioners' use of the tools, most notably using procurement to select providers, in an attempt to exploit competition to lower costs. At site two commissioners, being under the threat of NHS England's special measures, have been in effect pushed to decommissioning and procurement to maintain their independence. This same outcome of an increased number of private providers occurred when commissioners similarly use procurement in their attempts to achieve savings. This process is much more visible in services where there is already some history of private provision. This could be significant in the future when and if the private market develops further and potentially attains the capacity to provide services similar to that of a large NHS Trust.

Another concern as argued by Peckham (2015) is that the expansion of private providers could result in a fragmentation of the system. Many different factors are mentioned, one of which is the possibility that the regulatory bodies fail to integrate care – i.e., make sure that providers work together effectively. This potential unintended consequence of the reforms will be explored further in the subsequent section. This conflicting agenda, of promoting competition while simultaneously integrating care, has served only to amplify the issues with which commissioners are faced; balancing finances, and providing and coordinating care. At the same time, regulatory bodies are under pressure to regulate the service, adhere to financial objectives and to integrate various providers.

Internal/External Framework Explanatory Power – Pettigrew et al., (1992) receptive change

The approach taken to understanding the decision-making process adopted an internal/external conceptual framework (see figure 8, page 168) (Pettigrew *et al.*, 1992, Checkland *et al.*, 2013). The framework suggests that two sets of pressures can influence commissioners –external (top-down) pressures created by the Health and Social Care Act (2012), and internal (new service/local area) pressures. This approach has proved to hold some explanatory power, although it needs further refinement in light of the evidence generated from this study.

One dimension which seems to have been overlooked in the formulation of the conceptual framework is the significance of the experience of the commissioners themselves. At both sites, many of the GPs have considerable prior commissioning experience and adapting to new commissioning arrangements took less time than was anticipated. Initially, it had been thought that part of development process would relate to commissioners gaining experience in the new framework. This was aided by the fact that most of the commissioners previously worked for PCTs or other commissioning bodies. Hence, there is a reservoir of commissioning experience which the CCGs can draw upon (with senior commissioning roles being filled with these commissioners). This experience has helped commissioners at site one operate more effectively and manage contracts. On the other hand, regarding external pressures, the CCG is in a better position to allay the fears of NHS England when it comes to managing financial resources. Hence, these pressures (both internal and external) are a significant influencing factor on commissioners, limiting what options they have to pursue and how they can operate in the marketplace of providers.

The internal/external framework has proved to have some explanatory power for how commissioners reach decisions. Evidence from the research suggests that a complex network of different elements influences the decisions made by commissioners. Clinicians are particularly insistent on their role and independence and are predisposed to maintaining existing relationships, as evidenced by the data, to ensure the continuing provision of services. They genuinely believe that they are best placed to make the decisions which are necessary for their population and view NHS England as too remote to best allocate resources as effectively. The

limited resources have had a more profound effect than initially thought. This has particularly reflected in the way NHS England involves itself in the affairs of the CCGs. This research discovered other themes that support the argument that there is a lack of systematic central leadership in the NHS, as has been described especially in chapter six (i.e., site two). It suggests that NHS England has assumed a passive role in regard to most issues, not operating as was imagined at the start of the reforms (i.e., providing advice and guidance to CCGs). NHS England has only been proactive in dealing with financial matters and management, arguably to the detriment of clinical care and best outcome for patients.

The data suggests that the conceptual framework could be refined to include the relationship between the providers and commissioners in light of the regulatory framework's restrictions and effect on their practices. The further development of the regulatory framework in a period during which the NHS is faced with budget restraints is something that should be considered. Irrespective of the commissioning changes, if the budget reduction continues the commissioners may feel they have no choice but to abandon their plans and instead prioritise those that ensure their clinical and fiscal independence. NHS England is the key part of the regulatory framework which deals with this aspect and has been able to exert influence on CCGs. The future shape of commissioning will be affected by the adoption of Accountable Care Partnerships (ACPs) and Sustainability and Transformation Partnerships (STPs), which could lead to the merging of organisations to make necessary savings (Alderwick *et al.*, 2016). The effect of commissioning being upscaled in this fashion is important to study further.

Referring to the contexts for receptive change, the data from this study would suggest that of the eight criteria which Pettigrew *et al.*, (1992) outlined as being important for change to be successful, there are five criteria which were clearly seen during the study as enabling change to occur. All eight criteria are still relevant in understanding change in the new NHS, however, five proved to be more crucial in understanding the success of CCGs. These were environmental pressure, supportive organisational culture, managerial and clinical relations, clarity and simplicity of goals and key people leading change (see figure 9). In this context site one exhibited all of these characteristics, while site two achieved as many aims as it could, but the financial pressures restricted the ability of commissioners there to fully engage with the tools they had acquired as a result of the reforms.

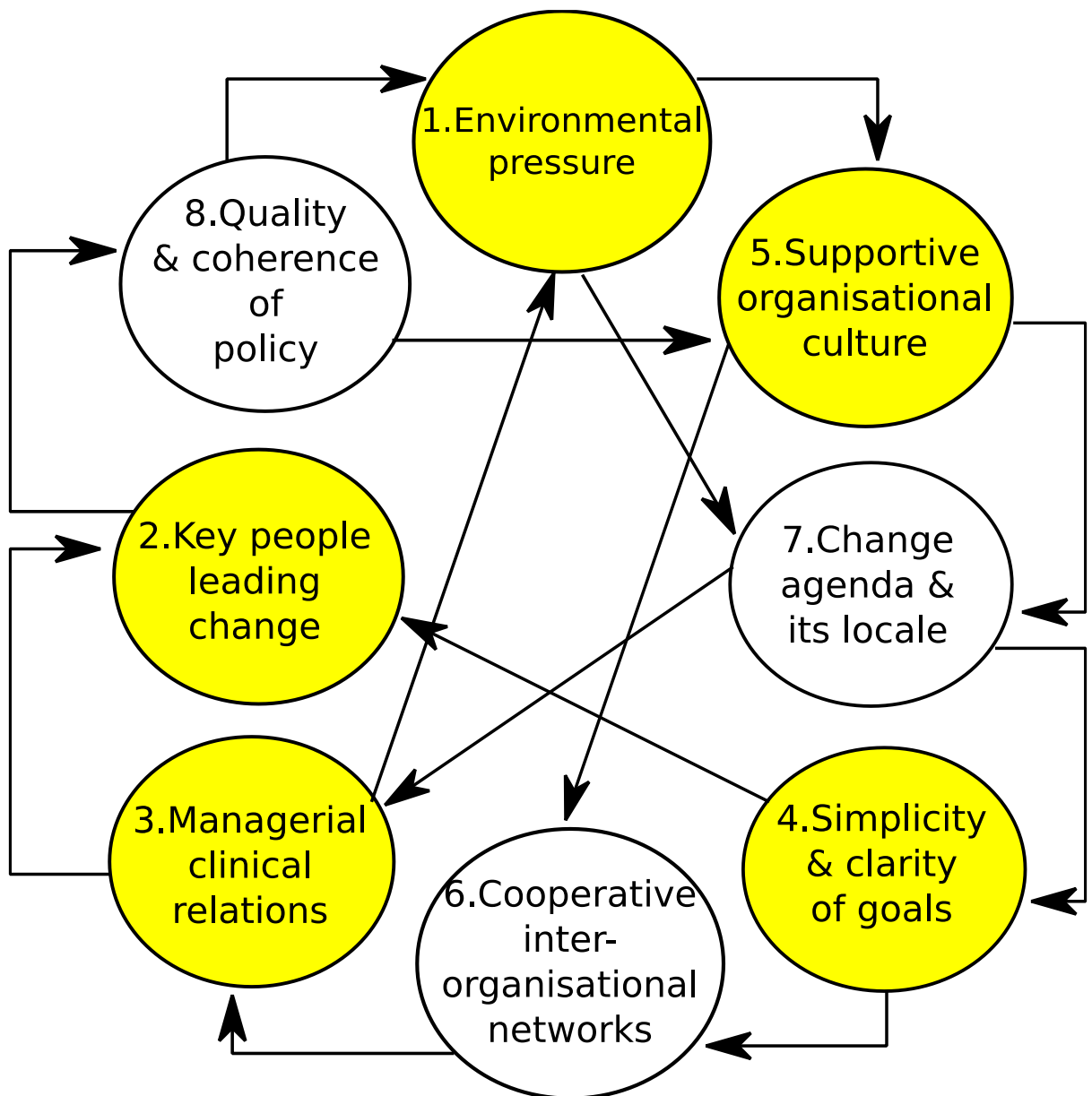


Figure 12 - Context for receptive change updated

Source: Pettigrew *et al.*, (1992) [emphasis added]

1. Environmental pressures related to the budgetary issues and the role of the external framework, that were faced by the CCGs. In this sense, the financial situation was key to understanding the actions and decisions of commissioners with regards to selecting providers. Budgets were set by NHS England and were outside the control of commissioners. As seen at site two, the severe pressures and threat of sanctions by an external organisation led to commissioning in a specific manner, one in which the commissioners sought to limit expenditure and so reduce the numbers of providers that they commission. They were unable to exercise their powers to commission and had to focus on reducing the financial pressures they were facing. In this respect it has affected the remaining processes within the CCG. This relates to other research in the field which drew a similar conclusion, that

financial pressures could be disruptive and inhibit the system from functioning as intended (Hunter *et al.*, 2015).

2. The second key element in successful change from this study was key people leading change. Both sites relied on strong leadership from several individuals who set the agenda and decided what the aims and objectives of the CCG were to be. They were empowered by the external pressures, with the commissioners at site one following the lead of the Chair who had experience of commissioning. This led them to following a system which identified clinical needs and attempted to address them, while maintaining the budgetary surplus of the CCG. The situation at site two was one in which the Chair was seeking to address the financial deficit and the threat of the sanction from NHS England. However, in both cases the Chairs were elected to lead on certain platforms. At site one, the Chair, Vice-Chair and Managing Director had been working together over a period of years and used this to ensure that the CCG continued to operate smoothly. At site two, the Chair and Vice-Chair had been elected to address the financial pressures and this led to the commissioning strategies which they employed. In this sense at both sites these clinical leaders were able to exert control over the agenda, illustrating the second face of power. This was the most common expression of their power and proved to be effective in environments where the agenda was key to completing their tasks. Both sites shared longer term aims which were implemented by staff with the ability and the power to carry out those aims.

3. Linked to the second factor are managerial-clinical relations. Without the close co-operation of managerial staff, the clinical commissioners would have struggled to achieve their aims. They enable the commissioners to carry out their work and at site two enabled the CCG to seek new ways to relieve the financial pressures. Through this cooperation, the clinical commissioners and managers are able to affect change in the way that their commissioning agenda needs them too. At site one this was through identifying clinical needs and methods of addressing them with the available resources and tools. At site two, this enabled the CCG to find ways of relieving pressure through seeking additional reduction in contracts or utilising procurement for the same aim.

4. The ability of actors to carry out change was also affected by the simplicity and clarity of the goals. At both sites the CCG leadership had very clear objectives and aims, which were communicated to other members of the organisation. At site one, this focused on commissioning new providers within their local health economy while at site two, the focus was firmly on alleviating the financial issues. The clear message at both ensured that there was a 'buy-in' from staff and a focus on delivering what was needed.

5. The next characteristic is a supportive organisational culture. This relates to the previous characteristics. Having a supportive culture is important to succeeding in the aims and objectives of the organisation. According to Pettigrew *et al.*, (1992), this relates to having an open risk-taking approach, openness to evaluation, a strong value base and a positive self-image. These develop over time and reflect the

values of key leaders within that environment. This was on clear display at site one, where commissioners did seek to be innovative and find solutions using the tools at their disposal. There was a somewhat similar situation at site two, but with a different focus and some limit to risk-taking and more of a focus on one key issue.

These elements all fit within the evidence from this study. The ability of powerful actors shaped the approach of commissioners and focused their decision making. The other elements of the Pettigrew et al., (1992) framework did have some bearing although this was much more limited than the five listed characteristics.

6. While co-operative networks proved to be an aid to commissioners in the study, they were not key determinants of commissioning behaviour. The presence of local commissioning collaborative (several CCGs commissioning some services together across their geographical boundaries) provided commissioners with some safety in cases of unexpected severe financial pressure, but they did not dictate the overall strategy of the CCG.

7. While the change agenda and its locale is somewhat important, the CCGs in this study did co-operate and function with other local actors in the delivery of care. Meaning that the locale wasn't as important as commissioners who were willing to work together. However, this did not dictate their approach to commissioning, which instead was much more affected by the external policy framework.

8. Finally, the quality and coherence of policy was not a key factor in the way in which Pettigrew et al., (1992) viewed it. The lack of strict rules and boundaries enabled commissioners to contend with issues which they thought were more important. They were able to adapt to and utilise external policy or clinical pressures by utilising commissioning tools as they saw fit, rather than being restricted by following regulatory guidance (which remained weak).

In this sense, the Pettigrew et al., (1992) framework remains an important work in understanding how change takes place. Many of its key characteristics remain important and assist in understanding how change may succeed in the NHS. However, the change seems to be developing organically and avoiding some of the rules and regulations which have been set up in the Health and Social Care Act (2012). Commissioners at site one were looking for ways in which to select and work with existing providers to avoid having to carry out procurements. The key influence of how commissioners behave is outside of their control and relates to the environmental pressures they face, usually financial concerns. These external factors will generally lead to a CCG electing a leadership group which could be suited to carry out an agenda which insulates the CCG from these factors. With cooperation of other actors, such as managers, they will be able to commission according to their local needs. This also relies on cooperation of other staff and finding methods which circumvent formal rules and to commission as they see fit, within a restricted area, outside of existing commitments to NHS Trusts. It serves as a useful guide for understanding the elements which will be helpful in

understanding if change is successful, and it highlights how vulnerable commissioners are to pressures which are outside of their control.

The strengths and limitations of the study

The research was qualitative and comprised of two ethnographies across two different CCGs sites. There are well-documented limitations and strengths to collecting data using this design and methodological approach (Giacomini and Cook 2000), and they will be discussed in this section.

The collected data is rich and allows for a fuller/more in-depth understanding of how commissioners work in the environment in which they were observed. This was one of the advantages of using a symbolic interactionist perspective, as it allowed the researcher to embed themselves in the work of the participants and to let them inform data collection. This does not mean that it can be presumed that other commissioners in different locales function in the same way, as previously mentioned the local context in which commissioners operate heavily influences their decisions. The major difference between the two sites that were studied was the availability of resources, as it determines how they approach commissioning new services.

Despite this, the evidence from this study is transferable. The conclusions that were drawn here can be applied to CCGs which are of similar size and which face similar resource pressures (surplus or deficit positions). They can be expected to behave similarly, using the tools at their disposal in a similar manner. One caveat to this is that the sites observed had the ability to draw additional resources from the commissioning collaborative clusters that they belong to, which is not something which is universal across all CCGs.

One key issue when conducting ethnographies is collecting credible data (Guba and Lincoln 1985). In this study the researcher had to collect the data in isolation, which can raise questions about the quality of the data. There was no other researcher available to validate the interpretations, particularly of the data collected through non-participant observation. The interviews were in part used to triangulate what the researcher discovered during the observations. Further, not all key members of the CCG were interviewed during data collection at site two, with several commissioners unavailable to participate. The research focused on interviewing the key commissioners and managers, while the staff members who implement decisions on a day-to-day basis did not participate.

Future research could explore the perspective of service providers and representatives of the framework (such as NHS England) to understand the development of the supply side in the new NHS. This would allow for a deeper and fuller understanding of the commissioning process, particularly as the Trusts can subcontract services, which is a possibility that was not explored as deeply as it could have been due to issues of access.

Gaining access proved to be a significant barrier during the research. Initial contacts with the CCGs were established via email. Arranging access with site one took three months and had to be negotiated with two gatekeepers. These discussions took place when the CCGs were still relatively new and just beginning to operate. After access to site one was negotiated, there were promising discussions with a second site. However, after four months the CCG ended discussions as a new Chief Officer was appointed who did not want to proceed. This was a setback as time was needed to identify an adequate second site and agree on access. Of the two alternative options, one agreed to proceed and an initial confidentiality agreement was signed. After a period of discussion, the communication ceased and nothing further was heard from the gatekeeper. This resulted in identifying another CCG where access was ultimately successfully agreed. The processes of securing access took over six months across both sites which prolonged the collection of data and necessitated a compromise about which sites were pursued. Also, the collection of data itself took longer than anticipated. However, this more prolonged period of data collection allowed the researcher to immerse themselves fully in the work of the CCG and to understand the creation of the social spaces within the decision making processes.

Accessing a different second site resulted in some compromise with regards to the desired criteria. The initial aim was to select CCGs which would have several characteristics in common, so that the comparison which would be conducted would be 'life for like'. The two sites shared several criteria, such as size, population, and access to private providers. Between the two sites, the key difference was the financial situation, but rather than providing to be a detriment to the study, it enhanced the data, as it provided new insights. There was also a practical consideration as well. The researcher had a limited budget and ability to continue contacting other CCGs to gain access. There was a pragmatic choice about selecting the best possible site which the researcher could access on a regular basis.

Elective procedures as one of the initially chosen focuses were replaced after research at site one. The majority of elective care was carried out by the Trusts in the form of contracts, as such there was little data that could be gained without access to them, the provider organisations. Elective procedures were replaced by MSK services, which yielded more insightful data (with commissioners at site two arranging access to a provider). The service was selected on the basis that there was a relative abundance of different types of provider that commissioners were able to choose. This provided the researcher with a good source of data. Mental Health services yielded data at both sites and this provided the researcher with the ability to observe differences in how CCGs commissioned the same type of service.

In addition to selecting a different site, there was the issue of gaining access to the Leadership Executive committee meetings. The candidate was denied access on the grounds of sensitive commercial data. The research did interview the three members that comprised that group (Chair, Vice-Chair and Managing Director) to gain some insight about its purpose and how it did/did not affect the decision-making process at site two. This was aided with some triangulation through

observing the other sub-committees. Any decision made by this group would also need to be ratified by these sub-committees and be approved by the Governing Body, which would suggest that the researcher would have discovered how these affected the decision-making process.

The political climate could have also had an impact on the nature of the data being collected. The first round of data collection took place during an election year, 2015, and this might explain why two CCGs declined to take part. Also, the commissioners appeared sensitive to what they perceived to be an uncertain political climate and so were less likely to disclose their genuine views. Whilst it is impossible to confirm that the commissioners were completely sincere and open, many of them did not appear to shy away from discussing their opinions of politicians and what they thought about further proposed reform and change. This indirectly also highlighted the importance of the broader environment in which the CCGs work, as many commissioners were openly wary of political interference and seemed dissatisfied with the structures within which they had to work.

The collected data was rich, with continuing access being granted to regular meetings of commissioners over the course of the ethnography and with the researcher being given limited access to providers at both sites. This allowed for data gathering from multiple sources and a comparison of the views of the commissioners on the one hand, with those of the providers that they have worked with over a prolonged period on the other. This means that the researcher was able to gain an in-depth understanding of the process from within as well as, outside the CCGs that were observed.

Towards a future research agenda

The evidence from this study has highlighted a need for further research. A common belief held by informants in this study was that they did not think that the framework created by the Health and Social Care Act (2012) will last. The perception is that the commissioning units that were created are too small to influence the larger Trusts and that future arrangements would follow the Accountable Care Partnerships (ACPs) model. The contractual issues between commissioners and providers is not a new phenomenon, and with an increasing focus on ACPs there will most likely be a change of rhetoric and further development of cooperation between providers and purchasers. There is the belief that commissioning as it has been practiced over the last 20 years may not be pursued by future policy makers (Ham and Murray 2018, Timmins 2017).

Further research into the way in which commissioners interact with Trusts and other provider organisations could validate the conclusions of this study. This is about the issue of the public/private balance in the NHS, wherein much more could be determined after further investigation, particularly of the nature of sub-contracting arrangements. Further research would need to secure access to Trusts and explore if and to what degree they may have engaged with private providers themselves to determine the actual level of privatisation.

Another direction of possible further research is a more detailed study and analysis of the private sector and third sectors to see if they are expanding and approaching levels of scale and quality to be a viable partner or alternative to NHS organisations. Most measures would suggest that they are not growing very rapidly (Lafond et al., 2017). The current evidence has confirmed that the private sector has so far been mostly focused on providing specific services, although recently there have been moves to penetrate the purchaser side of the NHS market, i.e. private companies have begun to purchase GP services. The data from this study found that the majority of private provider breakthrough was in services in which they generated profit. This new trend of higher private sector activity could present both a challenge and an opportunity for both the sectors in the future.

The development of private providers could be further encouraged by events linked to the UK leaving the European Union (EU) with some of the participants suggesting that larger health provider conglomerates may enter the UK market with a change in trade barriers. If there was to be a growth of private providers, the marketplace would develop and offer commissioners a more extensive choice of potential providers. Likewise, the conglomerates could begin to play a role in the future delivery of services and become part of the mixed economy of care. Taking into account the present deficit within the health service, the potential challenge of a growing, more assertive private sector means that the future of the NHS is more uncertain than at any other point in time, although there are still some that disagree with this analysis (Ham 2017).

The commissioning of Public Health services is also of interest. There was limited data about how CCGs interacted with Local Authorities and Councils with whom some CCGs work to deliver services. There is data that suggests that commissioners would struggle with the additional workload, also lacking some of the expertise to commission effectively in this context. If there is a move towards ACP-style organisations, the relationship between clinical and Local Authority commissioners could be critical to the success of such organisations.

Finally, the definition of privatisation and marketisation used during the research proved to be effective. Saltman's (2003) definition provided a clear path by which to track the process and to engage with commissioners. Many commissioners were not aware of the difference between marketisation and privatisation. This definition helped them engage critically with the subject matter while allowing the researcher to track two separate processes with some additional clarity. This distinction between these two processes could provide the basis for additional comparative research.

Policy Implications: The influence of the Health and Social Care Act (2012) on the selection of providers

The manner in which commissioners make decisions about services dictates the rate at which private providers will enter and be part of the NHS. Commissioners

have been given the power and the tools to make radical changes, such as decommissioning any provider they choose. They can purchase services from a wide range of bodies, public and private, and have the ability to decommission providers who are not meeting agreed targets.

Formally, the CCGs have wide-ranging powers in the selection of providers, but in everyday practice they are rarely able to use their autonomy to the fullest extent. This is because of a combination of internal and external pressures. At the outset, the autonomy of commissioners is limited to a 'periphery' space, as commissioners have no alternative but to commit the majority of their budgets to local Trusts. In many respects, CCG commissioners face restrictions which other, older primary care-led commissioners faced. The most important of these pressures is financial situation of the CCG. If the CCG is facing a surplus position, then they are able to resist other internal and external pressures and opt for the solution they feel is optimal, rather than be forced to compromise. In a situation where the CCG faces financial pressures, they are vulnerable to having their already limited autonomy restricted further, either through the regulation of the external policy framework or the pressures stemming from local providers.

The influences on the commissioners' decision-making are a combination of internal and external pressures. The financial pressures appear to be the critical determinant of the level of a commissioner's discretion. In a scenario in which the CCG has at its disposal a budget surplus, they are more likely to exercise a higher level of autonomy which allows them to pursue their own commissioning priorities without interference from the external regulatory framework. This allows a more effective relationship with the local Trusts and the freedom to choose any of the commissioning tools they feel are best suited in any given situation. However, even in this the commissioners remain limited in their choices, as the provider market has not matured and grown. Their options are restricted, and there is a public sector ethos where commissioners believe they should also still support other NHS bodies. This is one of the reasons that the private sector has not emerged as a credible alternative to public providers and has restricted itself to activities in the services in which they have traditionally been active and thriving. The autonomy of commissioners is limited by financial constraints, coupled with a market which is underdeveloped and still favours public providers and tools which have limited effectiveness in selecting new providers and/or changing the status quo.

Commissioners exercise their autonomy to the highest degree when they decide which tool to use to commission any particular service. This is an area in which their only constraint is the selection of tools that are on offer and which have been defined by the Health and Social Care Act (2012). It is also where whatever limited autonomy the commissioners have can be applied to the goal of maximising their effectiveness and control over the broader landscape. Believing they are best placed to meet local demands and possess greater knowledge of their area, commissioners generally have a clear idea of which provider they would like to secure for any service, and would ideally like to be in full control of that process. However, faced with financial constraints, the commissioners tend to opt for

options/methods which give them the maximum possible control, avoid risk from provider failure and legal challenges, and allows for faster service delivery. When dealing with Trusts, their significant partners, they generally opt for the transformation of existing contracts which is seen as the least expensive and least hazardous arrangement. The tendency is to avoid procurement as it is a lengthy and costly process in which they have little control over the final selection due to the formalities of the method, and there is a possibility that it could be overturned. The general feeling is that the commissioners are, on the whole, disposed to maintaining the status quo whilst using procurement only on the margins in the 'periphery' space to affect change and allow the possible entry of private or third sector providers into the system.

The balance between the public and private sectors has changed in the NHS but not to the extent that many of the critics of the Act feared. Exploring this via the matrix which was presented in chapter two, the private sector has managed to alter the balance in the provision of services to a limited extent. It has managed to expand operations in some services, albeit ones where they have been successful in the past. However, the private sector has not supplanted, or become a viable alternative to, the large existing public providers. Rather, they have carved out a niche as an alternative in some smaller elements of care. Privatisation, when it has occurred, has done so only within the provision of services. The private sector has not expanded its role to the funding of any services. The most effective characterisation of this process would be 'passive privatisation' in which the services granted to the private sector are those in which the treatment of patients is possible outside of hospital settings. Commissioners, have not been led or driven by any ideological agendas, but have instead used procurement as and when it can assist them in generating savings. This would, in turn, protect their autonomy from the external policy framework. Therefore, it can be concluded that the combination of internal and external pressures has helped to move smaller contracts from the public to the private sector, but on a very limited scale.

What has resulted from the reforms is an increase in the marketisation of the NHS. Commissioners are comfortable in using market principles when they feel they can secure a better deal. Procurement has become an accepted norm within the CCGs and commissioners have not been ideologically opposed to the introduction of these mechanisms, or even the appointment of private providers, but are more concerned with the length of time and other associated issues (i.e. the legal challenge, the need to re-procure). Indeed, if the private sector was developed enough to function as a genuine alternative to the large NHS Trusts, there would likely have been some movement on behalf of commissioners, exercising their autonomy to move away from existing arrangements. The majority of procurements still are awarded to public providers; therefore, there is no large-scale transfer of assets but an ever-increasing use of market principles and management, which represents a significant level of marketisation of the system.

The Health and Social Care Act (2012) brought commissioning back under the control of GPs, to make commissioning responsive to local needs. It promised to

involve the private sector to a more significant degree and to increase the flexibility of the NHS in this regard. The Act has had the effect of further marketisation of the system through the use of the described market mechanisms, the opening of the internal market to outside competition. The role of the private sector was additionally entrenched on the 'periphery' of the NHS but, more significantly, it has allowed them to present themselves as a direct competitor to public Trusts in specific fields. The private sector could move in the direction of extending its activity to services other than those they have traditionally occupied. Virgin Care has already purchased 21 primary care services in the UK (Virgin Care, 2017). The reforms have left the NHS a more marketised system, with the expansion of market mechanisms and in which there is higher potential for increased levels of privatisation.

Describing GP Fundholding, Le Grand stated: "*the constraints were too strong and the incentives too weak*" (Le Grand, 2002). This seems to be an accurate description of the current state of the NHS after the Health and Social Care Act (2012). While commissioners have the powers to change the service radically, they are in fact restricted in doing so by the dynamics between the internal and external pressures. In practice, they do not seem to have any incentive to change the status quo in seeking to ensure the continued provision of services in an increasingly complex and uncertain environment. There is little that the commissioners would gain from radically altering any existing services. The possibility that the reform has further opened the door to future privatisation is still a realistic possibility particularly in the current climate where austerity continues to dominate the public service discussion.

In the future, a more cohesive and integrated NHS without the present purchaser/provider split could allow for a more joined-up approach to care, that would also help to alleviate cost pressures. However, an obstacle to this scenario is that to make it possible, the present regulatory framework would have to be replaced, and future governments are likely to be reluctant to put the NHS through another radical restructuring.

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Appendix

Field Notes Template

Descriptive Field Notes

Actors Present

Timings of key events/interactions

Interactions between actors

Discussions about specific services

Decisions which have been reached

Reflective Field Notes

Impressions of meeting

Impressions of decision making process

Things to be brought up in interview

Focus for next observation

Interview topic guide

Interview Schedule with key informants/Topic Guide

Introduction

1. Confirm with the participant that they have consented and remind them of their confidentiality
2. Talk through the information sheet
3. Background information on the participant, how long they have been a clinical commissioner, thoughts on the new reforms, how the reforms have affected their job.

1 The new reforms

- How have the new reforms changed the day-to-day work of the commissioners?
- What are your thoughts on care being commissioned by GPs?
- What kind of working atmosphere does there exist in the CCG?
- How much extra responsibility does the head of a CCG need to take on?

2 The Commissioning Process

- How does the commissioning process take place?
- Are services tendered for?
- Are there preferred providers or arrangements that the CCG pursues?
- Which services are the most difficult to commission?
- How much input do other commissioners have?
- What sort of influence do the 'lay members' have?

3 The providers

- Have providers approached the CCG?
- If so, what types of providers have approached the CCG?
- What preference do they have?
- What role does the Health and Wellbeing board play?

Date

ADDRESS

Ref: CCG Access.

Vid Čalovski

PhD Researcher

T: +44 (0)1227 764000 switchboard F: +44 (0)1227 827868 E: vc202@kent.ac.uk www.kent.ac.uk/chss

Dear X, I am currently studying as a full-time PhD researcher in the School of Social Policy,

Sociology and Social Research at the University of Kent. The focus of my research is decision making in the commissioning process and how different providers are chosen in the wake of the implementation of the Health and Social Care Act (2012) and the accompanying policy framework.

I am writing to ask for permission to include your CCG as a site for my fieldwork. If granted access I will conduct ethnographic research, which will include observing the commissioning process and interviewing CCG members and another key people involved with the commissioning process. The research would take place over a period of approximately 12 months, with the initial stage consisting of observing and following the commissioning process. The second stage will involve follow-up interviews to gain a better understanding of the process.

The specific services the research would be examining would be elective procedures and mental health services. I am enclosing an information sheet with further details of the research; please do refer to it to discover what my research will look like in practice.

Once my fieldwork is completed, you would be given a summary of the findings of my research and I can provide other forms of feedback if required. Although I am not evaluating the commissioning process directly, the results may be useful to yourself and other commissioners in gaining a deeper understanding of how the process may have changed since 2012. This summary would include what may be the most common type of provider, the perception of providers and their views on the system as well as gaining a better understanding of the entire process.

I would also be happy to come and meet with you to discuss any concerns that you may have. I am also happy to speak with you on the phone if that is easier.

In keeping with Ethical Guidelines and Data Protection I would anonymise the results of the research conducted to ensure that nothing can be traced back to your

CCG. I have received ethical approval from my School Research Ethics Committee, however if you have any queries about the ethical approval please do contact the Director of Research Services, Simon Kerridge (directorofresearchservices@kent.ac.uk, 01227 82 3229).

My research supervisors are Professor Michael Calnan and Professor Stephen Peckham – Director of the Centre for Health Services Studies. Their email addresses are, M.W.Calnan@kent.ac.uk and S.Peckham@kent.ac.uk and their contact numbers are 01227 823687 and 01227 827645 respectively.

If you have any further questions, please do not hesitate to get in touch. Yours faithfully,

Vid Čalovski, BA, MA

Information Sheet

Information about the research

Exploring clinical commissioning decisions about the use of healthcare providers

Dear Sir/Madam,

I would like to invite you to take part in my research. Before you decide, I would like you to understand why the research is taking place and what it involves. I will go through the information sheet with you and will answer any questions you may have. The first section will outline the purpose and aims of the research, while the second section will provide you with information about the conduct of the study. If you have concerns please do not hesitate to contact me or my supervisors. Contact details can be found at the bottom of this sheet.

Section 1

Information about the research

The focus of the research is to gain a better understanding of the commissioning process and how providers are chosen. This piece of research is an ethnographic study that will involve non-participant observations of committee meetings as well as, interviews with members of the Clinical Commissioning Group (CCG).

I am a PhD student in the School of Sociology, Social Policy and Social Research (SSPSSR) at the University of Kent and have undertaken extensive research methods training.

Purpose of the research

The purpose of the research is to gain a better understanding of how the commissioning process takes place and how it has changed under the new arrangements brought in by the Health and Social Care Act (2012), and what role commissioners play in the process. The research will assist with assessing how these changes have (if at all) changed the public/private balance in the NHS.

Why have you been asked to take part?

I am asking all members of the CCG who take part in the commissioning process to be a part of the research.

Do you have to take part?

It is up to you whether or not you decide to take part in the research. You are free to withdraw from the research at any point without needing to provide a reason. Before making a decision, please allow me to go through the information sheet and answer any question that you may have. You will be provided with a consent form to sign and will be given a copy to keep.

1

What will be involved?

Your participation will involve taking part in a confidential, face-to-face interview with the researcher either at your own practice or at the CCG building during your normal work hours. The interview should last no more than 20 minutes and it will be recorded (with your permission) on a digital recorder so that your responses may be transcribed for inclusion in the analysis of the research. The type of questions that will be asked is explained below.

I am willing to travel to individual practices/office locations to interview participants. What sort of questions will be asked during the interview?

The questions will be about how the commissioning process takes place and your perceptions of the process. There will be questions about your role within the process and how providers are chosen for

certain services.

I will ensure that you will not be identifiable in the transcript or in any subsequent publication that emerges from the research.

Confidentiality

Any one that you may refer to while discussing an aspect of commissioning will also be anonymised and pseudonyms will be used in place of the participants' names in any publications of the results of the research.

Section 2

Confidentiality

Your responses will be confidential. The transcript of any interview that you give will be coded and anonymised so that you will not be identifiable, except to me. The only person who will have access to the recordings will be me, who will also carry out the transcription alone. Data which is kept during the process will be kept in line with the University's standards of data protection. The recordings will be deleted once transcription has taken place. The transcriptions will be put onto a password-protected computer with access being limited to me.

Use of quotations

If quotations are used in the final draft of the PhD thesis any details which could potentially lead to identifying the participant will be removed.

Who has reviewed the research?

The research has been approved by the SSPSSR Research Ethics Committee, as well as, both of my supervisors.

Who is organising the research?

The research will form the fieldwork element of my PhD thesis. It is being carried out by me with the guidance of my supervisors, who are senior staff within my School.

2

Further information and contact details

If you would like any further information please contact me - my contact details can be found at the bottom of this information sheet.

Complaints

If you have any serious concerns about this research, then please do not hesitate to get in touch with me. If you would like to speak with my supervisors, their details are also available at bottom of this sheet. If you do wish to complain formally, the please get in touch with the University of Kent' Director of Research Services, Simon Kerridge, directorofresearchservices@kent.ac.uk, 01227 82 3229. They will conduct an investigation and respond.

Yours,

Vid Calovski BA,MA

PhD student at the University of Kent – School of Sociology, Social Policy and Social Research (SSPSSR)

Email: Vc202@kent.ac.uk **Contact Number:** 0773 056 9469

Supervisors: Professor Michael Calnan & Professor Stephen Peckham

Email: M.W.Calnan@kent.ac.uk; S.Peckham@kent.ac.uk **Contact**

Numbers: 01227 823687 & 01227 827645

Consent Form

Consent Form for interviews Exploring clinical commissioning decisions about the use of healthcare providers

4. I confirm that I have read and understood the information sheet for the above study and have had the chance to ask questions. Please tick box

5. I understand that taking part in the project is voluntary and that I am free to withdraw at any time, without giving any reason, and without my rights being affected at any time during or after the interview. Please tick box

6. I agree to take part in the interview. Please tick box

7. I agree to the interview being voice recorded. Please tick box **Name of**

participant: _____

Signature: _____ **Date:** _____ **Name**

of Researcher: _____

Signature:_____ **Date:**_____

Vid Calovski PhD Candidate at the University of Kent – School of Sociology, Social Policy and Social Research (SSPSSR) **Email:** Vc202@kent.ac.uk **Contact Number:** 0773 056 9469