WHERE'S THE LOGIC IN COMMISSIONING?

EXPLORING THE INFLUENCE OF INSTITUTIONAL LOGICS ON INTER-ORGANISATIONAL WORKING IN THE ENGLISH NATIONAL HEALTH SERVICE

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Abstract

This thesis explores inter-organisational relationships and behaviours when complex healthcare pathways are planned, designed, procured and implemented in the English National Health Service (NHS) in a process known as commissioning. Commissioning and healthcare provision in the NHS is organised separately and operates as a quasi-market system. Clinical Commissioning Groups (CCGs) commission the majority of local healthcare for their populations and purchase services accordingly from many different types of healthcare provider organisations. Poor integration between different provider organisations has been suggested a contributing factor to the unsustainable demands the NHS is currently facing. New models of provision have been recommended in policy as a commissioning strategy to improve integration and these require collaboration and effective inter-organisational working between organisations.

Healthcare is a highly complex institutional field and the institutional logics perspective offers a theoretical framework to explore how institutions embedded within a field guide behaviour. Bureaucratic, market, corporate and professional logics are known to exist in healthcare and can be used to break down institutional complexity into abstract constructs to understand the demands organisations face but enquiry has tended to focus on sole organisations rather than inter-organisational behaviour. However the institutional logics perspective offers the opportunity to explore the influence of institutional demands on inter-organisational relationships in complex institutional fields.

This study sought to explain how logics influence inter-organisational behaviours as organisations work together to develop integrated care pathways. Using stroke service commissioning as a contextual example, the study explored three comparative case studies of the commissioning processes used to reorganise and develop stroke services into integrated care pathways across acute and community providers. Using methods associated with the ethnographic tradition, fifty-four semi-structured interviews with commissioners, providers, patient representatives and advisory bodies were completed, ten commissioning meetings were observed

and strategic documentation for each organisation were collected. Thematic analysis was used to identify key themes which were then viewed through the institutional logics framework lens to explore how logics were present and influencing the commissioning processes as they progressed.

The empirical findings suggest that an organisation's interpretation of the institutional environment influences how an organisation and their individuals behave. In turn those behaviours influence how the organisations they are attempting to work with respond. Establishing a shared goal between the organisations was crucial but an organisations response to institutional demands may make this difficult to achieve.

Collaboration was considered key to successful integration but this was only successful when commissioners were able to negotiate complex logics to facilitate shared goals and means of achieving them. This was most successful when organisations co-opted an alternative logic to compliment the organisations they were attempting to work with for different phases of the commissioning process. When complimentary logics were op-opted, organisations were better equipped to work collaboratively but if contradictory logics were in play, there was increased risk of inter-organisational relationships breaking down. Some commissioners used this strategy effectively to develop inter-organisational relationships while hiding the logic which informed their underlying goal which allowed them to maintain control of the commissioning process. This suggested that an organisations interpretation of the institutional environment and skills at using logics to manipulate the means of achieving goals was important.

In conclusion, when logics are used by organisations to compliment the beliefs and behaviours of other organisations when they attempt to work together, they are able to establish effective inter-organisational relationships that allow collaborative work towards shared goals. This may be an important characteristic of commissioning organisations as they attempt to commission new models of integrated care.

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Abbreviations

ACO	Accountable Care Organisation
AHSN	Academic Health Science Network
CCG	Clinical Commissioning Group
CE	Conformité Européene
CHC	Continuing Health Care
CST	Community Stroke Team
D of H	Department of Health
EEA	European Economic Area
ESD	Early Supported Discharge (for stroke)
EU	European Union
GP	General Practitioner
IRAS	Integrated Research Application System
MCP	Multispecialty Care Provider
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NPM	New Public Management
PbR	Payment by Results
PACS	Primary and Acute Care Systems
PCG	Primary Care Group
PCT	Primary Care Trust
R&D	Research and Development
SCN	Strategic Clinical Network
SHA	Strategic Health Authority
TPP	Total Purchasing Pilot
UK	United Kingdom
US	United States
WHO	World Health Organisation

Chapter 1: Introduction

The study

This thesis is concerned with understanding how organisations develop and use inter-organisational working relationships in complex institutional fields. The National Health Service is a complex institutional environment where different types of organisations are required to work together to deliver integrated pathways of healthcare. To do this an organisational process known as commissioning is used to plan, design, procure and implement healthcare using finite budgets allocated by the British government. Commissioners in local Clinical Commissioning Groups (CCGs) make decisions on the majority of health service requirements for their population and purchase services accordingly from qualified healthcare providers (Secretary of State for Health, 2012). Demand for healthcare and pressures on NHS budgets have been exceptionally high in recent years (Iacobucci, 2017a) and commissioners are constantly faced with challenging decisions about the best use of finite resources. This makes commissioning a key organisational concept in the NHS.

The NHS is divided into many component organisations which include CCGs and different types of healthcare providers. Provider organisations may include hospitals that deliver acute and emergency care; community providers that deliver different types of community based care to inpatients and outpatients; General Practitioners (GPs) providing list based healthcare; mental health providers; and third sector providers delivering supportive healthcare. Patients often require the involvement of more than one of these providers. This means that numerous organisational boundaries must be crossed by patients and professionals to ensure delivery of appropriate care. Recent government health policies have focused on developing improved integration between different NHS providers to create a more efficient, responsive and high quality service for patients as they pass from one organisation to another. Commissioners are required to play an important role in developing strategies to facilitate integration between provider organisations. It is not clear how they will respond to this challenge or how successful their strategies

will be but developing effective inter-organisational relationships is considered important to the integration agenda (NHS England *et al.*, 2014). This research aims to understand how the inter-organisational relationships between different organisations (healthcare providers and CCGs) within the same organisational field (healthcare) play out in practice to respond to complex demands placed on them as they attempt to address the problems associated with delivering the NHS in the current economic climate.

The research used the theory of institutional logics to conceptualise the complexity of the healthcare field as a basis to understanding inter-organisational working in a policy landscape focused on integration. This revealed the healthcare field to be complex and contradictory in nature, and contributed to diverse beliefs and behaviours of organisations and their individuals as they attempted to work together to deliver the integration agenda through commissioning. The following sections of this introductory chapter further introduce the research in this thesis to orientate the reader.

The context

Since it was established in 1948, the NHS has had to make difficult decisions about what services it provides and how those services are delivered and paid for. These decisions have been made in different ways over the years. In 1991 the healthcare market was introduced into NHS organisational administration and the concept of commissioning began to emerge (Klein, 2010a). The internal market separated the purchasing and provision aspects of NHS administration in an attempt to use neoclassical economic models to improve the efficiency of the NHS system through market forces. Although never a true market, purchasing decisions have since been delegated to local authorities in various organisations forms to make decisions about the healthcare that their local populations required. Different organisations that have been responsible for commissioning have been subject to regular reorganisation from central government making the impact of commissioning has been difficult to quantify (Le Grand, Mays and Dixon, 1998). This has made it

difficult to assess if commissioning as a concept in the NHS has been a positive or negative organisational change.

The organisations currently responsible for commissioning are CCGs which replaced Primary Care Trusts (PCTs) were introduced in the government white paper *Equity and excellence: Liberating the NHS* (Department of Health, 2010). CCGs came into effect in 2013 and continue to be responsible for commissioning (Secretary of State for Health, 2012) during a period of relative organisational structural stability. However as the NHS currently faces challenging financial times (Iacobucci, 2017a), commissioning is an increasingly difficult process and open to scrutiny. With little detailed theoretical understanding of commissioning, it is unclear how as an organisational process it is equipped to address the challenges the NHS is facing (Ham, 2008; Ham and Murray, 2015). This makes current NHS commissioning an interesting and important organisational process to study.

The specific context for this research was the commissioning of stroke care pathways in the English NHS. To investigate inter-organisational working through commissioning in practice, a case study within NHS commissioning was required. Given the current drive to integrate services (NHS England *et al.*, 2014), a case study that had clear clinical and commissioning boundaries but involved services spanning different organisations including CCGs, acute and community providers was selected. Stroke care was identified as a defined condition specific case study that had services in the different sectors of the healthcare system that were required to work together to provide a seamless pathway of care.

Stroke occurs when the blood supply to the brain is interrupted by either a blood clot or when a blood vessel in the brain bursts. It is the third largest cause of death in the United Kingdom (UK), the single largest cause of disability for people living in the community and associated with older age although 26% of stoke occurs in people under 65 years of age (Stroke Association, 2013). It is associated with many risk factors including smoking, obesity, high blood pressure and cholesterol making it an important problem for the NHS as it requires specialist intervention at many stages; prevention and treatments of risk factors; emergency treatment for the

onset of stroke; post stroke rehabilitation; and lifelong medical review and social care in many cases (Royal College of Physicians, 2016b). Stroke services have a strong evidence base to support the clinical interventions that are required at all stages of the disease. Clinical guidelines are available to support providers of healthcare to deliver high quality interventions and provide guidance to commissioners as to the services that are required(Dworzynski *et al.*, 2013; NICE, 2013; Royal College of Physicians, 2016a). In recent history, stroke was made a national priority with a detailed national strategy to reconfigure stroke services into specialised pathways of care from acute to community services (Department of Health, 2007b) along with substantial funding to ensure the strategy was delivered (Rudd and Williams, 2009). The National Stroke Strategy (2007) heralded wide scale reorganisation of acute services across the country and now almost all people suffering a stroke can expect to be treated in a dedicated stroke unit (National Sentinal Stroke Audit, 2014).

The National Stroke Strategy (2007) recommended that community services were made available to those requiring them. A community based intervention known as Early Supported Discharge (ESD) had been found to significantly reduce hospital length of stay and reduce death and dependency in stoke survivors with mild to moderate stroke (Langhorne and Widen-Holmqvist, 2007; Fisher and Walker, 2011). However despite strong evidence and policy drivers from central government (Department of Health, 2007b), implementation of ESD was relatively slow in comparison to the changes that had been made in acute care. Even more problematic was the implementation of longer term specialised stroke care in the form of Community Stroke Teams (CST) despite evidence continuing to emerge to support commissioning of such services (Walker, Sunnerhagen and Fisher, 2013).

The problems associated with developing community based services to support acute based care may reflect a wider problem of developing an integrated healthcare system. The abundance and clarity of guidance on stroke care makes it an intriguing commissioning topic to study as it would suggest commissioners have adequate resources to make sound decisions but the difficulties that have been experienced with commissioning community based stroke service may indicate

wider influences that hinder the commissioning process, especially when attempting to commission integrated pathways of care.

The theoretical framework

The theoretical framework for this study is the institutional logics perspective. Institutional logics are a concept situated in within the institutional theory literature. Institutional theory is used to explain social phenomenon using structure and agency to understand how institutions deeply embedded within society create the social orders that guide acceptable behaviour (Lawrence and Shadnam, 2008). It can be used to explain both individual and organisational behaviour (Dacin, Goodstein and Richard Scott, 2002) and has been used extensively to conceptualise healthcare (Scott, Ruef, P. Mendel, *et al.*, 2000b).

A key concept in institutional theory are the three institutional pillars which constitute the rule and belief systems that affect organisational behaviour and structure (Scott, 2001). Using healthcare organisations as an example, Scott (2001) described institutional pillars as social structures that inform agency and provide legitimacy through procedures, norms and conventions embedded within organisations. However the theory has been criticised for assuming pillars are defined by distinct boundaries and that they neglected the complex interweaving of the rules of culture and cognition into legitimised behaviour (Thornton, Ocasio and Lounsbury, 2012). This led to enquiry into the cultural cognitive aspects of institutional pillars and a deeper understanding of the inter-institutional systems in which organisations exist, followed closely by the institutional logics perspective.

Institutional logics are "*socially constructed, historical patterns of material practices, assumptions, values, beliefs and rules by which individuals produce and reproduce their material substance, organise time and space, and provide meaning to their social reality"* (Thornton and Ocasio, 1998). They provide a theoretical framework to allow the inter relationships between individuals and organisations to be understood within their social context by taking into account influences from different institutional logics such as the state, markets, professions and corporations (Thornton, Ocasio and Lounsbury, 2012). This allows individuals and

organisations to be studied through a theoretical lens to explain institutional complexity in depth as well exploring how change and stability occurs in organisations.

Research using the institutional logics perspective has shown how multiple logics co-exist in organisational fields in a constant state of flux. Initially certain logics were thought to dominate an organisational field, guiding behaviour until a new logic assumed a dominant position following a period of tension between different logics (Scott, Ruef, P. J. Mendel, *et al.*, 2000). More recently it has been suggested that logics can co-exist without creating instability (Greenwood *et al.*, 2011), or different logics may influence groups in different ways whether they are dominant or not (Reay and Hinings, 2009; Goodrick and Reay, 2011). This suggested that logics can be both a facilitator and constrainer at the same time (Waldorff, Reay and Goodrick, 2013). The scope of the institutional logics perspective allows organisational process to be broken down to an abstract constructs to conceptualise organisational complexity and change within the context of a complex organisational field.

Complex organisational fields create diverse institutional demands on organisations; the institutional logics perspective allows organisational responses to those demands to be conceptualised and predicted (Pache and Santos, 2010). For example a healthcare provider or commissioning organisation facing multiple conflicting institutional demands at the higher field level may resolve the dispute through compromise (Pache and Santos, 2010). However the influence of other similar organisations at the same level in the field is not well understood. At an organisational level, a greater understanding of how the inter-relationships between provider and commissioning organisations impact on organisational responses and inter-organisational working under the current integrated care agenda would be beneficial.

Being able to use the institutional logics perspective at different levels in the field makes the institutional logics perspective ideal for conceptualising the complex field of healthcare commissioning. Previous enquiry has concentrated on single

organisations, usually of the same structure and function within the organisational field. Healthcare commissioning provides the opportunity to study different types of organisations within the same field working together towards shared goals, making the study of inter- organisational relationships paramount. This study provides the opportunity to extend both theoretical knowledge on the institutional logics perspective by developing theories in inter-organisational relationships, and practical knowledge within healthcare commissioning to help improve the commissioning process within the current policy context.

Qualifications/disclaimers

For the purpose of this thesis, it is important to introduce relevant qualifications and disclaimers for the research. The focus of the research is commissioning as an organisational concept. Although situated within a clinical context, the study does not seek to explore if the services commissioned for stroke survivors are effective or indeed appropriate. The study explores how commissioning processes played out in practice and provides a greater understanding of how and why certain decisions were made and the outcomes they resulted in. It does not pass judgement on whether the right decisions were made from a clinical perspective but does try to understand how those decisions affected relationships and behaviour at organisational levels, and hence how that may have impacted on commissioning outcomes.

The commissioning outcomes found in this study were diverse and in some parts the processes used to reach those outcomes could be considered controversial. Given the sensitive nature of the subject, the three commissioning sites in this study are presented anonymously. All data has been anonymised and findings are presented with pseudonyms for all individuals and locations. Every effort has been made to ensure that anonymity is protected while retaining the integrity of the commissioning stories that emerged. The findings provide a unique learning opportunity for commissioning in practice and the lessons that are drawn are intended to improve future commissioning practice rather than berate previous decision making that was in the most part well intentioned.

Outline of the thesis

This thesis begins with Chapter 2 giving a detailed explanation for the context of this study; commissioning stroke services in the English NHS. The history of commissioning is explored in detail to contextualise what is known about commissioning as an organisational concept, as well as providing a detailed account of commissioning organisation today. The policy context for the research is outlined to explain the drivers informing commissioning as an organisational practice. This is followed by a review of stroke services from an organisational perspective to provide detail on the types of services explored in the case studies and contextual background to how organisational change has occurred in the past for stroke services, and intentions for the future. Stroke services are considered from a commissioning perspective to outline the challenges that have been experienced in the past. The chapter concludes by considering the problems facing commissioning in the current policy landscape.

Chapter 3 outlines the theoretical framework for the research by providing a review of the current theory related to the institutional logics perspective. At the beginning of the chapter, core conceptual definitions can be found which explain how the terms field, organisation and inter-institutional system are used in the research. This chapter explores how institutional logics emerged within institutional theory and presents an overview of the logics of the professions, bureaucracy, markets and the corporations that are used to conceptualise the organisational process investigated in this study as well as the rationale for using the institutional logics framework as the theoretical orientating strategy Following this a detailed exploration of the current understanding of the institutional logics perspective is given, outlining the key arguments for how the perspective is used to explain organisational stability, change, behaviour and relationships. Chapter 3 draws to a close by identifying aspects of organisational behaviour and relationships that institutional logics does not yet explain and presenting the theoretical research question and research propositions this study aimed to answer to expand current theoretical understanding within the context of commissioning. The chapter concludes by viewing commissioning and provider organisations through the lens of

institutional logics to set the scene for the case studies which follow later in the thesis.

In Chapter 4, details of the research methodology are given. This provides the rationale for rooting the study in the qualitative tradition and use of interviews, observations and document analysis within case study methodology as the means of collecting the empirical data. The three case study sites for fieldwork are introduced along with details of participants, data collection methods and analytical approach as well as reflections on the process from the researcher.

Chapters 5, 6 and 7 provide detailed accounts of the empirical findings in the three case study sites. Each site is initially presented as a 'commissioning story' to give a detailed description of the commissioning process that took place in each site. Chapter 5 tells the story of Westhall's failed commissioning attempts where competition dominated the process. In Chapter 6, the commissioning process in Edgeham demonstrates how manipulative collaboration was the key to success and in Chapter 7, the commissioner's passive approach shows how difficult change can be without leadership from commissioners. Each story is followed by analysis using the institutional logics perspective to draw out the abstract findings in relation to the research question.

In Chapter 8, the commissioning processed in each of the three case study sites are discussed within the context of the institutional logics literature. The use of logics to explain institutional complexity at the field and local level on the formation of inter-organisational goals is explored, followed by how logics influenced commissioning response strategies as a mechanism to maintain control of the healthcare system. The impact this had on inter-organisational relationships is discussed before a theoretical explanation of institutional logics and inter-organisational working is presented. The propositions outlined in Chapter 3 are revisited and adapted according to the empirical findings and the overarching research question is reconsidered. The Chapter concludes with a summary of how the institutional logics perspective has been extended using the research findings.

Finally, Chapter 9 draws together the conclusions of the research to consider 'Where's the logic in commissioning?' Here the institutional complexity of healthcare and commissioning is summarised to explain the challenges commissioners face when commissioning integrated care from multiple organisations that are expected work together. The implications for commissioning practice are outlined along with limitations for the study and suggestions for future research.

Chapter 2: Commissioning stroke services in the NHS

Introduction

The Department of Health (2010) describe commissioning as *'the process of ensuring that the health and social care provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers'* (Department of Health, 2010). Commissioning is a key organisational concept in the English National Health Service (NHS) designed to address the challenges of delivering high demand services using finite resources. It is an example of how different types of organisations in the same organisational field work together to deliver joint goals in a complex institutional environment. Recently commissioners have been under increasing pressure to ensure that services they commission are integrated between many different types of organisations in the system in an attempt to address the financial and quality issues the NHS has been facing (NHS England *et al.*, 2014). The main focus of this research was to understand how commissioning as an organisational concept effects how organisations in a complex field work together towards shared goals.

To make commissioning as a task more manageable, commissioning of services is usually confined to clinical specialities. Stroke was selected as the clinical context for this study of commissioning as it provided a well-developed speciality with a strong evidence base to support clinical commissioning decision making. Evidence suggests that stroke care should be delivered a seamless pathway of care from onset of stroke to long term support (Department of Health, 2007b) but the different elements of care are often delivered by separate organisations. As well as considering how high quality stroke services are designed, procured and implemented, commissioners must also consider how to improve integration between the different organisations required to deliver component parts of the stroke pathway. This made stroke commissioning an interesting and appropriate example to study the challenges facing commissioners as they responded to pressure to commission integrated care and improved inter-organisational working.

Healthcare is an example of an institutionally complex organisational field within which the NHS lies. To provide contextual background for the research, this chapter begins with an overview of the NHS to explain its complexity. NHS policy differs between England, Scotland, Wales and Northern Ireland and for the purpose of the research, reference to the NHS refers to the NHS in England (NHS England, 2017). NHS commissioning is a vast organisational concept of which stroke services commissioning is just one small aspect. For clarity, this chapter explores stroke service commissioning in two parts; NHS commissioning followed by an introduction to stroke services and how they are commissioned. The chapter is presented in this way as commissioning was the main focus of the research with stroke services used as an example of a commissioning process.

Given the complexity of healthcare fields, an understanding of the different organisations and policy landscape of commissioning and stroke services is important to allow the research to be contextualised. This chapter briefly explores the organisation of the NHS in England and how it has evolved to explain how commissioning emerged and developed as a key organisational concept. The way in which commissioning is organised today is then described along with influential policy drivers that are guiding current healthcare service development. Stroke services are then introduced to give an explanation of what stroke is, how it is treated and how services may be organised to deliver high quality evidence based care. This serves as background to understand what the organisational goals of commissioners and providers of healthcare were trying to achieve through the commissioning processes explored in this research. The chapter is not intended to be a systematic review of NHS administration and stroke services but a contextual overview of the challenges facing the NHS and commissioning. It concludes with propositions for exploration in the research that follows before the theoretical framework for the study is presented in Chapter 3.

The NHS

The NHS is a public national healthcare system in the United Kingdom (UK) funded by the state predominantly through taxation. It was established in 1948 and

provides healthcare free at the point of access. It has continued to do this despite immeasurable changes to society including social deprivation, child poverty, alcohol abuse, smoking, poor diets and obesity which has placed increased demand on the NHS (Iacobucci, 2017a). There is a social expectation that all healthcare should be continued to be provided irrespective of wealth and lifestyle choices (Iacobucci, 2017b). To meet the healthcare requirements of the population, the NHS has many component organisations that are responsible for the administration and delivery of healthcare using funding allocated by the UK Government (figure 2:1). In 2016/17 the UK government allocated £161.8 billion to health and social care services with £115.6 billion directed into the English NHS.

NHS services may be delivered by any qualified provider (Secretary of State for Health, 2012). Many of the provider organisations are NHS organisations but there are also numerous organisations from the private and third sectors that are contracted to provide NHS health and social care. The complex arrangement of organisations can make it difficult to understand and follow how funding flows through the NHS and from which pot of money different services should be funded from (Iacobucci, 2017a). The organisations of specific interest for this study are the Clinical Commissioning Groups (CCGs) who are responsible for commissioning stroke services and the providers of stroke services which are usually NHS hospital and community service providers. Although the study focuses on this particular area, CCGs do not work in isolation and have many organisational relationships with organisations in the NHS system.

Since the NHS was established it has undergone many policy reforms to address the different problems it has faced. Maintaining a balance of power between state administration and the medical profession who are required to deliver services has been challenging. To explore how the current organisational structure came into existence, background on professional dominance and the bureaucratic reforms that have taken place will now be explored.

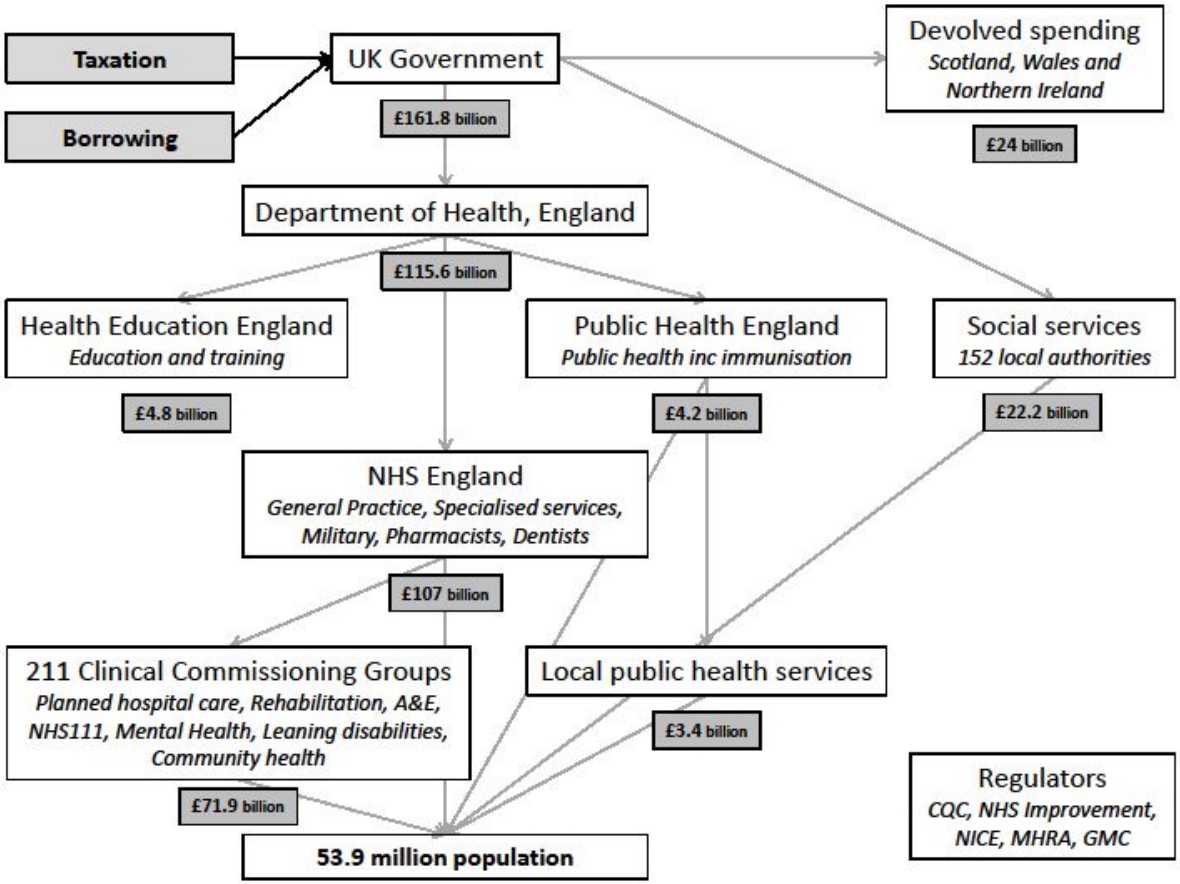


Figure 2:1: NHS organisations and funding flow in 2016/17. Adapted from Iacobucci et al (2017a)

Professional dominance in the NHS

Dominance of the medical profession has always been a key concept for healthcare and maintaining a balance between state and medical control of the NHS has always been problematic. Healthcare systems provide services using the skills of the medical profession and associated allied healthcare professionals based on the assumption that the medical profession are motivated by professional ethics and responsibility to act in the best interests of their patients (Le Grand, 2003). As a state funded system, the state relied on the medical profession to guide the development of the services required in the NHS but initially attempted to retain administrative control (Klein, 2010b). When first implemented, the NHS was found to be more difficult and expensive to administrate than initially expected and non-medical administration was questioned. The Guillebaud Report (1956) recommended increasing the number of medically qualified administrators to address expenditure problems through prioritisation of resources based on clinical justification. This strengthened the power the medical profession within NHS higher management. This has been referred to as knightly behaviour (Le Grand, 2003) but also a professional bureaucracy (Mintzberg, 1993) which increases power and control of a profession in an organisation.

Increasing the power of the medical profession created a bureaucratic hierarchy (Exworthy, Powell and Mohan, 1999). From an early stage in NHS history, hospital consultants had almost full control over how the NHS was organised and developed. This gave consultants freedom to develop specialist interests and their professional status and legitimacy gave them protection to challenge from the state (Le Grand, 2003). The medical profession defined the conditions and methods of their work to establish professional autonomy (DiMaggio and Powell, 1991) but by the 1960s there were concerns that medical professional power and control was ineffective. High demand for health and social care had become a problem in society but there was a heavy bias towards health rather than social care in the system. Inadequate social care failed to support a stretched healthcare system that was dominated by the medical profession (Klein, 2010a).

In an attempt to address increasing demand for health and social care, hospitals remained under central control but in 1967 the state devolved responsibility for social care provision to local authorities in an attempt to address specific local needs (Klein, 2010a). However under local control social care services began to vary across the country leading inequitable provision (Ham, 2009). This created an organisational boundary between health and social care which made reintegration of patients back into society following hospital treatment increasingly difficult and quality began to fall. To address the problem, social services were quickly returned to central control alongside health in 1968 (Ham, 2009). However return to universal state control was not considered responsive to local needs and services were again reorganised into Regional Health Authorities (Ministry of Health, 1973). During this period of change and reform, public administration was still unable to control how health services were delivered by the powerful medical profession in autonomous positions; the medical profession were unresponsive to the administrators that lay beyond their professional boundaries (Klein, 2010c). By the 1970's the medical profession had almost full control of NHS budgets but quality concerns remained with the government looking for alternatives to medical professional dominance (Klein, 2010c). However state administration was also falling out of favour.

Bureaucratic revolution through New Public Management

By the end of the 1970s the benefit of state controlled public services was being questioned. Rising costs and falling quality were common themes. The conservative party in power at the time based it's principles on an ideology of social hierarchy, self-interested behaviour and aspiration of privately financed systems (Green, 2002). Across the Western world a managerial revolution was taking place and the state looked towards the private sector trend for accountability as a solution to problems in many of their publically administrated industries were facing (Broadbent and Laughlin, 1997). The approach gained momentum in the early 1980s with the introduction of New Public Management (NPM). NPM was based on classical economic reasoning with the assumption that private sector models of markets and competition could be applied to the public sector (Broadbent and

Laughlin, 1997). The introduction of NPM into the NHS was used to alter the structure of the organisational arrangements to allow competition to drive quality and efficiency. Across the NHS, organisations were split into component parts to incorporate management structures. Management involving a hands-on approach brought in tight control on expenditure and an emphasis on output (Ferlie *et al.*, 1996). It was assumed that the NHS would embrace NPM into their existing values and standards (Klein, 2010c) but the changes threatened a culture which had previously promoted honesty and neutrality (Doig and Wilson, 1998).

Despite widespread resistance in the NHS to the new management strategy, the state was reluctant to abandon their approach and turned again to the private sector for assistance to improve implementation of their plans. An NHS Management Inquiry produced the Griffiths Report (1983) which was highly critical of NHS management practices and famously quoted *'If Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be looking for the people in charge'*. The report led to the introduction of general managers throughout the NHS with direct accountability to the state and financial incentives to improve performance (Griffiths *et al.*, 1983). Recommendations for change were based on the stark differences between the public and private sectors of the economy, but has since been criticised as under estimating the challenges that the NHS faces as the provider of healthcare and employment in a complex society (Ferlie *et al.*, 1996).

Internal markets and development of commissioning

Despite stronger management structures, the NHS struggled to make the efficiency savings required following the introduction of NPM. Internationally American style healthcare markets were becoming a popular mechanism to drive efficiency (Exworthy, Powell and Mohan, 1999). To investigate the role of markets in healthcare, the state sought guidance from an American economist on how to introduce competition into the NHS (Enthoven, 1985) but remained committed to retaining a public administrative structure. To do this the state introduced an internal market or quasi-market in an attempt to use the principles of a market without private sector involvement (Le Grand and Bartlett, 1993). The key feature

of the NHS internal market was the separation of purchasing and provider functions within NHS organisations. Purchasing organisations would later become known as commissioning organisations and were administrative structures responsible for making key decisions about the clinical services that were required to meet the needs of the local population. Since it was introduced the internal market has been subject to numerous reforms. The different organisational forms will now be briefly explained to contextualise how the commissioning organisations that are investigated in this study came into existence.

Health Authority Purchasing

In 1989 *Working for Patients* (Department of Health, 1989) set out plans to make the NHS more responsive to needs; stimulate a better service; enable hospitals which best met needs to get the money to do so; reduce waiting times and improve services; cut junior doctors' hours; help family practitioners improve their services through budget-holding; improve the effectiveness of the NHS; and improve value for money. The new internal market was at the heart of reforms. The *National Health Service and Community Care Act* (Secretary of State for Health, 1990) outlined how this would be achieved with GPs and local authorities tasked with acting in the interests of local populations to purchase health and social care from providers under the system known as Health Authority Purchasing. Both purchasers and providers remained publically funded organisations, with providers becoming self-governing trusts that were able to compete with each other for business. It was assumed that by giving purchasers the power to decide where to purchase services from, provider efficiency would improve to drive down the cost of services and create better value for money (Department of Health, 1989). Health Authorities were issued a weighted capitation budget and their purchasing responsibility became mandatory across the whole country. The blanket implementation of the scheme made it difficult to research the implications of the policy and make comparisons of its success across different sites (Mulligan, 1998a).

Instead of healthcare being funded through annual budgets, contracts for services were issued by Health Authorities as the purchasers of healthcare. Using a market system to force providers to compete for contracts was intended to spark

competition. However Health Authority Purchaser's powers were heavily restricted by the state and they were encouraged to maintain the activity and referral patterns that already existed (Mulligan, 1998a). In a true market, a shift from the worst performer to the best would be expected but with bureaucracy preventing change, there was little evidence that patterns of provision were changing under the quasi-market system (West, 1998). Data collected on Health Authority Purchasing only focused on activity measures such hospital length of stay which gave the impression of effectiveness but no indication of quality or access improvements (Mulligan, 1998a). It is unclear if Health Authority Purchasing was worth the massive reorganisation needed to achieve it (West, 1998) but the state reflected that the influence of the market was positive and continued to look for new ways to enhance its's influence.

GP Fundholding

Health Authority Purchasing was assumed to be successful in part and to incentivise the initiative further GPs were given the option to hold their own budgets and profit from any savings made through a scheme known as GP fundholding (Goodwin, 1998). GP fund holding ran between 1991 and 1999, and involved over half of all GP practices (Propper, Croxson and Shearer, 2002). Unlike Health Authority Purchasing, the scheme was optional and participating GPs were free to choose the services they purchased leaving Health Authorities with the responsibility of purchasing all other care required without any additional funds or incentives (Goodwin, 1998). Elective surgery was the most common example of GP fund holder purchasing as it was predictable and standardised; GPs chose their preferred provider hospital based on a negotiated a price often on an individual case basis. Hospitals were then incentivised to become more efficient for their GP fundholding patients but for the rest of the population, Health Authorities continued to purchase healthcare from hospitals using block contracts which did not have the same effect on provider behaviour (Propper, Croxson and Shearer, 2002). The savings GPs made may have contributed to an overall GP underspend of 3.5% in 1992/3 but most Health Authorities were in deficit (Mulligan, 1998a). This gave an impression of success for the GP fundholding scheme.

There was concern that the two different purchasing arrangements had created a two-tiered system where some patients had better access to services than others even when they were being treated for the same conditions in the same hospitals but there was little definitive evidence to suggest differences in service access for patients in GP funding holding practices and those not (Goodwin, 1998; Propper, Croxson and Shearer, 2002). To exploit the scheme further many GP practices collaborated and joined together to form consortia to pool resources and spread risk (The Kings Fund, 2012). Health Authority Purchasers also began to merge to overcome the problems they we experiencing with a lack of administrative infrastructure but this had the effect of distancing purchasers from the populations they were working for (Mulligan, 1998a). GP fundholding demonstrated some improvement with efficiency but ultimately competition was limited by a finite number of NHS providers and the system was heavily criticised for creating inequality for patients under the care of GPs who did not participate (Exworthy, Powell and Mohan, 1999).

Locality and GP commissioning

Based on the experience of Health Authority Purchasing and GP funding holding , the GP's unique knowledge of local population health needs and power to negotiate on their patients behalf was considered positive but the two-tier system that had developed was not (Goodwin, 1998; Mulligan, 1998a). To exploit the positive aspects, locality and GP commissioning was introduced which operated under the framework and budgets of Health Authority Purchasing but at a local level (Mays, Dixon and Publishing, 1996). The approach aimed to work with providers over longer periods of time to allow access to services to be developed to meet the needs of the local population but without direct control of the budget (Mulligan, 1998b). GP commissioning involved groups of mainly non-fund holding practices working together in a bottom up approach to propose service changes and developments to the Health Authority on behalf of their patients; in comparison locality commissioning drew together all GP practices in the Health Authority's area to gather the views of the GPs and channel those into the Health Authority's purchasing process (Mulligan, 1998b). Locality and GP Commissioning improved

relationships between GPs and Health Authorities but success was dependant on the local context and leadership style of the Health Authority which was most effective when it nurtured collaborative relationships (Shapiro, Smith and Walsh, 1996). Overall GPs considered that they had more influence on service reconfiguration under the scheme but while some positive changes were made, they were not always in the locality where they were initially intended to occur (Hart *et al.*, 1999).

Total Purchasing Pilots

The state continued to be committed to the use of markets and commissioning and GPs were keen to maintain a role. Some GPs were motivated to extend their role as healthcare purchasers and to build on this an experimental new voluntary scheme called Total Purchasing Pilots (TPPs) was introduced in 1994 to further explore the roles of commissioning and the market in the healthcare system (Miller *et al.*, 2015). TPPs built on the innovation that GPs had demonstrated with GP fundholding in their attempts to meet patient's needs more effectively (Mays and Mulligan, 1998). TPPs involved single GP practices or groups of practices with a delegated budget from Health Authorities. GPs were able to purchase all of the hospital and community health services not included in standard fundholding but the state offered little guidance on how this could be done, instead offering flexibility to GPs to use their expertise to improve efficiency (Mays and Mulligan, 1998). Concerns were raised that TPPs would incur higher administration costs and widen the gap between participating practices, thereby exacerbating the two-tier system that had been created with GP fundholding (Mays *et al.*, 1997). Evaluations of TPPs found that initiating local change was often successful but wider changes further afield were more difficult to achieve with GPs tending to focus on community services rather than risk destabilisation of acute provider organisations (Wyke *et al.*, 2003). This questioned the suitability of GPs being solely responsible for healthcare commissioning as change beyond their scope of practice was difficult to influence. However TPPs showed promise as they were being evaluated to examine the role of GP commissioning. Unfortunately the pilot was cut short by a general election and the true impact of TPPs was never realised.

In 1997 the new Labour Government relaxed the state's attitude towards the effectiveness of markets and GP fundholding was abolished along with the TPPs (Mays and Mulligan, 1998). New plans were made to replace the internal market with a new system referred to as integrated care in *The new NHS: Modern, dependable* (Department of Health, 1997). Purchaser/provider splits were retained but the focus of reform was directed towards patients being placed at the centre of care to allow decisions to be made based on need. This marked a move towards an organisational system based on co-operation rather than competition, with organisations working in partnerships to deliver high quality care, reduce waiting lists and integrate health and social care (Exworthy, Powell and Mohan, 1999). To drive quality improvement, new organisations including the National Institute for Health and Clinical Excellence (NICE) and the Commission for Health Improvement were introduced to deliver guidance and regulate standards. The *NHS Plan* (2000) outlined a 10 year strategy based on performance, integration and investment using huge increases in NHS budgets.

Primary Care Trusts and Practice-based Commissioning

To replace local Health Authorities and GP fund holders as the main purchasers of health and social care, Primary Care Groups (PCGs) quickly followed by Primary Care Trusts (PCTs) were introduced as new purchasing bodies, designed to reconnect services with local communities and influence their development (Department of Health, 2002). 481 PCGs replaced Health Authorities in 1999 with the responsibility of commissioning primary and community health services. It was intended that PCGs would then develop into PCT who took over hospital commissioning.

PCTs were tasked with purchasing the majority of primary, community, secondary and tertiary care. The function of PCTs was to assess local need, plan and secure health services using 80% of the NHS budget from NHS Trusts who continued as the main providers of healthcare (Figueras, Robinson and Jakubowski, 2005). PCTs were predominantly administrative organisations but did also provide primary and community services in an attempt to place this type of care at the centre of the NHS rather than the focus being on secondary care. This arrangement was intended to improve integration between the different sectors and improve the health of

populations in the local community (Farrar, 1999). The combination of provider and commissioning functions in PCTs blurred the boundaries of the internal market's purchaser provider split (Smith *et al.*, 2010) suggesting a weakening of the state's commitment to the market. Initially 303 PCTs were formed but the number was quickly halved through mergers when they were considered to small achieve results (Department of Health, 2005a).

As part of the changes, NHS Hospital Trusts which performed well were given Foundation Trust status, to devolve power from the centre and give hospital providers more power to develop services to suit local population needs. As public benefit corporations, Foundations Trusts were accountable to local communities through a board of governors and licenced that ensured the values of the NHS were upheld (The Kings Fund, 2012). Foundations Trusts were given the freedom to manage their own financial affairs. The changes were viewed as a response to the previous problems associated with the hierarchical organisational system in the NHS, and specific learning from the successes and failures of the introduction of an internal market (Allen *et al.*, 2016).

Patient needs were prioritised under the new policy and GPs were reintroduced into purchasing through practice based commissioning. Practice based commissioning used devolved indicative budgets from the PCT to purchase specific services in the community and from hospitals for their patients (Smith *et al.*, 2010). PCTs provided participating GP practices with information about the services that their patients were using to help inform commissioning decisions. If decisions generated savings, practices were able to invest the windfall in new services. Although initially not inclusive of all GP practices, the state intended to have full coverage of practice based commissioning by 2006 to bring commissioning decisions closer to the patient (Department of Health, 2005a).

During the PCT and Practice-based commissioning era the state retained markets as a guiding principle but adapted the approach using *'four inter-related pillars of reform'* (table 2:1) as a mechanism for improvement (Department of Health, 2007a). This attempted to address the supply problems associated with a quasi-

market by opening up the market new government approved suppliers from other sectors to increase the choice available to purchasers and patients. The state considered the approach to be effective and increased NHS budgets from £33 billion in 1997 to £67 billion in 2004 to maintain the momentum of improvement. Plans continued to focus on making the NHS more responsive, convenient and personalised to patients and by 2005 it was planned that patients would have the choice of at least five providers for their care (Department of Health, 2004).

Table 2:1: Brief for health reform evaluation programme (Department of Health, 2007a)**: Summary of the 'inter-related pillars of reform'. Adapted from Allen et al (2016)** (Department of Health, 2007a, 2007c)**.**

Pillar of reform	Characteristics	Rational
Demand	Enhanced patient choice from 'Any Willing Provider' Cost per case through introduction of 'PbR' Increase choice through 'Any Qualified Provider' policy	Empower patients and improve services Incentivise providers to improve quality and reduce waiting lists Increase diversity of market to create real choice
Transaction	Fixed price tariff for procedures based on national average costs	Incentivise providers to be more efficient
Management and regulation	Cooperation and Competition Panel guiding principles European procurement law Care Quality Commission Monitor	Standards of practice to govern practice (non-legal) Transparent (legal) Regulation and inspection Regulator of Foundation Trusts
Supply	Foundation Trust (state owned) Commissioner engagement with third sector	Mimic 3rd sector governance Expand supply through new providers

Despite the drive to increase choice for patients, commissioning through PCTs and Practice-based Commissioning was criticised for lacking organisational autonomy in comparison to secondary care counterparts and failing to develop the capacity and capability needed for system change due to a lack of clinical leadership and risk adverse managerial behaviour (Smith *et al.*, 2010). The quasi-market system was considered to be failing with professional dominance creating bias within the system for resources to be directed into acute care rather than elsewhere in the system (Ham, 2008). To address this, the World Class Commissioning Assurance System was introduced in 2007 as a tool to review and score the performance of PCTs against long term strategic objectives (Department of Health, 2007d). The Department of Health (2007c) set out 11 objectives to transform the way commissioners were expected to behave including local leadership; collaborative working; patient and public engagement; clinical engagement; local needs assessment; prioritisation of investment; service improvement and innovation; and developing strong procurement skills.

World Class Commissioning was an attempt to address the problems associated with establishing commissioning as an organisational principle in the NHS. Numerous reforms were seen to have hindered the establishment of commissioning as standardised practice and the World Class Commissioning objectives were intended to cement the purpose of commissioning (Sobanja, 2009). The outlook for World Class Commissioning looked promising as it showed commitment from the state to stabilise and develop commissioning but soon after it was introduced the financial crisis of 2008 hit. The period of high investment the NHS had enjoyed quickly changed to austerity. In 2009 predicted efficiency savings required for 2011 to 2014 were estimated to be between £15 billion and £20 billion. The government was losing public confidence on how effectively it was able to lead the NHS out of recession. In 2010 the government was replaced with a Conservative and Liberal Democrat coalition with NHS reform at the heart of their manifesto. The era or PCTs, Practice-based commissioning and World Class Commissioning was to be replaced with a new commissioning system in which forms the context for this research.

Commissioning context for the research

Reforms to NHS commissioning which began in 2010 form the policy landscape in which this research was situated. The political landscape has evolved but the organisational structure has not altered over the course of the research. Reform was driven by rising demand for healthcare from an aging population and concerns that standards of care were falling coupled with ongoing financial problems in the economy as a whole. The investment of the previous decade had not realised efficiency savings as expected and masked the problems the NHS was experiencing by absorbing the additional cost of population change and treatment advancements (Watson, 2013). Major reforms were considered necessary to make the NHS affordable again and reduce the risk of deterioration in quality. Changes to the organisation of commissioning were one of the most significant reforms to be implemented in recent times.

Clinical Commissioning Groups

Equity and excellence: Liberating the NHS 2010 set out a new NHS strategy (Department of Health, 2010). The new policy aimed to empower professionals to deliver high quality, evidence-based affordable care while at the same time making them accountable for the results they achieved. Patients would be involved in decision-making processes and encouraged to take control of care through the power of choice. GPs were to continue to use their knowledge of local population needs and be responsible for local commissioning decisions through compulsory membership to new Clinical Commissioning Groups (CCGs). CCGs were tasked with commissioning the majority of care from secondary and community providers. Initially they were not responsible for primary care commissioning but this function was introduced later in 2015. Developing the link between the different sectors was considered essential for creating a responsive healthcare system and placing GPs at the forefront of commissioning was a strategy to ensure that negotiations for the right services for the local population would be made (Smith *et al.*, 2010; Naylor *et al.*, 2013). Although reforms marked a change of organisational approach, the market system was retained and sought to be strengthened further as market like

behaviour between provider organisations was still considered the most effective methods of generating improved quality and efficiency (Allen *et al.*, 2016).

The reforms were finalised in the *Health and Social Care Act 2012* (Secretary of State for Health, 2012) and involved large scale structural reorganisations. The plan abolished PCTs and Local Health Authorities and replaced them with the NHS Commissioning Board and over 200 CCGs. The legislation was designed to create a level playing field for providers, while giving patients the freedom to be involved in decisions about their own and their local population's healthcare. Integration between health and social care remained on the agenda with new Health and Wellbeing Boards being tasked with bringing commissioners from the two sectors together (Secretary of State for Health, 2012). The reforms created a complex organisational network which required new inter-organisational relationships to be formed. The system was criticised for its over-complication of organisational processes and failure to liberate the NHS from bureaucracy (Walshe, 2013). However the plans did attempt to address problems of the past by making the CCGs mandatory and statutory with legal structures in place to ensure good governance and accountability, with clinicians rather than managers responsible for real budgets with exposure to full financial risk (Naylor *et al.*, 2013). However Naylor et al (2013) considered that although this established legal autonomy, the CCGs would be more constrained through horizontal and vertical accountability and were at risk of being restricted by residual ingrained organisational behaviours of the past which would restrict change. CCGs came into existence in April 2013 with a new organisational structure for commissioning that encompassed the whole primary care system (table 2:2).

Table 2:2: CCG Organisational structures	
Members	All GP practices in the locality with a nominated practice representative to attend CCG meetings on behalf of the practice
Governance	CCG Governing Body including elected GP chair, member representatives, executive team representatives, lay members and representatives from local partners (e.g. Providers, other CCGs) Specific committees report to the Governing Body
Management	Executive team and wider support team – either clinicians or professional managers Member council responsible for liaising with the governing body and executive team

Source: Secretary of State for Health (2012), Naylor et al. (2013).

Rather than commissioning for process or volume targets, CCGs were to commission for quality using the Commissioning Outcomes Framework (Secretary of State for Health, 2012). The Commissioning Outcomes Framework set out national outcome goals that would be translated by the NHS Commissioning Board into locally meaningful outcomes and indicators. The framework was intended to be used to drive local quality improvements, reduce health inequalities, and hold CCGs to account on the quality of health services commissioned (NHS Commissioning Board, 2011). CCGs were given the freedom to be innovative and manage their own budgets with strict limits on the amount that could be spent on administration to ensure that money was directed into clinical services (Secretary of State for Health, 2012). Emphasis was placed on competition with competitive procurement to be preferred over other methods of purchasing, although not in all circumstances and NHS commissioners were given responsibility for finding a balance between competition and co-operation between providers (Secretary of State for Health, 2012). However regulations controlling competition and patient choice were criticised for being misleading and confusing. It was implied that competition need not be forced if there was no clear benefit for patients which contradicted legal opinion that only in exceptional cases could competition be avoided (Gerada, 2013). Gerada (2013) argued that this may inhibit CCGs from making the right choices for

patients because of a tightly enforced market system driven by profit and not quality.

Although reforms are relatively recent, evidence has emerged which explored the impact of CCGs and commissioning arrangements. Prior to the 2013 legislation coming into force, the Pathfinder programme enabled aspirant CCGs to move forward towards becoming authorised organisations; these organisations were studied to learn lessons for the future development of CCGs (Checkland, Coleman, *et al.*, 2012). Checkland et al. (2012) found that despite relatively high enthusiasm and engagement in the Pathfinder programme, CCGs were emerging in a turbulent NHS which made change complex and confusing. This was made more challenging by expectation that CCGs were expected to develop within their local context without clear guidance about organisation structure (Checkland, Coleman, *et al.*, 2012). An important consideration for this research was that the historical background on which the CCGs were built was highly influential in how the new CCG tasks were perceived and approached; previously established institutional behaviours were found to impact on development (Checkland, Coleman, *et al.*, 2012), especially as histories exhibit an enduring nature and shape natural organisational relationships (Checkland, Harrrison, *et al.*, 2012).

Despite emphasis on competition, collaboration was a key theme for CCGs which suggested that the way in which organisations work together would be of particular importance and a key focus of this study. As CCGs came into existence in 2013, policy exhibited a softened attitude towards competition and markets implying that collaboration between providers was becoming a greater priority (Allen *et al.*, 2016). Prior to the data collection period for this research, the *Five Year Forward View* (2014) was published, setting out the NHS's plans for transformation. It focused on organisations establishing collaborative relationships and working towards an integrated system (NHS England *et al.*, 2014). It did not mention the need for competition despite CCGs being legally obliged to follow competition law and use competition wherever possible (Secretary of State for Health, 2012). To achieve effective integration of services and continuity of care for patients as they move between providers, collaboration between organisations is considered

essential (Ferlie *et al.*, 2013) and it would be logical to assume that competition may negatively impact on collaborative relationships. This suggested that at the time of this study the policy context was inherently contradictory with the *Health and Social Care Act* (2012) demanding competitive procedures and the *Five Year Forward View* (2014) promoting collaboration and integration using new models of provision as suggested alternative commissioning arrangements..

New models of provision

The *Health and Social Care Act* (2012) reforms attempted to address the problems the NHS was experiencing in the financial crisis and by 2014 it was widely agreed that change was no longer optional. NHS England published the *Five Year Forward View* (NHS England *et al.*, 2014) in response to challenges it faced. The underlying theme of the *Five Year Forward View* (2014) was that the current organisation of the NHS was financially unsustainable. An aging population, increased life expectancy and complex health needs, rising costs of medical and social care interventions were contributing factors (The Kings Fund, 2017) which drove the *Five Year Forward View's* (NHS England *et al.*, 2014) call for radical change.

The *Five Year Forward View* (NHS England *et al.*, 2014) set out a blueprint for how better integration in the NHS could be achieved using new models of provision (table 2:3). All of the models involved collaborative relationships between providers from different sectors of the healthcare system and required commissioners and providers to work openly together towards shared goals (Ham and Murray, 2015). The models focused on improving quality of care for patients while addressing the inefficiency within the existing system. The Five Year Forward View suggested that a different approach to commissioning was required to implement new models of provision. Commissioners were required to consider alternative contracting arrangements for the different models of provision outlined as a commissioning mechanism to procure care. For the purpose of this research, discussion will focus on the Primary and Acute Care System (PACS) model of provision as this study seeks to understand how different medium to large organisations work together to provide integrated stroke care (explanation for stroke services given later in the chapter).

Table 2:3: Summary of new models of provision proposed in Five Year Forward View (2014)

Model	Organisation	Benefits
Multispecialty Community Providers (MCP)	Groups of GP practices form federations, networks or single organisations to allow an increase in the range of services offered	Shift consultant and other health professionals from hospital to MCP to work alongside primary care Expand diagnostic services Direct admission to hospitals Manage a delegated budget
Primary and Acute Care Systems (PACS)	Vertically integrated care from different places in different health economies e.g. Lead provider and joint venture models	One accountable organisations Improved integration between organisations e.g. acute and community New models of care to address issues with traditional models
New care model – urgent and emergency care networks	Improved organisation and simplification of the emergency care system (building on major trauma centre models)	Increased access to out of hours GP and community care centres Seven day services
New care model – viable smaller hospitals	Sustainable local hospitals for non-specialised care	Shared administration with larger hospitals Locations for outreach specialised care Opportunity for PACS system
New care model – specialised care	Centralisation on specialised services to increase quality of care where a relationship between patient volume and quality exists	Increased access to expensive services and equipment Proven track record with stroke services
New care model – modern maternity services	Sustainable and modern maternity services led by increased numbers of midwives	Reduced hospital births and strain on acute services Safe and responsive care by specialists in locations where women want to give birth

New care model – enhanced health in care homes	In reach care home health care to prevent admissions and promote wellness	Regular assessment and proactive intervention Reduced hospital admission and improved quality of life.

Source: Five Year Forward View (2014)

The *Five Year Forward View* (2014) recommended PACS as a mechanism to provide NHS care to patients in the different locations and forms required e.g. hospital and community care. Two suggested but not exclusive methods of achieving this were Accountable Care Organisations (ACO) where different organisations joined together to form a new organisation, or a lead provider model where one organisation takes responsibility for proving the care required by working with closely with other organisations. ACO are relatively new concepts in healthcare where collaborating organisations are jointly responsible for quality improvement and reduction in costs (Rosenbaum and Burke, 2011) with modest evidence to support reduced overall financial spending through integration but little evidence to suggest improvements in healthcare quality (Colla and Fisher, 2017). In a lead provider model, the lead provider subcontracts aspects of care from other service providers which allows the lead provider rather than the commissioner to choose their preferred provider. Evidence suggests that lead provider models may be useful for improving co-ordination and collaboration between organisations but the impact on quality is not yet known (O'Flynn *et al.*, 2014).

Ham and Murray (2015) highlighted concerns with PACS including the stark differences between the different organisations that the models attempt to draw together including contracting, employment, and broader cultural differences as well as the time required to establish coherent and collaborative working practices. Although another form of reorganisation, the creation of PACS was thought be preferable as it represented internal evolution with an emphasis on local leadership rather than another top down reorganisation from the centre (Ham, 2017). The *Five Year Forward View* represented a change of direction in an already turbulent time. The new CCGs were still getting to grips with their existing commissioning arrangements and were struggling to form decisive plans for implementation of the

Five Year Forward View (2014) a year on from its publication (Maruthappu, 2017). Any moves towards developing PACSs have been slow and cautious suggesting uncertainty in how to proceed (Ham, 2017) reflecting again the uncertainty in the development of CCGs role (Checkland, Coleman, *et al.*, 2012).

The *Five Year Forward View* (2014) appeared to neglect existing commissioning policy and reflected the NHS England's views on how services should be organised and delivered, rather than aligning with the state's policy on health and social care organisation. Although PACS were seen to have the potential to improve integration, there were concerns that without changes to existing commissioning regulations PACS could be in breach of competition regulations by forming a monopoly (Ham and Murray, 2015) which questioned if the existing funding and procurement regulations were suitable for the new models of care being suggested. The contradictions between the collaborative and competitive approaches had not been resolved through alignment in policy or changes to legislation (Allen *et al.*, 2016) meaning that the research in this study was conducted in a turbulent political landscape with mixed messages being directed from the state and NHS to local health networks.

Commissioning summary and research propositions

As a state funded and administered organisational concept, the NHS has always been challenged with providing high quality healthcare using finite budgets. The NHS today is facing its most challenging times with spiralling demand and rising costs which is now considered to be unsustainable (NHS England *et al.*, 2014). Commissioning was introduced along with the internal market system in the 1990s to address similar problems using the principles of management and competition to drive efficiency and quality improvement.

Commissioning has since undergone numerous reforms but the basic principles have remained the same. CCGs are the current organisational arrangement for commissioning most of the services delivered by the NHS. State policy requires that commissioners use the market system wherever possible when commissioning services while following bureaucratic administrative procedures and relying on the

clinical expertise of the medical profession to guide decision making. This reflects the regular battle policy makers have had balancing the dominance of the medical professions informing how the NHS is organised with state controlled administrative procedures that have principles drawn from both the private and public sectors. It suggests that the NHS experiences multiple and often contradictory demands that may make it difficult for organisations to function effectively within it.

Of particular importance in current policy is the mismatch between competition and collaboration. The Health and Social Care Act (Secretary of State for Health, 2012) appeared to give commissioners freedom to find a balance between provider competition and co-operation but the policy lacked clarity. With integration considered essential, the new models of provision suggested in the Five Year Forward View (NHS England *et al.*, 2014) drew on principles of collaboration between existing providers of healthcare and made no reference to the need for competition to commission the new models. However with no changes made to policy on how commissioning should be conducted, there appeared to be little guidance on how to nurture collaborative relationships between organisations while still expecting competition to drive efficiency and quality improvements. The state appeared to project a disordered alignment with public, private and clinical professional administrative procedures and raises the question of how organisations are able to form collaborative arrangements when policy is confused and contradictory. Tensions between the medical profession and the state, and the state's position on healthcare as a public or private entity have never been fully resolved suggesting that the beliefs and behaviours of each group may have important implications for how policy is designed and implemented, and if it succeeds in achieving its intentions. To investigate this further a specific research context was required. This is described in the next section of this chapter.

The Research Context: Commissioning stroke services

Stroke is a major health problem and the fourth largest cause of death in the UK. Each year over 100,000 people in the UK suffer a stroke but many people survive and there are over 1.2 million stroke survivors living in the community (Stroke Association, 2017). Stroke occurs when the blood supply to the brain is interrupted by a blood clot blocking a blood vessel or a when a blood vessel bursts. The area of the brain effected is then damaged as it is starved of oxygen (WHO, 2013). As a stroke occurs, the sufferer commonly experiences sudden onset of weakness, numbness, speech difficulties and visual disturbance (Stroke Association, 2013). Severity can range from mild to severe loss of function or death. In some case recovery is spontaneous and complete but often stroke survivors are left with life-long residual impairments that may be exacerbated by the individual's personal and social circumstances (Walker, Sunnerhagen and Fisher, 2013). Around a third of all survivors live with severe disability (National Audit Office, 2010). The annual cost of the health and social care associated with stroke is around £1.7 billion in England (Stroke Association, 2017) although the cost to society through loss of productivity and welfare needs is thought to exceed £9 billion annually (Saka, McGuire and Wolfe, 2009).

Stroke is associated with but not isolated to old age (Care Quality Commission, 2010) and risk factors include smoking, obesity and high blood pressure meaning people living in areas of high social deprivation are at greater risk (Care Quality Commission, 2011). As the population ages and becomes increasingly unhealthy, the problem of stroke is likely to increase. As stroke treatments have improved, many more people survive stroke but are often left with disability and require long term health and social care in the community. This makes stroke a substantial health and social problem for the state that requires effective and cost efficient interventions to meet the needs of society in all sectors of the health service.

Stroke services

Health and social services for stroke fall into several categories; prevention, acute treatment, rehabilitation, community services and social care (Royal College of

Physicians, 2016b). Each of these categories are distinct but inter-related and delivered in different organisational contexts. This is often referred to as the stroke pathway (of care) and to be most effective all elements of stroke services should be joined up, integrated and funded from hyper-acute care to long term community support (Sudlow and Warlow, 2009). Although prevention is highly important, it is concerned with the management of co-morbidities and risk factors associated with stroke rather than the consequences of stroke itself. Similarly social care services usually provide generic support rather than stroke specific. This study is concerned with the commissioning of stroke specific services and for the purpose of providing relevant context, only stroke specific services will be discussed from herein.

Acute stroke treatment

Traditionally stroke was considered a consequence of aging. It was not until later in the 20th century that stroke was considered a disease that could be treated and managed (Pound, Bury and Ebrahim, 1997). A government white paper, *The Health of the Nation – A Strategy for England* (Department of Health, 1992) highlighted stroke as a priority sparking a research drive to investigate new treatments and care options. Following this, dedicated hospital treatment units for people suffering stroke began to emerge based on new treatments for stroke (Pound, Bury and Ebrahim, 1997). As stroke became better understood, it became clear that care delivered by specialised stroke professionals in dedicated stroke units was found to increase survival and independence with many more stroke survivors able to return to life in a community setting rather than institutionalised care (Stroke Unit Trialists' Collaboration, 2000).

To increase the chance of success, treatment needed to be delivered quickly after stroke onset (Stroke Unit Trialists' Collaboration, 2000) which required massive reorganisation of services across the country. This was initially slow but the National Stroke Strategy (Department of Health, 2007b) set out plans to deliver reorganisation with substantial financial support from the government. Soon patients suffering stroke were increasingly likely to be treated in a dedicated stroke unit. Many stroke units incorporated research communities and new treatments began to emerge. Thrombolysis treatment was a major breakthrough. When

administered within 4 hours of stroke, thrombolysis was found to be successful at breaking down blood clots in the brain and significantly reducing stroke symptoms in a specific group of patients when delivered by expert clinicians (Robinson, Zaheer and Mistri, 2011). However a lack of organisational structure prevented thrombolysis from becoming routine care (Pérez de la Ossa *et al.*, 2009) as the treatment relied on rapid assessment and treatment in a specialist centre.

Thrombolysis offered an opportunity to reduce the cost of stroke care. Predicted savings from reduced care needs in patients treated with thrombolysis were estimated at £16 million per year (National Audit Office, 2005). To encourage quicker response times to stroke onset, the *'Stroke – Act F.A.S.T.'* (NHS, 2008) campaign aimed to raise awareness and call for the general public to seek immediate emergency treatment for stroke and emergency calls for suspected stroke rose 54% (National Audit Office, 2010). Strong organisational links between ambulance services and hospitals, as well as stroke evidence and policy aided the development of hyper-acute stroke units and has helped to improve the care stroke sufferers are likely to receive. By 2015/16, 58.3% of stroke patients were admitted directly to dedicated stroke united meaning that 84.9% of eligible patients received thrombolysis (Sentinel Stroke National Audit Programme, 2016). Although progress has been made, the Sentinel Stroke National Audit Programme (2016) highlighted that some areas of the country have better provision than others and further work could be done to improve access to care, especially in post stroke rehabilitation services.

Stroke rehabilitation

Although the developments in acute stroke treatment sought to cure stroke symptoms, a cure remains elusive and many stroke survivors are left with residual impairments that require ongoing rehabilitation. Stroke rehabilitation is a labour intensive process used to promote active recovery, provide support as disability is overcome and prevent deterioration through careful planning for care needs (Gladman, 2000). Progress has been made in developing effective stroke treatments and treatment from a highly skilled specialist multidisciplinary team can lead to functional improvement and long term survival (Drummond *et al.*, 2005),

reduce length of hospital stay and allow more stroke survivors to return to their own homes rather than institutional care (Stroke Unit Trialists' Collaboration, 2000). Most stroke units offer early rehabilitation in hospital followed by two different types of community based stroke rehabilitation.

Early supported discharge

Early supported discharge (ESD) is a time limited intensive service for stroke survivors with mild to moderate symptoms which aims to accelerate discharge from hospital by delivering specialised interventions at home (Fisher and Walker, 2011). ESD reduces costs and improves long term outcome for eligible stroke survivors (Langhorne and Widen-Holmqvist, 2007; Hillier and Inglis-Jassiem, 2010; Fearon, Langhorne and Trialists, 2012). It is recommended to be part of the stroke care pathway (Quality Standards Programme, 2010; Fisher and Walker, 2011; NICE, 2013) and is now available in 81% of the country (Sentinel Stroke National Audit Programme, 2016).

The strong evidence to support ESD led to its inclusion in the National Stroke Strategy (Department of Health, 2007b) which helped to apply pressure to commissioners to include ESD as part of their stroke services (Fisher and Walker, 2011). Despite this translation and implementation of evidence into practice has been problematic (Walker *et al.*, 2013) and hindered by inadequate resources, poor guideline structure and insufficient educational training (Donnellan, Sweetman and Shelley, 2013). To provide greater clarity and detail about the ESD model, a consensus statement documenting the essential elements of the service was published (Fisher *et al.*, 2011) but gaps and variation in services still exist (Sentinel Stroke National Audit Programme, 2016).

ESD has a financial incentive which has been used to drive implementation. Hospital stroke care commands a defined payment was part of the Payments by Results (PbR) national tariff system (Department of Health, 2012). By reducing length of hospital stay using ESD, hospitals could expect a higher turnover of patients and generate a greater income from PbR while making cost savings on their care budget (Fisher and Walker, 2011). The NHS Improvement Programme (2008) recommended

'unbundling the national tariff for acute care to direct funding into specialist rehabilitation (whether into a rehabilitation unit, ESD or community team, or elsewhere)' (NHS Improvement Programme, 2008) to promote creative development of services but there was no specific guidance as to which organisations should deliver ESD or how money flows between different payments structures in different types of organisations may be managed. Overall, the implementation of ESD has been successful but slow and not to the extent of reorganisation achieved with acute stroke services.

Community stroke teams

Optimum stroke recovery requires provision of coordinated specialist rehabilitation for many months after discharge from hospital (Walker, Sunnerhagen and Fisher, 2013). ESD supports a select group of eligible patients but not the needs of the whole stroke population both at discharge from hospital and in the longer term. Community stroke teams (CSTs) offer a solution to this problem by providing less intensive but more inclusive and longer term stroke specific interventions (Fisher *et al.*, 2013). Evidence to support CSTs is less robust than ESD because they are less well defined and difficult to evaluate but to assist commissioning decisions Fisher et al. (2013) published a consensus statement advising how best to deliver long term stroke specific rehabilitation in the community.

CST may improve care and standard of living for stroke survivors (Walker, Sunnerhagen and Fisher, 2013) and address issues of abandonment often felt on discharge from hospital (Department of Health, 2007b). Reports suggest that over half of stroke survivors report unmet needs in the five years post stroke (McKevitt *et al.*, 2011) but progress to develop CST has been slow and inconsistent (Walker, Sunnerhagen and Fisher, 2013). In comparison to ESD, CSTs are rooted firmly in the community setting and often have less well established links to the acute hospital setting which may explain the difficulty in developing services of this type for the stroke population. The financial implications of CST are also less well defined than acute stroke units and ESD but they may be well placed to prevent post stroke admissions to hospitals and reduce the burden on acute services. However, these are more likely to be associated with general medical problems that stroke specific

problems which reduced the potential impact on the stroke pathway itself. Without a clear link to changes upstream in the stroke pathway, CST is likely to struggle to negotiate reallocation of funds in the same way that ESD had the potential to.

The challenge of commissioning a stroke pathway

Stroke services are an example of a clinical service that required different aspects of care to be delivered by different types of organisations. This was consistent with commissioning policy which called for improved integration between different types of organisations in the NHS, making it an appropriate context to explore the propositions made for the research. Responsibility for commissioning of stroke services lay with CCGs who decide which services their local population require and then purchase services from providers using procedures outlined in the *Health and Social Care Act 2012* (Secretary of State for Health, 2012).

Clinical guidelines suggest that stroke services should be delivered in a seamless pathway of care and the different provider organisations should work together in an integrated way to deliver high quality care (NICE, 2013; Royal College of Physicians, 2016b). To improve delivery of healthcare to stroke survivors and drive improved outcomes, hospital stroke services were successfully reorganised into dedicated stroke units (Stroke Unit Trialists' Collaboration, 2000; Department of Health, 2007b) but changes to the rest of the stroke pathway as it moves into the community setting have been slow and sporadic (Walker, Sunnerhagen and Fisher, 2013). This suggests that the commissioning drivers at different points in the stroke pathway may be different and commissioning services that cross organisational boundaries may be challenging making stroke a possible example of the problems associated with commissioning that have been highlighted in this chapter.

Conclusion

The chapter has shown how commissioning in the NHS is an example of an organisational process that may be challenged by contradictions between the beliefs and behaviours of organisations within the field. Commissioning as a concept has existed along with the internal market for over 25 years but has often been criticised for failing to make desired improvements to the efficiency and quality of

healthcare delivery in the UK. Current policy calls for integration and collaboration between organisations as a mechanism to address spiralling costs and falling quality but contradictions in the beliefs and behaviour of organisations may make this difficult to implement.

This research sought to explore the propositions made using stroke as a commissioning example where integrated services were considered essential to the delivery of a stroke pathway of care. The propositions that the belief and behaviours of organisations are important to how effectively commissioning is as an organisational concept can nurture collaborative inter-organisational relationship suggested that organisations in the NHS had become institutionalised into a particular frame of reference that guided their actions. To explore this abstract concept, a theoretical framework was required to frame the research theoretically and develop research questions that could be used to investigate the complexity of commissioning.

Chapter 3: Theoretical framework: Institutional logics

Introduction

Commissioning was presented in Chapter 2 as an example of an organisational process that required organisations in a complex and often contradictory field to work together collaboratively. It was proposed that the beliefs and behaviours of those organisations may impact on how effectively organisations would be able to establish effective inter-organisational relationships. To explore this empirically in the research, a theoretical framework was required that would allow beliefs and behaviours to be conceptualised and studied as inter-organisational relationships played out in commissioning process. Institutional theory and specifically the institutional logics perspective is presented here as the theoretical framework for the research.

Institutional logics are a theoretical concept situated within the broader literature of institutional theory. Institutions are social structures embedded within aspects of society that over time have developed resilience (Scott, 2001). These may include rules, norms and routines that become established as socially accepted as process of behaviour (Powell, 2007). Institutional theory has been used to conceptualise many organisational systems including healthcare. For example, in Scott et al's (2000b) seminal study of the United States (US) healthcare field, institutional theory was used to conceptualise how multiple institutional pressures within the field differ and compete, thereby creating conflict and variation. This research sought to understand how multiple institutional pressures within the United Kingdom (UK) healthcare system are being resolved through commissioning. Previous applications of institutional theory in healthcare suggested that the theory provided an appropriate theoretical framework to conceptualise the research, and it is within the boundaries of institutional theory's exploration of healthcare that this literature review is predominantly framed.

Within the institutional theory literature, institutional logics have emerged as a key concept (Thornton and Ocasio, 2008). Institutional logics have an important role in explaining the complexity of organisations by using a theoretical typology that can be used to conceptualise beliefs and behaviours (e.g. Reay & Hinings 2009; McDonald et al. 2013; Martin et al. 2015). This chapter will introduce institutional logics as the theoretical framework used in this research.

To do this, core conceptual definitions important to the research will first be outlined to explain how the boundaries of the field, organisations and inter-institutions were considered within literature review and the empirical study that follows. An overview of institutional theory will then be presented to demonstrate the theoretical underpinning of institutional logics. Following this, key literature examining how institutional logics can be used to explain organisational behaviour will be explored to gain an understanding of the current application of the framework and consider how effective it is in conceptualising organisations. Attention will be paid to what institutional logics claim to explain and where the theory lacks explanatory power. This will be used to direct the focus of this research and present the theoretical questions which were used to guide the empirical exploration of commissioning in the NHS presented in Chapters 5, 6 and 7.. Institutional logics will then be applied to the contextual setting of commissioning as a basis for explaining how the institutional logics perspective was used to frame the research before the methodology is detailed in Chapter 4.

Conceptual definitions

Conceptual definitions are important as they define the boundaries in which research is conducted and framed. Concepts like organisations and the fields in which they inhabit are important cornerstones of institutional theory but research often lacks clear conceptual definitions to allow studies to be compared (Zietsma *et al.*, 2016). The terms organisational field, organisation and inter-organisational system are defined below to give clarity to what each refers to when they are referred to in this research.

Organisational field

The term organisational field refers to *"those organisations that, in the aggregate, constitute a recognised area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organisations that produce similar services or products"* (DiMaggio and Powell, 1983). The boundaries of a field are not geographical or structural, but cultural and functional (Scott, Ruef, P. Mendel, *et al.*, 2000b) in the way in which organisations and individuals behave and interact in under a common meaning system (Scott, Ruef, P. Mendel, *et al.*, 2000a).

The term organisational field or field in this research refers to the field of healthcare, specifically healthcare in England within the confines of the services provided by the NHS in a similar way to how Scott et al (2000b) define their study of healthcare in the United States. However the field is not the NHS itself, but all organisations that are associated with the delivery of healthcare under the umbrella of the NHS i.e. it includes NHS service providers and administrators such as commissioning organisations, but also other government agencies and external organisations that may influence the way in which healthcare is delivered.

Organisation

An organisation refers to a structured social unit that functions to pursue a collective goal or purpose (Wooten and Hoffman, 2008). An organisation can therefore be more easily defined by its structural boundaries and within that, the goals and functions can be defined. For example, within this research commissioning and healthcare provision are both confined to their own organisations with different functions. These are explained in detail in Chapter 2. Organisations are not however purely structural. Organisations are embedded in social environments that influence their behaviours (Pache and Santos, 2010). This social environment refers to the influence of institutions at a societal level or field level known as the inter-institutional system (Friedland and Alford, 1991).

Inter-institutional system

The inter-institutional system refers to the social environment as it is socially constructed by institutions. *"Institutions consist of cognitive, normative and*

regulative structures and activities that provide stability and meaning to social behaviour" (Scott, 2001). Friedland and Alford (1991) considered that society was socially constructed with multiple ideal type institutions and referred to this as an inter-institutional system. The term is used in this research to describe the complexity of institutions within the field explored empirically . The concept of ideal type institutions as component of the inter-institutional system are elaborated later in the chapter.

Institutional theory

'Institutions are social structures that have attained a high degree of resilience. [They] are composed of cultural-cognitive, normative, and regulative elements that, together with associated activities and resources, provide stability and meaning to social life. Institutions are transmitted by various types of carriers, including symbolic systems, relational systems, routines, and artefacts. Institutions operate at different levels of jurisdiction, from the world system to localized interpersonal relationships. Institutions by definition connote stability but are subject to change processes, both incremental and discontinuous.' (Scott, 2001)

Institutional theory is a theoretical framework and orientating strategy used to analyse social phenomenon (Lawrence and Shadnam, 2008). It can be used to explain structure and agency at different levels in society and used to explain both individual and organisational action (Dacin, Goodstein and Richard Scott, 2002). Institutional theory seeks to understand how institutions embedded within organisations create a social order that guides acceptable behaviour (Lawrence and Shadnam, 2008). It is a large and diverse literature and for the purpose of this thesis, discussion is confined to neoinstitutional theory and the institutional analysis of organisations. Neoinstitutional theory is used to understand how organisational behaviour and structure is influenced by cultural rule and belief systems (Powell, 2007). Key concepts within the institutional theory will now be explained to conceptualise the literature within which institutional logics sits. To do this the concepts of isomorphism, institutional pillars, the inter-institutional system and

institutional change will be briefly explained before the institutional logics perspective is introduced.

Isomorphism

Organisations are systems of controlled and coordinated activity that arise in highly institutionalised contexts (Meyer and Rowan, 1977). Meyer and Rowan (1977) described how professions and practices are created under rationalised concepts of legitimate organisational work and how the formal structure of an organisation provided a blueprint for activity based on controlled administrative procedures associated with rational economic theory and Weber's (1922) theory of bureaucracy. They argued that this assumed that rational formal structure was the most effective way to control complex relational networks but neglected the wider institutional environment that contributed to organisational behaviour (Meyer and Rowan, 1977). To overcome this problem, institutional theory was used to begin to explain the complexity of organisational fields and how organisations operate within them.

Organisational fields are structured according to their institutional definition. This structuration is known as isomorphism and refers to how organisations change to become characteristically similar by creating a set of institutional rules to which they conform and legitimise behaviour. Early theorists explored how cultural influences from wider society led to the isomorphism of organisations within a particular field (Meyer and Rowan, 1977; DiMaggio and Powell, 1983). Meyer and Rowan (1977) for example considered that isomorphism was confined to an organisation's structure which may *'predispose organisations to the tensions of needing to simultaneously satisfy the external requirements of their institutional environment while accomplishing their internal technical mission'*. Therefore the goals of an organisation are more difficult to achieve when they are bound by structural institutions that have been created externally rather than internally. To overcome these organisations may change their structure to ensure that they are similar to other organisations in the same field. This makes their behaviours socially acceptable as they appear to conform to external structural expectations.

DiMaggio and Powell (1983) theorised that as an organisational field becomes more structuralised, organisational isomorphism of forms and practices increases, thereby making organisational forms look increasingly similar through a process of organisational rationalisation. Structuration consists of four parts; increased interaction between the organisations in a field; the emergence of defined inter-organisational process; increased information exposure; and increased activity awareness between organisations in the field (DiMaggio and Powell, 1983). How structuration occurred was considered to be dependent on sources of rationalisation and the institutional activity of the professions, the state and the markets associated with an organisation (DiMaggio and Powell, 1983). These early developments in institutional theory concentrated on how institutionalised organisational practices were diffused and reproduced but failed to address the influence of agency and self-interested individual behaviour (Thornton, Ocasio and Lounsbury, 2012).

Institutionalised practices are said to be legitimised when they become recognised, accepted and taken for granted (Carroll and Hannan, 1989) as they are reproduced in organisations. DiMaggio (1988) criticised his own work for failing to explain how institutions originated or disappeared but suggested that through preference for certainty and legitimacy, individuals are unlikely to behave against predetermined norms or manipulate organisations for their own gain. This appeared to neglect the possibility of autonomous behaviour. To address this DiMaggio and Powell (1991) called for a wider scope of enquiry to include broader sociological themes that considered the cognitive and cultural elements of organisations and institutions rather than concentrating on structuralism. However their theory continued to neglect the influence of self-interested behaviour and agency, instead focusing on 'mindless cognition'. This was criticised for its narrow scope and used to attack organisational isomorphism as a viable line of enquiry (Thornton, Ocasio and Lounsbury, 2012). In parallel, theories were developing to suggest that institutions were composed of institutional pillars that provided a deeper explanation for organisational and individual behaviour.

Institutional pillars

Scott (1995) identified the *'theoretical fault lines'* of institutional theory to draw together the key pillars that support organisations. These were termed institutional *'pillars'* that constituted belief and rule systems which affected organisational behaviour and structure. The pillars were formed from social structures that influenced agency through formal and informal procedures, norms and conventions embedded within society and organisations (Scott, 2001). Scott (2001) considered that organisations used structural and procedural rule and belief systems as they attempted to legitimise agency, thereby maintaining behaviour within accepted boundaries.

This line of enquiry allowed the wider complexity of the social environment to be embraced, conceptualised and understood by defining the institutions under which society is able to function. It accepted that organisations were subject to external processes that may exert different types of pressures. For example, through coercive processes the state exerted control over organisations through regulation; normative processes sustained by powerful professional groups and educational systems; and mimetic processes allowed habitual responses to uncertainty (DiMaggio and Powell, 1983). Scott (1995) built on this concept to show how the institutional environment comprised of regulative, normative and cultural-cognitive 'pillars' which contributed to an organisations stability and acted to provide meaning to behaviours. The regulative pillar referred to the rules and governance of organisations, the normative pillar encompassed the norms and values of social life within these structures, and the cultural-cognitive pillar defined how identity and meaning were interpreted within a given reality.

Scott (1995) considered institutional pillars to be associated with organisational legitimacy. He considered that each pillar had an identifiable source of legitimacy that was distinguishable but also related to sources of legitimacy in the others pillars. For instance, the regulative pillar allowed organisations to conform within legal constraints; the normative pillar aligned these constraints within moral beliefs and the cultural-cognitive pillar allowed meaning to be attributed to legal and moral obligations. The three different sources of legitimacy complemented each other to

define and justify organisational behaviour (Thornton, Ocasio and Lounsbury, 2012). Within an organisational field, pillars may vary between organisations and groups of individuals with specific functions within those organisations. However the theory suggested that the pillars were distinct entities but the boundaries may not be so clear.

Institutional pillars may be problematic because the normative pillar neglects to differentiate between potentially conflicting institutional logics (Thornton, Ocasio and Lounsbury, 2012). By using the example of conflict between professional and religious institutional logics, Thornton (2012) questioned if morality and ethics versus science and progress could be separated by a profession's use of cultural-cognitive processes. Norms and regulations may not be clearly separated from culture and cognition, because culture and cognition are required to instate and understand the meaning of norms and regulation. Thornton (2012) considered *'culture and cognition as more abstract concepts than norms and regulations, but also that norms and regulations were elements of culture and cognition as culture and cognition are the way in which individuals come to understand the meaning of norms and regulations'*. This suggested that a deeper understanding of the cultural cognitive pillars and a more complex explanation of inter-institutional systems was called for that addressed the different pillars and the agency that resulted at the boundaries and within the wider context of society.

Inter-institutional systems

Society is formed of many institutions which together form an inter-institutional system. The concept of the inter-institutional system allowed both individuals and organisations to be considered together (Friedland and Alford, 1991). To address the lack of cognitive and cultural considerations in previous institutional theorisation, Friedland and Alford (1991) sought to stimulate discussion around the interference of societal institutions in individual and organisational behaviour (Thornton, Ocasio and Lounsbury, 2012) and consider the competitive or collaborative relational aspects of institutions between different levels in society (Friedland and Alford, 1991). This provided the foundations for the institutional logics perspective which can be seen as a meta-theory whereby institutions could

be categorised as institutional orders, and subsequently broken down into different elements (Thornton, Ocasio and Lounsbury, 2012).

Institutional orders are the institutional subsystems of society (Friedland and Alford, 1991). Within each institutional order, a set of cultural symbols and material practices are used to inform a particular aspect of life. Friedland and Alford (1991) suggested examples of institutional orders could be the market, the bureaucratic state, democracy, the nuclear family and religion and considered that all aspects of society could be broken down into various combinations of these institutional orders. These components shaped individual and organisational interests, motivation and behaviour, and informed a sense of identity to allow a conscious and unconscious understanding self and associated legitimate action (Friedland and Alford, 1991). This development broadened the scope of enquiry into the components of institutional orders that could be found in the wider social sciences, and thereby allowed interdisciplinary theorising (Thornton, Ocasio and Lounsbury, 2012). Thornton (2004) conceptualised institutional orders by mapping them onto a matrix. The different institutional orders could be arranged across the x-axis, with the components of the orders mapped onto the y-axis (figure 3.1).

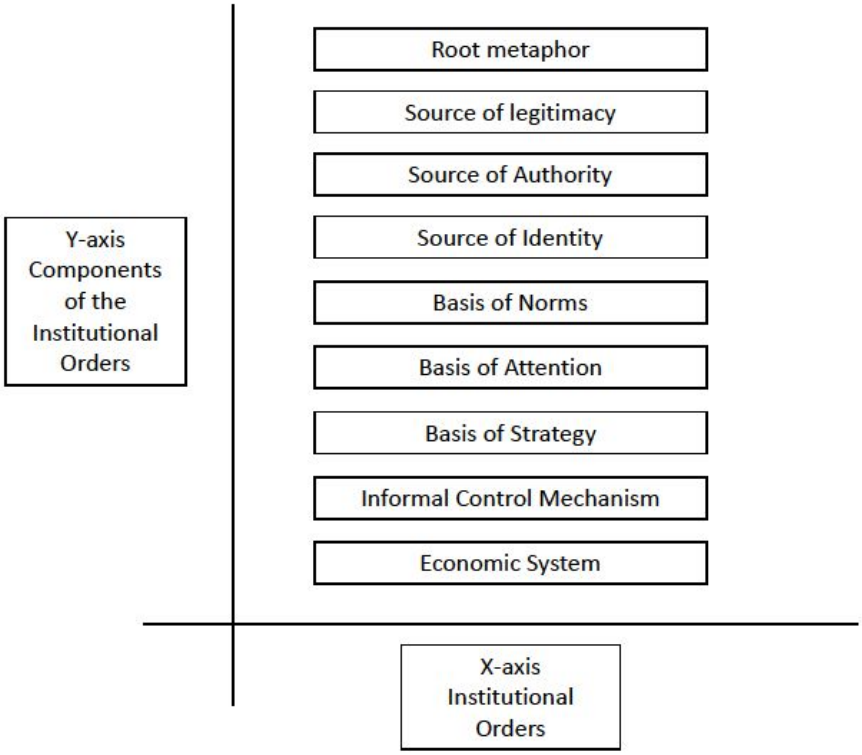


Figure 3.1: Matrix of institutional orders and components of institutional orders (adapted from Thornton, 2004)

The matrix allowed theoretical ideal type categories to be generated that could then in turn be used for empirical enquiry. By using ideal types, research could be focused towards certain components rather than attempting to consider all aspects of phenomenon simultaneously. The advantage to this approach was that organisational complexity could be acknowledged while focusing on specific components. Acknowledging the complexity of inter-institutional systems allowed contextual factors to be addressed and understood in real time as context is a fluid entity which may constantly change and adapt to the influences and pressures it experiences within society. Context allowed institutions to invisibly define the rules by which actions are performed and make action understandable and meaningful to the individuals in the contextual environment (Lawrence and Shadnam, 2008). This suggested that in turn, institutional orders could evolve and adapt with the context in which they existed but in the past institutional theory had neglected the dynamic characteristics of organisations and their contextual environment. It tended to focus on the persistence and homogeneity of institutions rather than considering them

fluid entities that could evolve and change over time (Dacin, Goodstein and Richard Scott, 2002).

As institutions change over time, certain institutional characteristics or the components of institutional orders may strengthen or weaken in different contexts (Powell, 2007). Changes in the inter-institutional system may be subtle, giving institutions time to adapt and evolve slowly or they may be sudden and create institutional uncertainty. For example, the introduction of the market into the organisation of NHS healthcare in England in 1991 created a dramatic change in the organisational context from one previously informed by bureaucratic institutions to those of free market institutions (see Chapter 4 for a detailed explanation). In situations where context continuously changes either subtly or dramatically, understanding how institutions influence and adapt organisational behaviour is important for organisations longevity in their existing forms.

As individuals and organisations behaviours change they may strengthen and become institutionalised, or weaken and said to be deinstitutionalised (Scott, 2001) whereby the legitimacy of previous action is eroded (Oliver, 1992). It may be the weakening of some institutions that is more important as it creates instability and the opportunity for organisational change (Friedland and Alford, 1991). Scott (2001) suggested that the *'weakening and disappearance of one set of beliefs and practices is likely to be associated with the arrival of a new set of beliefs and practices'*. In the example of the NHS market, organisational beliefs and practices changed from healthcare provision decisions purely influenced by the professional opinion of clinicians to provision driven by market forces and competition with an increased emphasis on efficiency. This example suggests that organisational fields potentially have many different types of institutions that influence organisational behaviour. Each institution may have key characteristics that require further explanation to understand their effect on the rule and belief systems within organisations and society.

Friedland and Alford (1991) recognised that an understanding of the influence of cognition on the rule and belief systems within organisations and society may play

an important role in organisational behaviour and change but their ideas about institutions were not acted upon until Thornton and Ocasio (1999) worked on the concept of institutional logics. They considered institutions within organisations to be rooted in society level institutions and not in the structure of organisations that had been proposed by DiMaggio and Powell (1983). Since then the concept of institutional logics has emerged as a theory to explore the inter-institutional system.

Institutional logics

The institutional logics perspective was born out of the developments in institutional theory described above. Institutional logics have been defined as *'socially constructed, historical patterns of material practices, assumptions, values, beliefs and rules by which individuals produce and reproduce their material subsistence, organise time and space, and provide meaning to their social reality'* (Thornton and Ocasio, 1998). The institutional logics perspective has been developed into a theoretical framework to allow interrelationships between organisations to be understood within their social contexts taking in account influences from different institutional orders such as family, state, market, professions and corporation (Thornton, Ocasio and Lounsbury, 2012).

Institutional logics built on Friedland and Alford's (1991) work on defining institutional orders and their components by allowing the relative influences of different aspects of society to be taken into consideration when considering how organisations and individuals behave. Logics define the goal of a particular group or organisation and give a sense of shared purpose. It is thought that the interests, identities, values and assumptions of individual and organisations are embedded within institutional logics (Thornton and Ocasio, 2008) and logics shape action by defining the social expectations for behaviour (Goodrick and Reay, 2011). Institutional orders or logics provide the basis on which taken for granted rules are constructed and thereby inform and guide behaviour within an organisational field at individual and organisational levels (Scott, et al. 2000a). Similarly to institutional orders, a number of different institutional logics may exist within organisational

field, each with their own unique rules which allow experience to be perceived within a given reality (Thornton, Ocasio and Lounsbury, 2012). Each institutional logic can be characterised as a variant of it's ideal type.

For example the logic of the professions has a well-defined knowledge base which informs the rule and belief system that guides how they behave as individuals or as a professional group (see Freidson 2001a). However when professionals are brought together to form a corporation operating under the principles of business, they may be subject to different demands that rely on their professionalism to generate money. Goodrick and Reay (2011) used this example to show how pharmacists may be influenced by different institutional orders as they act out their profession in a market place. The institutional logics perspective can be used to understand how this is achieved by breaking down the components of each institutional logic into an ideal type framework that characterised structure and agency (table 3:1).

The institutional logics perspective has the scope to explain behaviour at multiple levels of organisations from the individual to wider society. Behaviour at the micro level (e.g. individuals) can be explored within the context of macro level (e.g. the state). This allows the theoretical framework to be used to understand how macro level institutional logics may influence micro level individual behaviour. It can be used to define and map behaviour to ideal types, to determine what logics are influencing behaviour and how. As a logic filters through an organisation it is possible that it may be open to interpretation or altered as it approaches the micro level. Of particular importance could be the translation of logics from the macro level to the micro level which may influence how an organisation changes and evolves. Conversely micro level behaviour and above may in turn influence macro level behaviour under the influence of different logics operating at different levels. In both scenarios, how logics are interpreted and acted out by individuals is important.

The institutional logics perspective can be used to explain how logics are formed in different levels within organisations, and how they may interact and influence the way in which organisations evolve over time (Thornton, Ocasio and Lounsbury,

2012). For example, at the micro level in the NHS different professions behaviour such as clinicians and managers may be explored to understand how individuals compete and negotiate in response to the institution pressures they experience; at the meso level different sub-organisations such as providers and commissioning groups may be in conflict or cooperation; and at the macro level such as policy drivers institutions may be contradictory or counter dependent (Friedland and Alford, 1991). This allows for the existence of multiple logics at multiple levels within an organisational field, and the opportunity to explain institutional complexity in depth and also explore the possibility for change as well as stability. To do this, the institutional logic perspective can draw down on the elements that comprise the ideal type logics that are of particular interest.

Ideal type institutional logics

The inter-institutional system is central to the institutional logics perspectives as it allows a model of ideal types institutional logics to be developed and built upon as a theoretical and methodological tool (Thornton, Ocasio and Lounsbury, 2012). Ideal types were first used by DiMaggio (1991) to help explain how the structuration of an organisational field can contain different cultural models. The ideal type can be used to characterise those models. The characteristics of the ideal types help to define the rule and belief systems that the institutional logics inform, and there by legitimise behaviour to allow social practices to be justified and reproduced. Ideal type institutional logics are based on the institutional orders first described by Friedland and Alford (1991). This list was not designed to be exhaustive and therefore many ideal type institutional logics may exist. For the purpose of this research, the ideal types described here are limited to the professions, bureaucracy, markets and corporations as these are most relevant to the healthcare organisational context in which this research was situated.

Ideal types may be used as a tool for empirical analysis whereby using ideal types, researchers are able to generate a rich but generalisable understanding of the social processes observed without becoming overly burdened by the complexity of the situation (Thornton, Ocasio and Lounsbury, 2012). This means that the research lens can be focused on certain aspects of the social process to allow abstract theory to

be developed rather than merely an over detailed account of the situation being observed. The ideal type institutional logics described here have already been characterised within the literature. Thornton et al (2012) provides a detailed summary of the known characteristics of know ideal types within the inter-institutional system. An overview of this for the ideal types of interest here is given in table 3:1.

Table 3:1: Inter-institutional system ideal types (Adapted from Thornton et al (2012))

	Institutional logic ideal type			
Characteristic	**Profession**	**Bureaucracy**	**Corporation**	**Market**
Root metaphor	*Relational transactions and networks*	*State redistribution of resources*	*Corporate hierarchy*	*Transactions*
Source of legitimacy	*Specialist knowledge*	*Democracy*	*Market position*	*Money*
Source of authority	*Professional association*	*Bureaucratic domination*	*Top down management*	*Shareholder*
Source of identity	*Personal reputation*	*Political party in power*	*Bureaucratic mechanisms*	*Faceless*
Basis of norms	*Membership to association*	*Citizenship*	*Employment*	*Self-interest*
Basis of attention	*Status in profession*	*Community interests*	*Status in hierarchy*	*Status in market*
Basis of strategy	*Reputation*	*Increased community good*	*Increased market share*	*Efficiency and profit*
Control mechanism	*Professional hierarchy*	*Politics*	*Organisation*	*Analysis*
Economic system	*Personal capitalism*	*Welfare capitalism*	*Managerial capitalism*	*Market capitalism*

Professional logic

Professional groups are formed from collections of individuals with similar skill sets that have taken time and effort to acquire through training, and once achieved are verified and maintained through membership to professional associations (Freidson, 2001a). Professionalism refers to how a profession is grounded in the nature of its work and from a medical professionalism perspective, attributes of professionalism reflect societies expectations of the profession (Swick, 2000). Professionalism and a professional logic are different constructs but professionals are said to follow a professional logic (table 3:1) that places a strong emphasis on the credentials and reputation of the individual. This legitimises their work and creates strong boundaries to the scope of their practice. Deviation from the professional logic is likely to incur severe consequences that ultimately would threaten an individual's membership to a profession.

Many different professional logics exist that are unique to the professional behaviour they inform. Healthcare represents an organisational field where a number of professional logics may co-exist to support different types of professionals in the context. Healthcare systems provide a service based primarily on the specialised skills of the frontline workforce. These individuals include doctors, nurses, therapists and many more, each with their own unique skill set and professional values. The specialist knowledge they exhibit is not secret but takes time and effort to acquire (Freidson, 2001a). At the core of the medical professional logic, clinicians often present themselves with a central logic of providing patient care based on experience combined with clinical evidence, and with the ultimate goal of doing good. This has been used to legitimise their position in society and resist change (Scott, Ruef, P. Mendel, *et al.*, 2000b). Delivering quality care is presented as their primary goal but under the logic of professionalism other goals may be sought to strengthen the professional logic within organisations. Scott et al. (2000) found that the medical profession used specialisation within their practice to exploit scientific and technical advances and improve patient care while increasing their power and status at the same time.

Power and status may be important for maintaining an institutional logic. The professional logic has an identity based on reputation and uses a reputational strategy to limit non-conformity (Thornton, Ocasio and Lounsbury, 2012) making it powerful for legitimising change. As described in Chapter 3, the medical profession were influential in the design and implementation of the NHS, giving the medical profession a privileged position at the top of the NHS organisational hierarchy (Klein, 2010b). The state's commitment to aligning plans for a healthcare service with a professional logic allowed the medical profession to influence how the NHS was developed through the mid-twentieth century (Klein, 2010c). During this time, the medical professional was held in high regard by the public and the government, allowing the profession to develop autonomy and internal regulatory governance.

However, despite the success of the professional logic in dominating the development of NHS healthcare, professionals require economic and organisational support to continue to practice. This may be achieved through other institutions such as the market where skills are traded through transactions. The influence of other logics may strengthen or weaken the professional logic which in turn may cause the profession to loose it's soul (Freidson, 2001b). Changes to the professional logic of pharmacists has been documented (Goodrick and Reay, 2011) and suggests that the professional logic alone is insufficient in today's society. Similarly, the professional logic may become problematic for other groups. By the 1970's, the English government had concerns that the powerful position the medical profession had created in the NHS was leading to self-interested behaviour that capitalised on the healthcare system for individual gain at the detriment to the NHS which was facing increased costs, reduced quality and variation in care (Mechanic and McAlpine, 2010). The government's logic became incompatible with that of the professionals instructed to deliver it's healthcare service. To readdress the balance of power, the government introduced bureaucratic mechanisms and a bureaucratic logic (see below) began to be institutionalised within the field (detailed explanation given in Chapter 3). The new bureaucratic logic exhibited in health policy sought to increase managerial power over the medical profession (Klein, 2010a).

The changes reflected a global change in healthcare organisation and although the professional logic was subdued by the introduction of bureaucracy, it was not eliminated (Reay and Hinings, 2005). In response to top down control from the state, the rise of evidence based medicine and external governance structures have allowed the medical profession to continue to operate under surveillance (Martin, Leslie, *et al.*, 2013). By legitimising the work done by the medical profession, the bureaucratic logic used to control the dominance of the professional logic ultimately allowed it strengthen its position again within healthcare organisation as societies trust was regained. The rules and norms of the medical professional logic have altered to become more acceptable to today's society, and allow the professional logic to once again influence healthcare organisation.

Freidson (2001b) suggested that the continued presence of a professional logic in healthcare was important to counterbalance the bureaucratic and corporate logics that had become increasingly strong and influential, and the professional logic would work towards the interests of patients and improve the quality of care they receive. This position may view the role of the professional logic idealistically (Martin *et al.*, 2015) but recognises how coexisting logics may be important when attending to the needs of a diverse network of stakeholders in organisations like the NHS. After a period of sustained interest in competition and efficiency, professionals may have left themselves open to attack by being over reliant on their logics of doing good for the benefit of others (Freidson, 2001b). Freidson (2001b) comments that under the professional logic, professionals often have an insular view of their own profession and tend to over defend their logic rather than adapt and work towards complimenting other competing logics in the system. The professional logic is therefore under constant threat from other logics in the system.

Bureaucratic logic

Friedland and Alford (1991) identified the bureaucratic state as an institutional order. Bureaucracy refers to the administrative system of a governmental organisation, whereby legal order legitimises the rational-legal authority of the state system of control (Weber, 1922). The main characteristics of bureaucracy

were defined by Weber (1922) as a fixed jurisdictional area ordered by rules and laws, managed by hierarchical organisation using written policy. Weber (1922) viewed rationalisation in Western society as an *'iron cage'* that trapped individuals in systems based solely on efficiency, rational calculation and control devoid of values, beliefs and emotions. He considered democratic societies to demonstrate an over reliance on bureaucracy for all aspects of state administration, which was often delivered by unelected civil servants who acted in their own interests rather than that of the community and thereby threatened the very nature of democracy itself (Weber, 1922). Thornton (2004) questioned the term bureaucratic state as she considered bureaucracy to refer to the structural form that the state use to carry out its objectives, and then in subsequent work refers to this institutional order or logic as that of the state. However bureaucracy can also be considered a culture with both structure and agency (Phillips and Knottnerus, 2009). While this research was situation within a state system (the NHS), bureaucracy is embedded culturally (Exworthy, Powell and Mohan, 1999) and for the purpose of this research it will be referred to a bureaucratic logic.

Under a bureaucratic logic control is achieved through bureaucratic dominance (Thornton, Ocasio and Lounsbury, 2012). This may be enforced through standards by which organisations must comply. These constitute the regulative pillars of the organisation. Some rule and governance systems may be internally created by organisations, but often organisations are subject to external standards that are state generated. For example, within the European Economic Area (EEA) the letters 'CE' (Conformité Européene) appear on many products that are traded within the single market. The CE marking demonstrates that the manufacturer has ensured that products meet European Union (EU) safety, health or environmental requirements; compliance with EU legislation; and allows free movement within the European market (Gov.uk, 2012). The CE marking system is an example of how the bureaucratic logic seeks to protect the community as a whole through regulation which is enforced through the legal system, making it very difficult to ignore.

Thornton and Ocasio (2008) define the bureaucratic logic as a redistribution logic based on the principle being *'for the good of the whole community'* situated within

a welfare capitation system. Bureaucratic logic is of particular importance for large scale state administered systems such as the NHS predominantly funded through taxation and available to all members of society, *'free at the point of access'* (Klein, 2010b). State controlled administration was considered the most effective way of delivering high quality and equitable healthcare to the population, suggesting a strong bureaucratic logic at the time of the NHS's creation. The way in which the NHS is funded has not changed which again suggests the bureaucratic logic has remained highly influential. However the way in which the NHS is organised and delivered has changed many times demonstrating that the bureaucratic logic within a democratic state has the potential to change and adapt as power shifts between political parties. This shows how a logic may vary in ideal type characteristics while retaining the core components of the ideal type logic.

The dynamic state of logic ideal types also reflects wider changes in society. The organisation of society has continually changed over time. For example, the introduction of New Public Management (NPM) (see Chapter 3) into democratic societies was common across the world and marked a change in state organising principles for healthcare and many other industries as the public sector sought to be more business-like (Reay and Hinings, 2005). Throughout these changes bureaucracy remained strong, but the way in which it influenced and achieved it's goals changed.

Each government has its own policy and agenda for the NHS which is guided by different forms of the bureaucratic logic embedded within their own institutions. The bureaucratic logic will exist within the NHS for as long as it remains a publicly funded organisation and therefore for the context of this research the influence of the bureaucratic logic needs to be considered. While the bureaucratic logic has always been influential in the administration of the NHS, it has coexisted alongside and been influenced by other logics. The professional logic was dominant until the late twentieth century and through the 1980s a shift towards more business like healthcare was apparent (Reay and Hinings, 2005). As this occurred, interest in the use of markets in the healthcare system was gaining strength (Enthoven, 1985) and the introduction of the internal market in 1991 marked radical changes to the way

the NHS healthcare was organised and an alignment of the bureaucratic logic with the market logic.

Market logic

The basis of a market is the concept of transaction. The market logic has been characterised as being faceless, self-interested and motivated by profit in a market capitalisation system (Thornton and Ocasio, 2008). Markets are used to improve efficiency and quality within an industry (Thornton, 2004). They rely on competition to drive supply and demand (table 3:1). A market is a relatively simple concept but to be effective it requires supply, demand and competition to work effectively to create an efficient and profitable system.

As a market logic becomes prominent, the problem of resource competition affects organisational actions and decisions (Thornton and Ocasio, 2008). Therefore if a resource becomes scarce, the demand for that resource will increase. To address this, the price of the resource rises until the supply and demand stabilises. Increased demand may also be stimulated by high quality products which purchasers prefer to lower quality products. Here supply of high quality products may increase and flood the market. With more supply, producers may be forced to lower their prices as purchasers look for cheaper alternatives of the same product. The market system is highly effective for the transaction of many types of commodities. For example, in the mobile phone industry, Apple developed a high quality product that commanded such demand that prices are rarely lowered, and as the product dominated it forced other suppliers such as Nokia out of the market.

The concept of the market was introduced into healthcare as a mechanism to address the rising costs of healthcare (Klein, 2010c). By stimulating competition between providers, it was hoped that efficiency and quality would improve using the economic principles described above. It was thought that by passing responsibly of purchasing healthcare to local health authorities, the local authorities would have the power of choice which would in turn force healthcare providers to consider more carefully how they spent their budgets and thereby improve the quality of the services they delivered while reducing costs (Secretary of State for

Health, 1990) (see Chapter 3 for detailed explanation). This principle was not unique to the NHS. During the latter part of the twentieth century many governments across the world changed their approach to administration as they attempted to control organisations in a more economically viable manner (Scott, et al. 2000a).

However the NHS healthcare market was not a true market as local authorities could only purchase from specified providers. Providers remained part of the NHS organisation but operated as independent NHS Trusts with their own management systems (Secretary of State for Health, 1990). The quasi-market system was guided by the principles of competition to drive improvements in efficiency and quality but was strictly regulated by administrative systems which limited the degree to which a market could operate. Without all the characteristics of the ideal type market logic, the logic does not influence behaviour in predictable ways.

Initially market principles in the NHS were at an organisational level but due to the limited success patients were given the opportunity to act as consumers. Consumers act in numerous ways to stimulate market forces. As consumers of healthcare, patients are encouraged to play an active role in the planning and delivery of healthcare. The *'new public health movement'* has seen a shift away from the structural inequalities of society and the causes of illness towards an individualised model that encourages people to act as consumers of health (Shaw and Aldridge, 2003).

The market logic has become and remains an important influencing institution within healthcare but is strongly linked to the bureaucratic logic. The three logics of the professions, bureaucracy and the market are thought to co-exist within the healthcare field (Scott, Ruef, P. Mendel, *et al.*, 2000b). The rise of bureaucracy and the markets as influencers of organisational behaviour led healthcare systems to move towards business-like healthcare that could be likened to the emergence of a corporate logic.

Corporate logic

From the descriptions of the professional, bureaucratic, and market logics it is apparent that the boundaries are blurred and different logics as may appear from

the ideal types (table 3:1). Professional bureaucracy is an example of bureaucracy that is not centralised and reliant of independent professionals controlled with standardisation of work (Mintzberg, 1993) demonstrating elements of the professional and bureaucratic logics. Similarly market principles have infiltrated into bureaucracy as states attempt to administer public organisations using private principles. Within all industries being a viable business is important. Placing business at the heart of an organisation's interest suggests that the role of the corporate logic is influential.

Corporations have been identified as an institutional order with ideal type characteristics (table 3:1) (Thornton, Ocasio and Lounsbury, 2012). Corporations are structural hierarchical systems which impose top down management with strong bureaucratic influences. Their strategy is to expand and diversify to strengthen their position in a market. Corporations often rely on professions to deliver services. For example lawyers, accountants, architects all operate within organisations that allow professional practice to take place. As a group professions are stronger and their practices are legitimised. However the corporate logic seeks to control professionals through administration techniques such as individual performance management, standard operating procedures and guidelines, and stringent audit and governance systems. This approach in private sector businesses has been viewed as been the most efficient business practice for many decades but was not the traditional model for healthcare. Since the 1990s, NPM has been used in the NHS as a method of administrative control that can be associated with the corporate logic. In a publically funded system like the NHS who's core value remains the provision of free healthcare at the point of access, the influence of the corporate logic could weaken the medical professions duty to place the patient at the heart of care (Mechanic and McAlpine, 2010). This made the influence of the corporate logic of interest for this research as it focused on how services are designed and delivered by professionals in an era of business-like healthcare.

Logics in organisational fields

Different types of organisational fields may have different types of logics which could include any number of logics in any combination. It is how those logics guide

the behaviour of organisations which is of interest. How this occurs is related to the combinations of logics that exist, how they interact with each other to create institutional demands and then how this influences organisational and individual behaviour. This may involve the logics of interest to this research described above, as well as other known logics or even unknown logics. The ideal type logics allow known logics to be identified and theory to be developed about how they work alongside each other and influence the field.

The descriptions given of the ideal type institutional logics of interest in this research show that while different types of logics have distinct characteristics, the boundaries between different logics are not always clear. For example the corporate logic shares characteristics with bureaucratic and market logics. However different logics in one field may be seen to share characteristics, but in another they may not. The professional and market logics are both said to have their root metaphor based on transactions but have different sources of legitimacy (table 3:1). Professional logic is legitimised through specialist knowledge and markets through money which may seem to be contradictory but in a healthcare market the sources of legitimacy may act to strengthen each other. Therefore some logics could be seen as complimentary in certain contexts. For example the bureaucratic logic and corporate logic have many similar normative and regulative aspects in the way they influence control of organisations through managerial control (Thornton, Ocasio and Lounsbury, 2012). The market and bureaucratic logics both seek to normatively reduce waste of finite resources but at the same time contradict each other through their beliefs in how a market should operate in the healthcare context. Therefore logics may be complimentary, contradictory or simply co-exist under different organisational circumstances and conditions.

This makes institutional logics a fluid and dynamic phenomenon that exists in a constant state of flux. The understanding of how institutional logics emerge, exist and influence an organisational context has evolved. Early work to understand institutional logics focused on how certain logics dominate an organisational field. Although it was recognised that multiple logics may exist, it was assumed that a dominant logic could emerge but would then need to be maintained to retain its

influence or challenged to allow a new logic to assume a dominant position (Scott, et al. 2000a). However as a new logic assumed a dominant position, a prolonged transition period could precede the change in dominance and two logics may co-exist (Hoffman, 1999). This suggested that logics may not be exclusive and incompatible.

Recently the idea that logics are inherently incompatible has been challenged further in favour of the idea that logics are able to co-exist alongside each other without creating instability (Greenwood *et al.*, 2011). A single logic may hold a dominant position but the dominant logic may change over time and influence agency in different ways; at the same time less dominant or declining logics may continue to influence practice within a field (Reay and Hinings, 2009; Goodrick and Reay, 2011). This gives rise to the concept that logics may constrain behaviour at the same time as facilitating it, but how this occurs it not clearly understood (Waldorff, Reay and Goodrick, 2013).

As logics change the transition period between logics could lead to conflict when radical change occurs (Reay and Hinings, 2005) suggesting that the differences between the changing logics may be influential to organisations negotiating a transition period. The relationship between the logics is important for understanding how change in an organisations behaviour occurs and how stability is maintained (Thornton, Ocasio and Lounsbury, 2012). Logics which appear to challenge each other in a contradictory manner may create the opportunity for change by giving rise to an unstable organisational field where new practice can be developed and sustained through partial autonomy (Thornton, Ocasio and Lounsbury, 2012).

Logics that appear contradictory can sometimes have shared goals that allow both logics to coexist. As the bureaucratic and corporate logics have become more influential in healthcare, medical professionals have collaborated with administrators to allow them to work towards the same goals while allowing them to retain their commitment to the professional logic (Reay and Hinings, 2009). Adopting this approach in healthcare could offer a better experience for patients as

it may force two competing logics within organisations to compromise and place patients at the centre of care and result in improved efficacy and quality. This suggests that in complex organisations different groups of individuals may respond differently to logics but also have the ability to change their own behaviour to accommodate possibly contradictory logics while remaining attentive to their own logic and goal. The way in which multiple logics coexist and evolve within organisations could be important for understanding how an organisational field changes.

Changing institutional logics in an organisational field

Developing the theory that multiple logics can coexist, Goodrick and Reay (2011) proposed that logics within a field are arranged as constellations. Focusing on the pharmaceutical industry, they conducted a historical case study of US pharmacists over 150 years to show how changes in how professionals work was related to the wider constellations of institutional logics in society guiding their behaviour. By examining historical documents relating the pharmaceutical industry dating back to 1852, and mapping ideal type characteristics of the professional, corporate, (bureaucratic) state and market logics to different eras for the profession, Goodrick and Reay (2011) were able to show that the arrangements of logics and their influence changed over time but that they could be arranged in different ways which in turn effected how they influenced professional work. This showed how the same logics exist within different fields but are arranged in unique constellations that influence and guide behaviour, and may lead to different responses depending on the configuration. Viewing logics as constellations allowed field level logics to be seen to simultaneously influence behaviour because the concept of constellation allows the pattern to be captured at a given point in time (Goodrick and Reay, 2011). This implied a dynamic and constantly evolving institutional context.

The case study only identified one period in time where a single logic dominated (Goodrick and Reay, 2011) which questioned previous theories about dominant logics, and opened the possibility of multiple logics influencing at the same time rather than just one or two. Goodrick and Reay (2011) build on this by identifying that logics could be both competitive and cooperative at the same time. A

competitive relationship between two different logics could imply that one logic is strengthening while the other is weakening, but a collaborative relationship could suggest that two different logics work together to influence and strengthen a particular practice (Waldorff, Reay and Goodrick, 2013). In situations where multiple logics exist, this could imply that there are winning and losing logics but Goodrick and Reay (2011) showed that this was not always the case. They demonstrated that an increase in one type of logic does not always mean that there is a decrease in strength of another logic (Goodrick and Reay, 2011). This is acknowledged by identification that logics within an organisation cannot necessarily be varying proportions of a pie, but that the pie itself may be expanding (Goodrick and Reay, 2011) or even diminishing. Seemingly competing or complimentary logics may also represent differing demands for different types of individuals in an organisation. A logic may be competitive and cause conflict for certain groups within an organisation but collaborative for others. How and why some individuals within the same organisation respond to different types of logic is not clearly understood.

Organisational responses to field level institutional logics

The way in which an organisation responds to field level institutional logics depends on how the organisation experiences those demands (Pache and Santos, 2010). The experience of institutional demands is related to the nature of the logics themselves and the characteristics of the organisation which influences how institutional demands are interpreted. Within the same field, different organisations may respond differently depending on their own goals within that field (Greenwood and Hinings, 1996). Pache and Santos (2010) have suggested how institutional pressures at the field level are related to organisational responses with the proposition that *'fragmented fields that are moderately centralised are more likely than other fields to impose conflicting institutional demands'*. They describe how fields become fragmented when they contain many uncoordinated organisations and are centralised when they rely on one dominant logic. This arrangement has been found to be common in healthcare where numerous organisations are legitimised through state regulation (Scott, Ruef, P. Mendel, *et al.*, 2000b) but also applies to

many state regulated sectors such as education and the military where decision making is centralised (Pache and Santos, 2010). The approach taken by Pache and Santos (2010) focused on the top down field level influence of institutional logics by concentrating on the nature of the demands from the field level, and then explored how organisations internally represent those demands.

The nature of demands at the field level can be described using the institutional logics perspective. For example, in a centralised situation the influence of the state may have a strong bureaucratic logic that focuses on regulation and so organisational responses are likely to be predictable as it makes the institutional demands difficult to negotiate. However, in a market logic situation the element of choice and market forces may allow organisations to be diverse in their responses. If the field is less centralised, other institutional logics may come into play making responses more difficult to predict. In this situation the internal representation of the institutional demands is important which refers to the extent to which an organisation adheres to a given institutional demand or logic (Pache and Santos, 2010).

In situations of conflict between logics, individuals in organisations are forced to make strategic choices about which institutional logics they will attend to and which they will ignore. The response to conflict may impact on the goals of an organisation, means of achieving those goals or in some case both. For example the goals of an organisation may be well defined, but the means of achieving those goals may be conflicting as a result of complex institutional field level logics. In this case conflicting institutional demands may provide an organisation with several means of achieving their goals but the organisation must then decide which institutional demand to satisfy and which to ignore. Alternatively complex field level logics may make achieving organisational goals difficult to achieve and the goals may need to be readdressed.

Pache and Santos (2010) suggested that goals are often a reflection of the core of an organisation, making them inherently non-negotiable whereas means of achieving goals are more fluid and open to adaption and change. This is because

changing organisational processes to achieve goals does not necessarily mean that an organisation's core values have to change i.e. functional processes can be adaptive and compromising to ensure that goals are met without affecting the integrity of the organisational core. The way in which organisations respond to a source of conflict will be influenced by internal representation of institutional logics within the organisation (Pache and Santos, 2010).

The internal representation can be effected by the institutional logics within the field as they provide the boundaries for behaviour (Friedland and Alford, 1991). Different groups may be more committed to certain logics than others. For example the professional logic may command a strong commitment from professional groups (Greenwood and Hinings, 1996) because they have been socialised into the behaviour guided by this type of logic (Pache and Santos, 2010). However organisations are rarely comprised of one defined group, and therefore some groups within organisations may align themselves with an alternative logic (Greenwood and Hinings, 1996) which creates the potential for instability in the internal representation of field level logics through competition between groups within an organisation. Greenwood and Hinings (1996) theorised that this could lead to competition within organisations as different groups compete to defend their preferred logic. Conversely new organisations entering a field may be unaffected by the institutional conflict as they have not been exposed and socialised to existing institutional demands (Greenwood and Hinings, 1996) allowing them the opportunity to adopt a new logic.

When an organisation is exposed to conflicting institutional logics, choices must be made to determine which logic to attend to and which to neglect. Pache and Santos (2010) developed a model that built on a typology of responses to institutional demands (Oliver, 1991). Oliver (1991) proposed that organisations will acquiescence, compromise, avoid, defy or manipulate when facing institutional demands. Using this typology, key tactics (table 3:2) can be identified in an organisations response to demands which can be used to predict organisational response.

Table 3:2: Oliver (1991) typology of response strategies to institutional demands

Response	Strategy	Tactics
Acquiescence	Passive	Habit forming
	Adoption of institutional demand	Imitation of behaviour
		Compliance with demands
Compromise	Partial conformity	Balance competing demands
	Mild alteration of institutional demands	Pacify resistance
		Bargain for demand alteration
Avoidance	Preclude necessity to conform	Concealing non conformity
	Rejection of institutional demand	Façade of acquiescence
		Escaping the institutional field
Defiance	Aggressive avoidance	Ignoring demands
	Explicit rejection of institutional demands	Challenging demands
Manipulation	Active change	Co-opt other demands
	Alteration of institutional demands	Influence demands
		Control source of demand

While the typology was useful when demands were clear, when demands were conflicting the model had lower powers prediction (Pache and Santos, 2010). Pache and Santos (2010) argue that the nature of institutional conflict interacts with the internal representation of those demands to shape experience and the subsequent response decisions made. This means that different organisations that may appear to be structurally similar may interpret institutional conflict in different ways and in turn this interpretation could lead to variation in responses. This makes prediction of outcomes more difficult. However, the responses may be different

depending on where the source of the conflict lies; i.e. if is in the goal of the organisation or the means by which that goal is achieved.

Conflicting goals are challenging because they threaten the core of the organisation. Situations like these may be common in organisations that are dependent on the state for their direction and funding. Regular changes to state demands on the goals of the organisation forces an organisation to attend to the external institutional pressures inflicted on it. Pache and Santos (2010) proposed that when this occurs, the response would be related to the internal representation of institutional demands. When internal representation is not aligned with the external institutional logic, the organisation is likely to use avoidance and defence to avoid change; when the demands are only partially represented internally, the organisation is more likely to avoid, defy or manipulate through it's responses (Pache and Santos, 2010). This suggests that how organisations internally represent institutional demands may be different depending on the circumstances and the individuals faced with meeting those demands.

Pache and Santos (2010) suggested that when conflict is confined to the means of achieving organisational goals, rather than the goals it is less problematic because the demands are peripheral and negotiable making compromise a more appealing solution especially if the internal representation of the demands is absent or limited. When demands are internally represented with a single interpretation, organisations are more likely to use avoidance and defiance to other responses (Pache and Santos, 2010) as individuals seek to satisfy and protect their own logic. This is most likely to occur when the organisation is comprised of similar individuals.

Multiple internal representations are most likely to occur when at least two different groups of individuals co-exist within an organisation. In this situation, the two groups are likely to fight for dominance because their practices are contradictory and strong socialisation into the practices limits compromise (Pache and Santos, 2010). Pache and Santos (2010) demonstrated how their model could be used to predict the adoption of different responses. These are summarised in table 3:3, which gives the likelihood of the different adoption strategies for

different scenarios of internal representation of conflicting external institutional demands.

Table 3:3: Model of responses to conflicting institutional demands (Pache and Santos, 2010)

Response determinants		**Likelihood strategy adoption**			
Nature	**Internal representation**	**Compromise**	**Avoidance**	**Defiance**	**Manipulation**
Goals	Absent	Low	High	High	Low
	Single	Low	High	High	High
	Multiple	Low	Low	Low	High
Means	Absent	High	High	Low	Low
	Single	Low	High	High	Low
	Multiple	High*	Low	Low	High**

Goals refer to the aims and objectives of an organisation; Means refer to the organisations actions to achieve their goals; Balanced power between representations allows compromise; ** Unbalanced power allows control from one representation over the others.*

The model demonstrates how conflicting institutional logics within an field can result in different responses depending on how they are internally represented within an organisation (Pache and Santos, 2010). The approach is predominantly top down and suggesting that logics are only influential from higher levels of society. It does not allow for the influence of the meso level logics within organisations or account for individuals' autonomous behaviour at the micro level. The model assumes that individuals in organisations are exclusively influenced by the field level logics and neglects other sources of institutional demands that may be pre-existing for the individual or may originate from other sources in the organisation or elsewhere. Equally it does not account for inter-organisational relationships where two or more organisations are attempting to working together under the same field level institutional demands. In many circumstances organisations may have to work together to address field level pressures or achieve

mutual goals which involves interaction between organisations and individuals. Understanding how multiple organisations and their individuals work together in a complex organisational field may be important for understanding how and why some organisations are able to collaborate and why some are not.

Pache and Santos (2010) allude to conflicting internal representation that may result from the existence multiple groups of different individuals but do not delve into the micro level interactions of institutional logics and individuals. Understanding these relationships may be important in understanding how organisations resolve conflict and decide how they will respond to institutional demands. It may also be important in understanding how groups of individuals work across organisations to facilitate inter-organisational working. Different organisations may have the same or different internal representations of field level logics and as a result it could be assumed that this would influence organisational responses.

Current theory neglects to understand how individuals work across organisations. Institutional theory has suggested that individuals are constrained by institutions and unable to make autonomous decisions. However it is possible that individuals and their groups of similarly socialised individuals may be influential in determining how organisations respond to institutional demands. Thornton et al (2012) suggest that co-existing logics within a field may create the opportunity for actors to have partial autonomy in this situation.

Partial autonomy

The institutional logics perspective often focuses on the top down influences of logics described above. There has been less attention paid to the micro level practices of how interpretations of logics influence organisational behaviour. At the micro level, autonomous individuals may play an important role in these processes. Individuals are considered autonomous if they have the capacity to make decisions for themselves. However within institutional theory autonomy is problematic as it suggests that institutions constrain behaviour and organisational decisions, making change is difficult to achieve (Scott, Ruef, P. J. Mendel, *et al.*, 2000).

Institutional theory was originally used to explain how organisations achieve stability through isomorphism. During this process the structure of an organisation morphs into a socially acceptable configuration and individual behaviour is constrained through the need to conform to an organisation's rule and belief system (Scott, 2008). The institutional logics perspective allows organisations to be explored to understand how they retain stability or identify how they change (Thornton and Ocasio, 1998) by embracing the cognitive and cultural aspects of institutional systems. It acknowledges that behaviour may not always be constrained by the institutional environment and can be used to help explain how individuals may achieve partial autonomy within organisations as an opportunity to stimulate change (Thornton, Ocasio and Lounsbury, 2012).

As already discussed, individuals and organisations have the potential to be influenced by multiple co-existing institutional logics. When logics are complementary, the boundaries which guide behaviour may be clear but when logics are competing they have the potential to contradict one another. In this situation, behaviour may conform to one logic but not another. An individual may deal with conflict of this type by compartmentalising norms from different institutional logics (Thornton, Ocasio and Lounsbury, 2012) in a concept known as organisational loose coupling (Weick, 1976; Meyer and Rowan, 1977). Loose coupling refers to organisations that are autonomous and unresponsive to each other rather than being part of a hierarchical system (Weick, 1976). Weick (1976) suggests that loose coupling can occur in different forms such as the absence of regulation, decentralisation of power, reduced influence from the higher levels of the hierarchy and lack of consensus around organisational goals.

For loosely couples organisations, Meyer and Rowan (1977) described how front of house practices are ceremoniously introduced to legitimise action but not ever implemented in back room processes. This allowed organisations to actively avoid conflict that may challenge their core behaviour. At a micro level this may allow individuals facing institutional conflict to loosely couple their own logic from that of their actions (Thornton, Ocasio and Lounsbury, 2012). This suggests that individuals could be manipulative in how they behave in an institutionally conflicted

environment but as yet there is little evidence to understand how and why individual behave in this way or if there is a particular type of individual who is prone to this approach. Thornton et al (2012) comment that this type of behaviour may be associated with defence strategies to protect positions in an organisation or gain promotion. While institutional theory traditionally assumes strategic behaviour is restrained in institutionally complex organisations to retain legitimacy (Pache and Santos, 2010), it is possible that some institutional logics may be more open to strategic manipulation than others (Thornton, Ocasio and Lounsbury, 2012).

In situations of institutional complexity, individuals may have high levels of autonomy as they conduct their work within organisations (Hallett, 2010) which contradicts the behaviour that would be predicted by traditional models of institutional theory. When responding to multiple logics, responses may be segmented with different groups responding differently to different logics (Reay and Hinings, 2005, 2009; Goodrick and Reay, 2011). This may cause conflict between different groups but could also lead to collaboration as groups of individuals with different behavioural responses to certain logics may find common ground when responding to high level pressures. Reay and Hinings (2009) showed how under a corporate logic, medical professionals and non-medical administrators were able to align their logics of professionalism and bureaucracy to continue to strengthen an organisation's business-like approach to healthcare. In this situation rivalry served no purpose and by working together towards a shared goal they were able to strengthen the legitimacy of their individual groups and that of the organisation.

The ability for individuals to do this in practice is likely to be related to previous experiences, expectations and the structural and cultural restraints faced as they seek to legitimise their behaviours (Martin *et al.*, 2016). Martin et al (2016) explored this anomaly by investigating individual behaviour after a period of intensified complexity as institutional expectations were centralised and formalised to become legitimate. By exploring multiple organisations within the same complex institutional field Martin et al (2016) show that divergent outcomes can occur at the level of practice in response to the same higher level institutional pressures. At an

organisational level Martin et al (2016) suggest three ways in which organisations may mediate the influence of different logics within their field (figure 3:2).

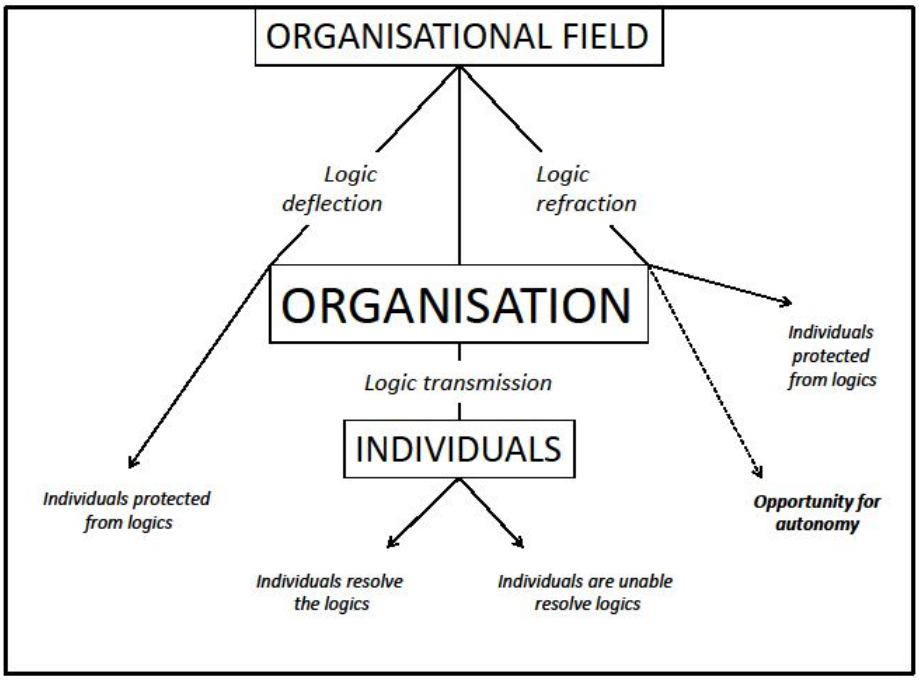


Figure 3:2: Schematic representation of Martin et al (2016) theory of organisation's mediation of field level logics and the influence they have on individuals

Martin et al's (2016) theory of how organisations mediate field level logics suggests that organisations may deflect, transmit or refract logics (figure 2:1). Through deflection they protect individuals' needs to conform to logics; through transmission the logic filters through an organisation leaving it to the individuals to either resolve demands or leave them unresolved; and through refraction the organisation may protect some individuals from logics while leaving some individuals protected and creating an opportunity for autonomy in others. Martin et al (2016) found within their study evidence of selective decoupling of logics in some of their case studies which created the opportunity for partial autonomy and a basis for further investigation into their theory.

The model of deflection, transmission and refraction of logics concentrates on macro level influences of field levels logics on micro level behaviour. The organisation itself is likely to be important in how it deals with macro level logics but as yet this has not been investigated within the model suggested by Martin et al (2016). In increasingly complex organisational fields, being able to satisfy multiple logics may be an important characteristic for organisations. The inherent characteristics of organisations are likely to impact in their ability to do this which in turn impact on individual level behaviour. The role of individuals in this process is also likely to be important. This is likely to be made more difficult when different groups from different organisations are required to work together to find common ground as the organisations and their individuals may have different characteristics. Reay and Hinings (2009) have demonstrated how this may be achieved within a single organisation, but do not suggest how multiple logics may be satisfied across different organisations. This suggests that there may be a gap in the institutional logics perspective literature that does not explain how organisations work together which could be important for understanding the complexities of inter-organisational relationships in contextual situations like commissioning in the NHS.

Theoretical gap in the literature

This overview of institutional logics has shown that it is a useful and interesting theoretical perspective that has the potential to explain and predict organisational behaviour in complex organisational fields. However the institutional logics perspective has tended to focus on the top down influences of field level logics and organisations in isolation rather than how micro level individual and inter-organisational practices affect organisational behaviour and relationships.

As a theoretical perspective institutional logics continues to grow and develop, and extending theory on how individual and inter-organisational practices influence the interpretation and responses to complex field level institutional logics could improve the application of the framework. The aspects of institutional logics discussed in this chapter have raised a number of questions that merit further exploration.

As an extension Oliver's (1991) typology of response strategies to institutional demands, Pache and Santos (2010) have developed a model which may be used to predict organisational responses depending on the organisation's interpretation of field level logics. However the model assumes only top down influence from field level logics rather than the lateral influence of organisations at the meso level of the field and the influence of individuals within those organisations. Further work is required to understand how organisations within an organisational field work together rather than considering them in isolation as the relationship between organisations and the perceptions of other organisation's behaviours and responses could impact on how organisations internally represent institutional logics.

The work of Goodrick and Reay (2010) showed that multiple logics may co-exist and change over time within an organisational field but were not able to explain and why some logics were competing and some were collaborative. Within a field there is potential for the arrangement of logics to be competing for some organisations and collaborative for others meaning organisations may be able to experience and interpret field level logics in different ways. If organisations experience logics differently this could have implications inter-organisational relationships. Therefore understanding how organisations interpret institutionally complex fields could be important for understanding how some organisations successfully work together and others do not. Martin et al (2016) provided some explanation for this by theorising that organisations transmit, deflect or refract logics to give individuals within organisations either protection from logics or the opportunity for partial autonomy. This suggested that individuals involved at the micro level of the organisations could be important for how an organisation is perceived by other organisations and subsequently work together.

Under the current understanding of the institutional logics perspective, the theory neglects inter-organisational working and when organisations are required to work together, how they overcome institutional complexity to find common ground. A clearer understanding of the role of individuals in this process could be of particular importance and raised the question of how individuals from different institutionally

complex organisations work together to satisfy multiple institutional logics to allow the organisations to successfully meet their goals.

Theoretical research question and propositions

This research will therefore focus on developing a better understanding of how organisations within a complex organisational field work together and find ways to attend to the complex institutional pressures they face. It will explore how field level institutional logics are represented, interpreted an acted upon through inter-organisational working at the organisational and individual level. It will aim to address the following overarching research question:

How do institutional logics in an institutionally complex organisational field effect how organisations are able to work together to achieve their shared goals?

To address this question, investigation was required at an organisational and individual level between organisations within the same field that are obliged to work together on shared goals and objectives. The process of commissioning in the NHS provided the ideal setting for this as commissioning requires multiple organisations to work together towards shared goals of providing healthcare to the population. Chapter 2 described the complex institutional field in which commissioning is situated. There were similarities between the theoretical gap in the institutional logics literature and the propositions made about the problems being faced by NHS commissioners in the healthcare field. However before the research could take place, further work was required to explore how NHS commissioning could be conceptualised using institutional logics.

Using institutional logics to conceptualise NHS commissioning

Commissioning integrated healthcare where separate organisations are expected to work together collaboratively was a current political topic that required investigation if it was to have potential as a solution to the problems the English NHS was experiencing at the time of this research. Chapter 2 explored commissioning as an organisational concept broadly and then specifically through the delivery of stroke services which provided a clinical example of an integrated

service that crossed multiple organisational boundaries. Clinical evidence and guidelines suggested that stroke services should be delivered as a stroke pathway with coordinated services for stroke survivors delivered seamlessly from organisations. Previous attempts to develop and improve the stroke pathway have varied from highly successful in the acute setting to sporadic and variable in the community setting. It was not clear why commissioning community based services had been more challenging but it could involve the challenge of integrating the working practices between different types of organisations. This was thought to reflect the wider challenges facing commissioning and the propositions for exploration in this research were therefore relevant for both commissioning as a concept and stroke services.

The institutional logics perspective was explored this chapter identified how as a theoretical perspective, it had the potential to explain and predict organisational behaviour in complex organisational fields. Previous investigations using the perspective had focused on the top down influences of field level logics on organisations in isolation rather than how micro level individual and inter-organisational practices affect organisational behaviour. The institutional logics perspective offered the opportunity to explore the impact of logics on inter-organisational working through investigation of the research question outlined above. This gave potential for the application of the theory to be extended as well as offering the opportunity to develop a practical understanding of the problems associated with commissioning integrated care through exploration of the propositions made in Chapter 2.

The basis of the institutional logics perspective uses ideal type logics to characterise organisations (Thornton, Ocasio and Lounsbury, 2012). The characteristics of ideal type institutional logics help to define the rule and belief systems that organisational and individual behaviour inform. The ideal types of the professions, bureaucracy, markets and corporations were identified as the most relevant to the healthcare organisational context. This research used these four logics to create a generalisable understanding of the social processes observed in the commissioning processes followed (see Chapters 5, 6 and 7).

The ideal type institutional logics relevant to this research were outlined in table 3:1. For this research, a theoretical understanding of the institutional logics informing commissioning and healthcare provider organisations was required to ground the research findings in theory. To explore the research context using this concept, the ideal type representation of commissioning and provider organisations were considered. The characteristics of each of the logics of interest were applied to a theoretical understanding of commissioning and provider organisations described in Chapter 2 to use as a basis to explore the organisations investigated in this research. This was the author's interpretation of how an ideal type commissioning or provider organisation may be represented using institutional logics based on how these organisations are described in the current policy landscape. This interpretation is given in table 3:4.

Table 3:4: Ideal type Commissioning and Provider Organisations

	Ideal type Commissioning	Ideal type Provider
Root metaphor	**Market - bureaucratic** *State redistribution of resources with elements of a market system*	**Corporate - professional** *Relational transactions of professional knowledge in corporate hierarchy*
Source of legitimacy	**Market - professional** *Decisions legitimised through money and clinical evidence*	**Professional – corporate** *Specialist knowledge used to determine market position*
Source of authority	**Bureaucratic** *Action controlled through policy and governance structures*	**Corporate - professional** *Clinical standards enforced through top down management*
Source of identity	**Bureaucratic - market** *Defined by political party in power*	**Professional – corporate** *Professional reputation maintained through bureaucratic mechanisms*
Basis of norms	**Market -bureaucratic** *Citizenship for equitable access*	**Market - bureaucratic** *Citizenship for equitable access*
Basis of attention	**Bureaucratic** *Community rather and individual attention*	**Professional – bureaucratic** *Status in profession and community good*
Basis of strategy	**Market - bureaucratic** *Economic efficiency for community good*	**Market - corporate** *Reputation, efficiency and profit*
Control mechanism	**Bureaucratic – market** *Finite resource allocation*	**Corporate - professional** *Clinical and managerial hierarchy*
Economic system	**Market - bureaucratic** *Welfare and market capitalisation*	**Corporate- market** *Managerial and market capitalism*

Using ideal types of the professional, bureaucratic, market and corporate logics to characterise healthcare commissioning and provision there appeared to be clear differences in the types of organisations involved in NHS commissioning. For example the root metaphor of commissioning was based on the bureaucratic and market logic. Commissioning organisations were under pressure to follow clear and strict governance structures and top down direction from the centre on how to commission healthcare. This was viewed to be associated with the bureaucratic logic but also influenced heavily by the market logic as policy dictated that the public healthcare economy operates as an internal market using market principles to drive improvements in cost and efficiency.

In comparison, over time provider organisations were given the freedom to become more independent in their decision making and operate as businesses meaning that they had more traits associated with the corporate logic. They were also the organisations where the medical profession delivered their services which mean that they were strongly influenced by the professional logic.

The two different characterisations show how as the NHS has evolved and been split into component organisations, each organisation ideal type has developed a characterisation that reflects their function. Ideal type characterisations are theoretical representations and therefore the organisations studied in this research are likely to follow different representations of ideal logics depending on their own interpretations of the institutional environment and the context in which they exist. The ideal type characterisations presented here provide a basis on which analysis and comparisons used in this research were made. Further explanations of this are given in Chapter 4.

Institutional logics research propositions

This identified the institutional logics perspective as the theoretical framework to investigate inter-organisational working within the context of commissioning as an organisational process. Institutional logics were considered an appropriate orientating theory to allow the complexity of commissioning to be explored to allow both theoretical and practical findings to be uncovered both for the contextual

situation and in wider context through theoretical generalisation. The following propositions are made to guide the research that follows and are based on the gaps in the literature identified in this chapter.

Proposition 1: Conflicting institutional logics in the field will lead to different organisations having different interpretations of the institutional demands placed on them leading to different values, practices, rules and beliefs

Proposition 2: Conflicting institutional logics in the field will make it difficult for different organisations to develop and negotiate shared goals

Proposition 3: Differences in interpretations of logics by organisations will lead to different values, practices, rules and beliefs which will make it difficult for organisations in the field to establish effective inter-organisational relationships

Conclusion

This chapter outlined the theoretical frame work used to orientate the research. It identified institutional logics as an appropriate theoretical framework to investigate the based on the problems associated with commissioning identified in Chapter 2 as well as identifying an opportunity to extend theoretical knowledge through further enquiry. An overarching theoretical question was outlined to explore *how institutional logics in an institutionally complex organisational field effect how organisations are able to work together to achieve their shared goals* along with propositions outlined above relating to the specific context of commissioning for the research. An overview of how institutional logics were used to frame the organisations of interest in preparation for further details on the research methodology which will now be detailed in Chapter 4.

Chapter 4: Methodology and research design

Introduction

To conduct high quality and meaningful research, a robust approach to the methodology and methods is required (Silverman, 2013). This chapter outlines the methodological approach and research design that was used in this research. It follows on from Chapter 2 where the contextual setting for the research was explained along with the challenges facing commissioning in the NHS, and Chapter 3 where institutional logics was outlined as the theoretical framework for the research. The current understanding of institutional logics was used to identify an overarching theoretical research question to guide investigation of the contextual and theoretical propositions:

How do institutional logics in an institutionally complex organisational field effect how organisations are able to work together to achieve their shared goals?

The chapter begins by explaining the research paradigm used to underpin the case study methodology used in this research. An explanation as to why the case study approach was considered the most appropriate methodology for the study is given followed by the chosen research methods themselves. This is supported by the full research protocol which can be found in Appendix I. The chapter then includes a discussion about how and why the three case study sites were selected, how access was gained, the methods used to collect data, and the data analysis strategy followed by a brief discussion of quality considerations for the research. The final section is the researcher's reflections on the research process.

Research paradigm

The research paradigm defines the framework for how reality is observed and provides a set of rules and beliefs by which research is conducted (Guba and Lincoln, 1994). This allows reality to be characterised according to the ontological and epistemological assumptions that are made by the researcher.

Ontology describes the basic elements of reality and tends to fall into three main traditions; materialism which assumes the world is composed of matter; idealism which assumes reality is a mental or spiritual state; and constructionism which assumes the social world is constructed by participants themselves (Benton and Craib, 2001).

Epistemology is the theory of knowledge and is characteristically concerned with developing criteria to distinguish knowledge from beliefs and prejudices by evaluating claims that something is known through the justification and reliability of different types of evidence (Benton and Craib, 2001). The research paradigm influences the choice of methodology used to investigate research questions as well as reflecting the researchers own ontological and epistemological assumptions.

The overarching research question for this research sought to understand the influence of institutional logics on how organisations within the same institutionally complex field are able to work together to achieve shared goals. Chapter 3 explored the institutional theory and institutional logics literature as the theoretical framework for this research. Institutional theory literature in the past tended to focus on the structuration of organisational fields to describe interactions between organisations (DiMaggio and Powell, 1983) while neglecting the influence of agency and self-interested behaviour from individuals in organisations (Thornton, Ocasio and Lounsbury, 2012). Focusing on the structure of organisations suggested that realist ontological assumptions about what exists in the world played an important role in describing organisations. As the theory developed, broader sociological themes that considered the cognitive and cultural elements of organisations and institutions were considered rather than concentrating on structuralism suggesting that constructionist traditions were beginning to influence enquiry. In turn this led to the development of the institutional logics perspective (Thornton, Ocasio and Lounsbury, 2012).

The institutional logics perspective provides a meta-theoretical framework for analysing the inter-relationships between institutions, organisations and individuals in social systems as a means of understanding how rationality is perceived and

experienced (Thornton, Ocasio and Lounsbury, 2012). Thornton et al. (2012) acknowledge that theoretical frameworks are often associated with an ideological commitment to paradigms (Kuhn, 1962). Ideologies can be considered rigid and value laden whereas the institutional logics perspective allows for the symbolic as well as the material aspects of institutions, which in turn allows for changing values (Thornton, Ocasio and Lounsbury, 2012). Despite Thornton et al (2012) distancing themselves from specific research paradigms, the institutional logics perspective can be considered a socially constructed concept.

Social constructionism allows for the construction of reality through social interaction (Berger and Luckmann, 1991). The incorporation of the social aspects of organisations through the institutional logics perspective suggests that institutional logics could be considered to be socially constructed rather than imposed on organisations which may be assumed from a realist perspective. As fluid and dynamic concepts of social situations, institutional logics have the potential to change over time (Goodrick and Reay, 2011) and be influenced by other social orders which co-exist (Reay and Hinings, 2009). This reflects how institutional logics in organisations have been seen to change and adapt over time as they form different constellations (Goodrick and Reay, 2011) which allows organisations and individuals to change and adapt over time depending on how the logics interact and influence each other.

Institutional logics allow for multiple interpretations of the institutional environment using characterisation of ideal type institutional logics (Friedland and Alford, 1991; Thornton, Ocasio and Lounsbury, 2012). The different logics allow for reality to be constructed in different ways depending on how an organisation or individual is influenced by the institutional demands it faces. This suggests there is not a single objective reality but that each individual and organisation constructs their own version of reality. Under the social constructivist paradigm this is not problematic as it allows for the construction of multiple versions of reality (Berger and Luckmann, 1991) making it an ideal paradigm in which to explore the influence or institutional logics in organisations. By exploring the experiences and perceptions

of individuals, the layers of different social constructions of reality can be explored to create a rich description of organisations and organisational behaviour.

Using a social constructionist approach, a contextual situation can be built which incorporates the views and perspectives of all those involved in the social processes or inter organisational working (Eisenhardt, 1989). These principles allow the depth and detail of a social situation to be explored and contextualised before the institutional logics framework is applied as a method of understanding the complexity that is uncovered. By seeking the experiences of individuals involved in an inter-organisational process, the individual's interpretation on that situation is sought. To do this the research was designed to incorporate the interpretations or multiple individuals in contextual situations that represent inter-organisational working using the assumption that participants in the research will socially construct their version of the reality that they experienced.

Research design

A social constructionist approach requires a qualitative methodology to understand the different individual perspectives of a contextual phenomenon to be interpreted (Denzin and Lincoln, 2011). For this study, this involved exploring multiple perspectives from individuals in different organisations as they attempted to work together towards shared organisational goals and understanding how institutional logics may be influencing inter-organisational relationships as they played out in practice. To achieve this, a research design was required that allowed the individual and organisational behaviours displayed through a commissioning process to be understood and contextualised within the institutional logic framework.

A qualitative approach allowed for an understanding of social experiences to be explored using a combination of methods; this provided a rich account of the organisational process from which theory can be developed (Denzin and Lincoln, 2011; Silverman, 2013). To allow for the complexity of the contextual situation and use of multiple qualitative methods, the case study approach was implemented as the research design for the study (Yin, 2009b).

Case study approach

Case studies are a frequently used qualitative methodological approach in social science research. Although the theoretical research question for the research could have been studied in many different contexts, commissioning in the NHS offered the opportunity to study a real life example of inter-organisational working in a highly complex institutional field (see Chapter 2 and 3) making case studies an appropriate methodological approach. The case study methodology also reflects the approach taken by others working within commissioning research (Segar *et al.*, 2015) which allows for the opportunity of comparisons between findings.

The case study approach involves '*empirical inquiry about a contemporary phenomenon, set within its real world context – especially when the boundaries between the phenomenon and the context are not clearly evident*' (Yin, 2009b) but within case study research there is a variety of approaches. Yin (2009) and Stake (1995) offer two different perspectives with epistemological commitments rooted in positivism and constructivism respectively. A positivist approach often satisfies the demands and expectations of those interested in health service research but risks neglecting the messy reality of studying a real life context (Segar *et al.*, 2015). Therefore finding a balance between difference types of approaches to case study methods is important.

Case study methodology is a naturalistic and constructionist approach which allows complex situations to be explored using multiple data collection techniques (Rubin and Rubin, 2012a). Yin's (2009) abbreviated definition of the case study method alludes to the intricate relationship between phenomenon and context, and that studying complex conditions is vital to understanding phenomena. A case is *'a complex, functioning thing'* with *'a boundary and working parts'* (Stake, 1995) and therefore studying commissioning as an abstract concept in isolation from its real world use would fail to provide meaningful findings. For example, interviews alone could give descriptive responses to the question but without the rich data hidden within the context, understanding the phenomenon as a whole would be

challenging. The research sought to go beyond description to understand and explain the phenomenon of commissioning and inter-organisational working.

Understanding the organisational processes used in commissioning required exploration of a complex social situation and acknowledgment that each stakeholder in the commissioning process may hold their own perspective on a unique and complex sequence of events. In acknowledging and accepting the different views each stakeholder takes, it was intended that the research would construct a fluid conceptualisation of a commissioning process that reflected the beliefs and attitudes of all those involved. Each stakeholder's construction of the commissioning process would be viewed through their own unique lens, which was dependent on their own experience, knowledge and expectations (Rubin and Rubin, 2012b). By drawing the different perspectives together, the conceptualisation sought to understand the commissioning process from all viewpoints. Approaching the research in this way allowed for a predominantly inductive methodology that drew on principles of grounded theory (Glaser and Strauss, 1967) with the intention of building theoretical explanations based on what was discovered in the data as it is collected and analysed. Taking naturalist viewpoint allowed complex commissioning processes to be explored within their individual context it without over simplifying it (Rubin and Rubin, 2012b). Flexibility within the approach allowed the researcher to adapt the methods as the research progressed (Stake, 1995) rather than being constrained by a prescriptive approach.

However rather than taking a purely inductive approach such as those that may be used in grounded theory (Glaser and Strauss, 1967) the research was guided by the findings of the theoretical and contextual literature reviews (Chapter 2 and 3). The theoretical literature review of institutional theory and institutional logics revealed that little was understood about institutional logics in complex fields influence how organisations work together. The concept of inter-organisational working was important in the NHS following calls for health services to be commissioned using integrated approaches. The focus of the research was directed towards answering the question of how institutional logics influence inter-organisational working. Focus using the research question and propositions allowed the method to specify

the type of organisations approached for inclusion in case study research and determine the type of data that was required (Eisenhardt, 1989). This was important as it reduced the risk of being overwhelmed by data and was considered an acceptable method in case study research (Yin, 2009b).

The case study field work in the research was focused using a constructionist approach with an understanding of the literature guiding the data collection and analysis that followed. This approach allowed data collection to be focused while not restricting it to preconceived ideas. Throughout the data collection process new ideas, theories and concepts were considered as they emerged in the data but the focus remained on generating a better understanding of how inter-organisational working played out in commissioning practice using case study methodology.

Generalisability of results to allow practical application of the findings has been raised as a potential problem for case study research. However case study research aims to make analytical generalisations rather than statistical generalisations (Yin, 2009b) and the case studies should not be thought of as a sample, but the opportunity to shed empirical light on a theoretical concept. The generalisations made from each case study in this research were at a higher conceptual level than that of the case study itself, and thereby have the potential to influence policy in the same way as statistically generalisations derived from experimental research (Yin, 2009b).

Rather than focusing on one case study, a multiple case design was used in this research as evidence from multiple case studies has been considered to be more robust (Herriot and Firestone, 1983). Comparing multiple sites was likely to make for more interesting findings with both theoretical and practical implications. This is known as the replication logic (Yin, 2009d). Yin (2009b) describes this method as the careful process of selecting case study sites that will either predict similar results (literal replication) or predict contrasting results for anticipated reasons (theoretical replication). Case study sites were selected that were working towards similar commissioning goals to allow the different approaches taken to achieve those goals to be explored.

Case selection

Case study research allows a particular context to be studied intensively and cases should be selected on the basis that they will illicit data to answer the research questions (Yin, 2009d). Yin (2009) defines a case as a the *'unit of analysis'* with clear boundaries which define what is in the case and what is not. While Stake (1995) also defines cases as bounded systems, his interpretive approach allows greater flexibility for the researcher to use intuition to define the boundaries. Here the researchers own experience of the NHS allowed the boundaries of each case to be considered pragmatically. Case study research can involve one case or multiple cases; this research used multiple sites to reflect the variation in commissioning practice that is already known to exist within the NHS (see Chapter 2). Although cases must be carefully selected for multiple-site case studies, Yin (2009) suggests that cases should be selected pragmatically to maximise access to relevant data and the selection process should not involve excessive investigation that may result in a mini case study of the site before it has begun. To ensure that cases were selected appropriately, an informant with detailed knowledge of the region where the cases were selected from was called upon to guide the selection process.

Case site selection timeline and rationale

The research required contextual situation to explore the complexity of inter-organisational relationships from an institutional logics perspective and the concept of commissioning in the English NHS was chosen as an appropriate setting for the research to take place (see Chapter 2) as it provided access to an organisational field where inter-organisational working had been prioritised. The boundaries of the case studies were influenced by changes in policy that occurred prior to the data collection period. A timeline of key documents relating to the selection of the case study sites and other key events in the research is given in figure 4.1.

In 2013 the Better Care Fund was announced as a pooled budget to help Clinical Commissioning Groups (CCGs) work on delivering integrated services, with a focus on moving services out of hospitals into the community (NHS England *et al.*, 2014). Prior to the data collection period, CCGs were focusing their attention on

commissioning integrated care but contextual example was required that could be defined to allow the data collection process to be focused. As services are often commissioned according to clinical specialities, stroke services were identified as a defined speciality where the benefits of integrated pathways of care had already been established and were compatible with the integration agenda (see Chapter 2). The stroke pathway in terms of how it was commissioning and clinically organised was important in informing the boundaries of each case study.

Commissioning of stroke services was the responsibility of the CCGs which came into effect in April 2013 following the Health and Social Care Act 2012 (Secretary of State for Health, 2012) (figure 4.1). Most CCG's do not always work independently and tend to commission many specialist services with their CCG neighbours. For services like stroke which require specialist large central acute hospital interventions, CCGs tend to commission alongside other local CCG's. Dedicated stroke units are often found in these large central hospitals (see Chapter 2) and usually provide stroke care for multiple CCG populations. Studying single CCG's would therefore not reflect the organisational nature of stroke services and could not be used to define the boundaries of the case alone.

In comparison to acute stroke services, stroke rehabilitation services may be inpatient, outpatient or community based and could be delivered by acute or community providers. Stroke specific rehabilitation services for stroke survivors may be provided by the acute provider, the community provider or both. Stroke guidelines recommend that stroke survivors have access to specialist stroke rehabilitation services immediately after their stroke and access to these services should continue in the community setting once a patient leaves hospital (NICE, 2013; Royal College of Physicians, 2016b). However despite widespread coverage of acute and hospital based rehabilitation stroke services, provision for community based services can be variable with some areas only having generic rehabilitation services (National Sentinal Stroke Audit, 2014). When considering commissioning arrangements for stroke, CCGs need to consider the different organisations that provide different types of services and how these organisations, both acute and community providers can work together and develop services to provide a

continuous pathway of specialist stroke services from the acute to the community setting. The boundaries of the case studies therefore needed to include all organisations involved in the commissioning and delivery of the stroke pathway in each geographic location selected. In selecting appropriate cases, the case study site boundaries for the research were taken to be the acute provider and any associated community provider(s) delivering or having the potential to deliver stroke specific services along with the CCGs responsible for commissioning services from the different providers.

To account for demographic variation, cases were selected from the same region. Across the country regions are divided into Strategic Clinical Networks (SCN) that bring together service users, providers and commissioners to help make improvements in specific clinical areas including stroke. SCN often have their own priorities and to ensure that each case study site selected was following consistent direction, two case study sites were initially selected within the same SCN with a specific interest in stroke services.

The SCN in the selected region had developed a regional stroke pathway specification (Document 4, Community Stroke Service Specification, AHSN/SCN 2013) for use by commissioners to allow development of evidence-based services across the area. The SCN shared a close working relationship with the Academic Health Science Network (AHSN) who also had had a stroke specific work stream. Together the SCN and AHSN had developed close relationships with the commissioners in the area responsible for stroke.

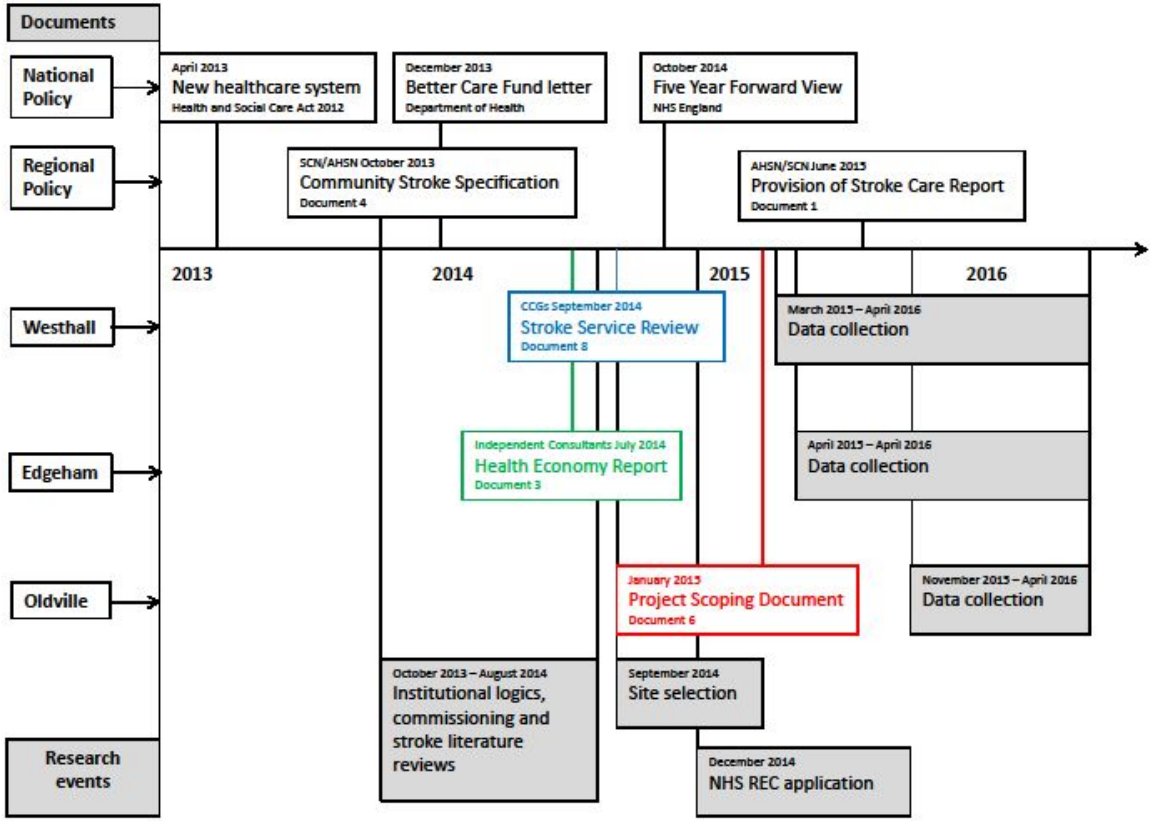


Figure 4.1: Timeline of key study events and documents relating to site selection and data collection

The Community Stroke Specification (Document 4, Community Stroke Service Specification, AHSN/SCN 2013) was used as a benchmarking tool to assess variation and highlight where improvements could be made. The AHSN worked closely with local stakeholders to investigate current service provision, highlight best practice, and feedback variation and areas in need of improvement. They published these findings in a report in June 2014 (Document 1, Provision of Stroke Care Report, AHSN/SCN 2014) to show the variation across the region and continue to encourage improvement. Prior to the report being published an AHSN representative was asked to act as a site selection informant to guide the case study site selection process based on their knowledge of plans to address commissioning arrangements in the region as they were being formed.

Two sites were initially identified as suitable case study sites. Sites were given pseudonyms to protect the identity of the sites and the stakeholders involved in the research. One site was located in Westhall and considered to be of a high standard with only a few minor areas highlighted for improvement (Document 1, Provision of Stroke Care Report, AHSN/SCN 2014). It was chosen as a best practice example for stroke service commissioning although a local review by CCGs had identified that services were fragmented and inequitable in some communities. As a result it had been targeted by the Local Transformation Board as a priority for incorporation into larger integration plans (detailed account given in Chapter 5: Westhall Case Study).

The second case study site was located in Edgeham and had significant failings in the community based stroke specific services (Document 1, Provision of Stroke Care Report, AHSN/SCN 2014) and in the wider health economy which was at risk of bankruptcy (Document 3, Health Economy Report, Independent Consultants, July 2014). Edgeham was chosen as a case study site to reflect how a commissioning process attempted to implement best practice where services were previously inadequate. Similarly to Westhall, plans were in place for wide scale transformation of the health services and stroke was prioritised for improvement within the wider integration plans (detailed account given in Chapter 6: Edgeham Case Study).

Both Westhall and Edgeham covered inner city, suburban and rural areas served by a single acute hospital in the main town which provided standard stroke unit care. Early Supported Discharge (ESD) and community based stroke services in the longer term were provided to greater and lesser extents throughout the two sites. Westhall had two options for ESD services and Community Stroke Teams (CSTs) which were provided by different providers but these were fragmented and varied in quality. Edgeham had an ESD service provided by the acute hospital and generic community based rehabilitation provided by multiple teams from a single community provider, which were fragmented and highly variable.

Westhall had 4 CCGs and Edgeham had 3 CCGs which commissioned stroke services. In each site, the CCGs intended to work together to commission stroke services which covered the whole area with one CCG taking the lead for commissioning arrangements in stroke services. The commissioner's plans to review and address commissioning arrangements were both focused on a need to develop services into an integrated system which would involve input from multiple organisations within the timeframe for the research. Gaining local permissions and ethical approval access to study the sites will be discussed in the next section.

As the data collection period progressed in Westhall and Edgeham it became clear that two very different examples of stroke service commissioning were emerging. Westhall was facing significant challenges as previous commissioning arrangements and relationships between the different organisations involved in the process were impacting on how effectively the commissioning process progressed. In Edgeham, commissioners decided to take new and alternative approach to the commissioning process by deciding to incorporate neurology services into their plans. As these unexpected developments unfolded it became clear that the two case studies were no longer representative of a best practice example and an example of another area trying to implement best practice in a different context.

To provide an alternative perspective a third area was considered to allow commissioning processes to be explored in another context. Oldville was located in the same SCN and also had significant problems with their community stroke

service provision. Commissioners were also under pressure to attend to the integration agenda and were interested in how stroke services could be used as an example of reorganisation towards an integrated system. Organisationally, Oldville was similar to Edgeham in that it had no specialised community stroke services beyond ESD. Commissioners had reviewed existing community stroke service provision and begun to make plans towards reorganisations and making new commissioning arrangements. Oldville was therefore selected as an additional case study site to provide an additional perspective to the research in November 2015.

Access

Gaining ethical approval to complete the research was complicated as it required approvals beyond the scope of the Nottingham University Business School Ethics Committee. As the research was to be conducted in the NHS, to complete the research in the selected sites special permission was required. Access needed to be granted both through permission from a NHS Research Ethics Committee (REC) and the relevant Research and Development (R&D) departments in the organisations where the research was to take place.

Initially an agreement needed to be obtained from the University of Nottingham for them to act as the sponsor of the research. This involved developing a research protocol in line with the University of Nottingham's standard format (see Appendix I for the research protocol used in the ethics applications). The standard format for the protocol was designed for use with clinical trials rather than qualitative research which meant that the protocol had to be adapted to fit a structure designed for clinical trials. To ensure that the requirements of the University were met, the practical details of the data collection process were outlined with allowance made for the fluidity required for qualitative research. For example, a range was given for expected numbers of participants recruited to the study rather than a target. Additional information sheets (see Appendix II) and consent forms were also developed in accordance with the University of Nottingham guidelines.

Once the protocol and other supporting documents for the study had been finalised and the University of Nottingham agreed to act a sponsor, an application could be

made to REC. Prior to this the selected sites of Westhall and Edgeham were contacted through their local R&D Department research officers to discuss access. In Westhall and Edgeham, the research officers were open to discussions about using the forthcoming commissioning processes in stroke but deferred final decisions of involvement to the lead commissioners for stroke. The commissioners were willing to allow the commissioning processes for stroke to be studied as long as their administrative involvement was kept to a minimum. The commissioners were willing to be included as participants in the research and to act as a key informant to help identify other stakeholders involved in the commissioning process but did express some concerns about involvement.

The commissioner's main concerns lay around confidentiality and ensuring that the case study sites remained anonymous. This was because the research may include sensitive commissioning information focused on contracting and costs that could not be shared amongst providers. However the commissioners felt that they were able to reduce any risk by ensuring that any documents that were accessed were first screened to exclude any sensitive information. Their other main concern was the time commitment associated with involvement. The commissioners were willing to commit an hour or two for interviews but were reluctant to be involved any further than this. This was considered to be acceptable as it was intended that all stakeholders would be invited to participate which would spread the burden of inclusion over a large number of people. These considerations were included in the research protocols which were reviewed and accepted by the commissioners and the research officers who acted on behalf of the organisations involved in the research before the NHS REC application was made.

Once access to Westhall and Edgeham had been negotiated agreed in principle, a formal NHS REC application was made to Wales REC 6 (REC reference 15/WA/0008, protocol number 14105, IRAS project ID 165321) for proportionate review. The Proportionate Review Service was used as the study raised no material ethical concerns as the data sources were confined to within organisations unless data was publically accessible. No patients or carers would be contacted unless they held a formal role as a lay representative in the organisations being researched. The

research would also only take place in administrative areas of the involved organisations. Clinical areas and information would not be accessed.

The application was reviewed via a teleconference rather than a full meeting of the REC as is consistent with proportional review. The application was given a favourable opinion on 9th January 2015 with the condition that 'Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned'. With REC approval in place, R&D approval was sought from the relevant organisations in Westhall and Edgeham. Approval to commence the research was granted in Westhall on 25th February 2015 and in Edgeham on 16th April 2015.

In October 2015, additional approval was sought to add Oldville as an additional case study site. No further REC approval was required as no changes were made to the protocol. Oldville R&D department granted approval for access on 10th November 2015.

Data collection

Data collection for case studies can involve many different methods depending on the opportunities available and good case studies should aim to access as many types of data sources as possible. Using multiple sources of evidence allows the researcher to address broader issues that may emerge in the case study and converge lines of inquiry (Yin, 2009c). This forms the basis of triangulation which works on the principle that different reference points will intersect to identify the truth in the case study (Silverman, 2013).

This research required a detailed exploration of commissioning in the case studies to understand organisational behaviour as it was enacted by stakeholders involved in the process. This required a detailed understanding of each stakeholder's role and behaviour in the process before it could be viewed through the institutional logics lens to understand how institutional logics were influencing the process as it played out. This placed individual stakeholders at the centre of the data collection strategy and methods were required that could gain insight into each stakeholders unique perspective on their experience and perceptions of the commissioning

process, the institutional influences that were informing their behaviour and how their interpretation of these influences were affecting how stakeholders from different organisations were able to work together towards a shared goal. The methods therefore required data collection to focus on the individual as well as incorporating a broader understanding of organisational practices and inter-organisational working. Semi-structured interviews were selected as the main source of data collection from the individual stakeholders with complimentary data from documents and observations to understand how the individual perceptions influenced wider inter-organisational working.

Different approaches were required for the different data collection methods. For the interviews, the aim was to capture as many perspectives as possible from the individuals involved in the process using a structured data collection plan. However for documents and observations required a more opportunistic approach as access allowed. The final data set included 47 semi-structured interviews, 10 site specific documents and approximately 30 hours of observation from 10 commissioning meetings. Details of data are given in Appendix III.

Interviews

Semi-structured interviews were used as a means of capturing individual experiences (Rubin and Rubin, 2012) about the events leading up to and during the commissioning process. This allowed a rich descriptive account of each commissioning process in the three case studies to be built using the perspectives of individuals from different organisations. Generating accounts from different individuals allowed the case study to be explored within the context of inter-organisational working and build an understanding of how the relationships between different individuals and organisations played out in practice.

As part of the ethical approval procedure, an example topic guide was developed as part of the research protocol (Appendix I). The questions were intended to explore the stroke commissioning process by addressing issues such as how commissioning decisions were prioritised, how decisions were made within the current policy landscape, how commissioners worked with other individuals and organisations to

develop a commissioning process, how the commissioning process was progressing, and how past commissioning decisions were influencing current practice. As the research progressed, the questions were adapted to ensure that specific aspects of the commissioning process in each site were addressed. For example, as commissioners worked towards procurement of existing community stroke services as a route to develop a lead provider model between the acute and community providers, the stakeholders were specifically asked about this method of commissioning and how it had impacted on achieving their shared organisational goals. Questions did not focus on institutional logics as this was an abstract concept but care was taken to ensure that known aspects of commissioning that drew on the professional, bureaucratic, market and corporate logics were explored. For example, the influence of policy on commissioning decisions was explored in all sites to determine how organisations were responding to bureaucratic demands from central government and local administrative centres.

To ensure that all aspects of the commissioning process were covered, sampling for the interview participants intended to include as many participants as possible from the different organisations involved. To identify potential participants for interview a chain referral strategy was used (Biernacki and Waldorf, 1981). Chain referral sampling is often used for hard to reach populations or populations that are dispersed (Heckathorn, 1997). For commissioning, identification of all those involved was potentially problematic as commissioning is not a clearly defined practice that occurs in the same way in all organisations. The variation in commissioning practice means that an approach to commissioning may have varied in each site and key participants may not have been invited if a structured purposive sampling strategy was used. The chain referral sampling technique allowed for individual tailored invitations to participate to be made to potential participants which was thought to increase response and recruitment rates to studies (Heckathorn, 1997).

The chain referral sampling strategy relies on a key informant to begin the process (Biernacki and Waldorf, 1981). This involved an initial interview with the lead commissioner in the CCG who was responsible for overseeing commissioning

arrangements for stroke. As part of the interview, the participant was questioned on who they worked with to commission stroke services in their own organisations and other organisations. If any other names or organisations were mentioned during the interview, the participant was asked who these people or organisations were and what their role was in the process. Following the interview, the people identified were contacted and invited to take part in the research. This process was used in all subsequent interviews until no new participants were identified.

All participants were issued with a study information sheet (Appendix II) prior to the interview which explained the study rationale; gave details on how their data would be anonymous and confidential; and how quotes may be used in this thesis and other publications. The information sheet informed participants that they may be invited to interview up to three times over the study period depending on their involvement in the commissioning process. Participants were also made aware that interviews would be audio recorded and transcribed verbatim. They were also informed that following the interview, they were able to request their interview transcript and request removal of any quotes they were uncomfortable with being included in the study. Participants were given the opportunity to ask questions before inclusion in the study was verbally confirmed and interviews were arranged. Before the interview commenced, participants were asked to give written consent.

Fifty four participants were recruited and interviewed for the study. Interviews lasted between 30 and 90 minutes. Details of the interviews are given in Appendix III. Although it was initially anticipated that participants may be interviewed on up to three occasions, each participant was only interviewed once as the timing of the interviews allowed the process to be captured retrospectively in the main. A number of participants were also reluctant to commit to a second interview for various reasons unique to each case study commissioning process. In Westhall the procurement process that formed the main part of the commissioning process created tension between stakeholders and the commissioners in particular were reluctant to discuss the process as it progressed and they considered it to be a breach of confidentiality to discuss it. Through this period a detailed description of events was built using provider stakeholder interviews, documents were access was

available and through observation at a commissioning meeting after the process was completed. In Edgeham good access to commissioning meetings was achieved and secondary interviews were not necessary as participants were followed through the process in the meetings. In Oldville progress was very slow and little change occurred during the data collection period and secondary interviews were not required.

Observations

Observations of commissioning practice in the field setting provided the opportunity to experience and explore how individuals from different organisations work together and negotiate the commissioning process in a real world setting. Including observations as part of the case study protocol allowed inclusion of additional data that may confirm or contradict the findings of the interviews, and add new dimensions for understanding the context (Yin, 2009c). These may have included the emotional and cultural aspects (Silverman, 2013) of inter-organisational working that may not have been captured as part of the interviews. Gaining an insight into these aspects allowed the participants to be better understood as individuals influenced by different institutional demands in the system.

Plans for direct observations of commissioning meetings were included in the protocol (Appendix I) for the study. Direct observations were used as the data collection technique which allowed the researcher to observe the commissioning process as an outsider rather than being involved in the process (Yin, 2009b). The researcher aimed to take a neutral stance while collecting data and focus data collection by using specific aims for the observation process. The aims of the observational data collection were to confirm the commissioning process that had been described by participants in the interviews, consider how individuals from different organisations build and form working relationships, and to consider the how logics from different organisations were influencing how individuals worked together towards shared goals. To record the observations, hand written field notes were made during observations. Field notes generated through direct observation were the researchers interpretations of the situation they were observing (Yin,

2009c). Although plans to include observation data as much as possible in the research were made, gaining access to appropriate observation opportunities was problematic.

In Westhall relationships between the organisations had become strained before the case study data collection began meaning that there were few commissioning meetings organised that would involve all the stakeholders. The commissioners had decided to proceed with the commissioning process using a procurement exercise which meant that they were not able to meet or discuss the process under procurement regulations. Access to a procurement debrief meeting between providers and commissioners after the exercise was denied for confidentiality reasons. In total only two commissioning meetings were observed in Westhall but neither of these directly related to the commission process itself.

In Oldville numerous meetings involving providers had taken place discuss plans to review and reconfigure services before the data collection period commenced. During the case study, one commissioning meeting was observed where stakeholders met to discuss plans. As the data collection period progressed, little progress was made towards implementing plans and no further commissioning meetings were arranged.

In Edgeham access to commissioning meetings with providers was easier to negotiate as meetings were held regularly between the stakeholders. Commissioners met three times with provider stakeholders to design the new service they planned to commission. Each of these meetings were observed along with two other commissioning meetings with providers where details of implementation plans were discussed.

Two regional meetings held by the AHSN and SCN were also observed but these were only attended by representatives from Westhall and Edgeham. In total 10 commissioning meetings were observed during the data collection period with a total of approximately 30 hours of observation data (Appendix III). Although observation data was not as plentiful as anticipated, the data collected in each site did reflect how commissioning was approached in each site with Edgeham taking a

more collaborative approach, Oldville a passive approach and Westhall following the rules of procurement. When meetings were attended, data was collected that was useful for sense checking details of the commissioning process that had been offered in the interviews and to give an insight into how individuals and organisations were working together in terms of their goals and relationships. An example of the field notes used to record data is given in table 4.1.

Table 4.1: Edgeham Contracts meeting December 2015

Scenario	Description of events	Comments
Providers request details of how long the commissioners expect reconfiguration of services to take as they *'don't know how to do this'* (Jackie, Strategic Manager, Community Provider)	Jane (Commissioning Manager) suggests it should take 3 months to reconfigure services to meet existing demand and a further 3 months to filter private demand into new service	The commissioners push for change by end of the financial year but without firm plans. Providers look to the commissioners for guidance and are willing to accept their expectations
Options for a lead provider model are discussed	Community lead, Acute lead or combined lead are the options. Providers are keen to discuss, consider and negotiate at a later date	Providers are open to considering how they can work across organisational boundaries but want to time to consider this before they start negotiations
Commissioners announce preferred option is Community lead and they want a decision today to allow incorporations into wider integration plans as a trail blazer	Commissioners force Provider's to make a decision despite them requesting more time to consider the options. Integration plans are prioritised over the finer details of the new contract and specifications	The commissioners appear to be in control of the Providers but they are controlled by wider plans. They are willing to rush to ensure they meet deadlines, demonstrate competence with integration plans and can't be seen to fail

Documents

Where possible documents were accessed to supplement the data collected through interviews and provide greater detail on the commissioning process.

Documents may form a substantial part of case study evidence and can be accessed from a number of sources (Yin, 2009c). With extensive searches now possible on the internet, it is possible to be overwhelmed with document evidence and therefore documents should be carefully selected to ensure that they enhance case study evidence rather than compromise it (Silverman, 2013). The most important use of documents in case study research is to corroborate and augment evidence collected from other sources such as interviews, and when contradictions are found these can be used to guide enquiry deeper (Yin, 2009c). Using documentary evidence in this way allow a specific search strategy to be implemented.

During interviews and observations, when reference was made to a specific document, the document was prioritised for inclusion in the case study evidence. For example, the SCN and AHSN had produced a regional Community Stroke Specification (Document 4, SCN/AHSN, 2013) which was designed to guide commissioners as they commissioned community stroke services; this document was used in all three sites as an important reference document as they considered stroke service commissioning. Similarly the SCN and AHSN produced a report which highlighted good practice and areas for improvement in all three of the case study sites which was an important reference document for understanding and comparing commissioning priorities between different types of organisations. Both of these were available in the public domain and easily accessible.

For local documents, many of these were not publically available. When documents were mentioned in interviews, access to the document was requested within the confidentiality guidelines outlined in the study protocol (Appendix I). The documents included local reports, commissioning plans and business cases. In most cases participants allowed these documents to be used as long as they remained anonymous. Details of documents collected for evidence are given in Appendix III.

Data analysis

Interviews audio recordings and field notes were transcribed in full, stored, organised and analysed in Nvivo 11 along with collected documents. Analysis of the data involved sorting, naming, categorising and making connections through the

researchers interpretation of what words, actions and events mean and how they are understood (Boeije, 2010). The case study design yielded a high volume of data and an analytical strategy was required that would allow a systematic approach to analysis. Yin (2009a) suggests four different strategies that could be used exclusively or in combination with each other through the data analysis process. These included *working with the data from the ground up, developing a case description, relying on theoretical propositions and examining plausible rival explanations* (Yin, 2009a). The four strategies are outlined in table 4.2 with reference to their application to this research.

For this research, *developing a case description* and *relying on theoretical propositions* were the main analytical strategies used (table 4.2). Relying on theoretical propositions was important as the research question specifically called for an understanding of how institutional logics influenced inter-organisational working. The strategy allowed data collection to be focused towards propositions and help to ensure that relevant data was being collected (Yin, 2009a). However as the data collection progressed it became clear that each commissioning process being followed was highly complex and application of the institutional logics perspective from the outset could risk losing the richness in the data as it was collected. The initial strategy used was therefore developing a case description so that the complexity of each case study could then be explored through the institutional logics framework with loosing detail.

As data was collected, the analytical strategy began with the initial focus being development of a rich case description of each commissioning process. Once data was transcribed and organised in Nvivo11, the coding process began and continued concurrently alongside data collection. The data coding process involved reading the data and separating it into meaningful parts to create order in an otherwise bulky and diverse set of accounts of the case (Boeije, 2010). For the analytical strategy used in this research, data was initially open coded, before subsequent rounds of axial coding and selective coding using the institutional logics framework were applied to the data collected (table 4.3)

Table 4.2: Case study analysis strategies (adapted from Yin, 2009)

Strategy	*Working with the data from the ground up*	*Developing a case description*	*Relying on theoretical propositions*	*Examining plausible rival explanations*
Description	Inductive approach based on grounded theory	Organising data into a descriptive framework	Following the theoretical propositions of the research question	Defining and testing plausible rival explanations in the data
Advantages	Using the data to suggest analytical path not biased by preconceived ideas and concepts	Allows a rich description of the case to be built and further lines of enquiry to be identified	Focuses data collection and analysis on concepts identified in literature searches	Can be used alongside other strategies to develop alternative explanations and allow further data collection
Disadvantages	Challenging to be truly inductive when theoretical concepts have been explored in research design	Risks over simplification of a complex case study	Risks finding alternative explanations in the data by fitting data to the propositions	Rival explanations may alter focus or be discovered too late leaving insufficient time to collect additional data
Application in research	Research question called for influence of institutional logics to be explored making a purely inductive approach difficult to achieve	Developing a 'story' for each commissioning process would allow themes to emerge within and across the cases	Allows use of the institutional logics framework to identify logics in action in the data	Allows for additional explanations to be considered for further investigation in subsequent research
Analytical strategy	No	Yes	Yes	Possibly

Table 4.3: Analytical strategy

Research question	*How do institutional logics in an institutionally complex organisational field effect how organisations are able to work together to achieve their shared goals?*		
	Step one	**Step two**	**Step 3**
Analytical strategy	Open coding	Axial coding	Selective coding
Step question	*What are the key themes in the commissioning process?*	*How was the commissioning process initiated, conducted in practice and concluded?*	*How did institutional logics influence inter-organisational working during commissioning?*
Step sub questions	*What were the factors involved in initiating the commissioning process?* *What were the key events in the commissioning process?* *What was the outcome of the commissioning process?*	*How were initiation factors used to negotiate an inter-organisational gaol?* *How did organisations work together to achieve the commissioning goal?* *How did the commissioning process influence the outcome?*	*What institutional logics were influencing the commissioning process?* *How were different organisations interpreting and using institutional logics?* *How did institutional logics influence inter-organisational working and commissioning outcomes?*

Step one: Open coding

Open coding is the process of *'breaking down, examining, comparing, conceptualising and categorising data'* (Strauss and Corbin, 2007). The process is often used as the first stage of qualitative data analysis and involves careful reading of all data and allocation of labels or codes to data sections. The open coding process encourages a thematic approach to analysis as each code represents the researcher's interpretation of meaning in the data, which then allows the data to be broken up into pieces and groups according to the themes identified (Boeije, 2010). All coding was completed in NVivo 11.

Open coding results in a list of codes that can be used to identify data relating to the same code. Data sections may contain multiple codes which allow comparison and associations to be made across codes. Although it was not clear at the start of the open coding what data may have been relevant to the study and what was not, the aim of the open coding process was to understand the themes commissioning process in each commissioning site (table 4.3). This was done by examining the events that led to the initiation of the commissioning process, exploring the commissioning process itself and considering the outcome of the commissioning process. Coding in this way allowed the phases of the commissioning process to be identified and organised within the data set.

The purpose of using open coding as the initial data analysis phase was to become close to and familiar with the data as it was collected (Boeije, 2010). It allowed exploration of the case studies through reading and re-reading of the data to allow the data to be organised before the next phase of analysis commenced. As the process continued a clearer understanding of the commissioning process emerged and questions were then raised about why events and behaviours occurred at different time points. The open coding phase continued throughout the data collection period. Once data collection was completed, a final round was completed. No new codes were identified in the data and the researcher was confident that saturation had been reached (Silverman, 2013) and the next phase of analysis could begin.

Step two: Axial coding

Axial coding involves putting data back together in a new way following an open coding process by making connections between categories (Strauss and Corbin, 2007). The purpose of this phase of data analysis was to determine the important events in each case study by reducing and reorganising the data set to ensure that codes represented the best interpretation of the events of the commissioning process as they unfolded (Boeije, 2010). This process was used to identify the key events in the each case study using the codes identified in the first stage of open coding. By considering the relationships between the different categories that identified in stage one, the axial coding process allowed categories to be refined using systematic axial coding (figure 4.1).

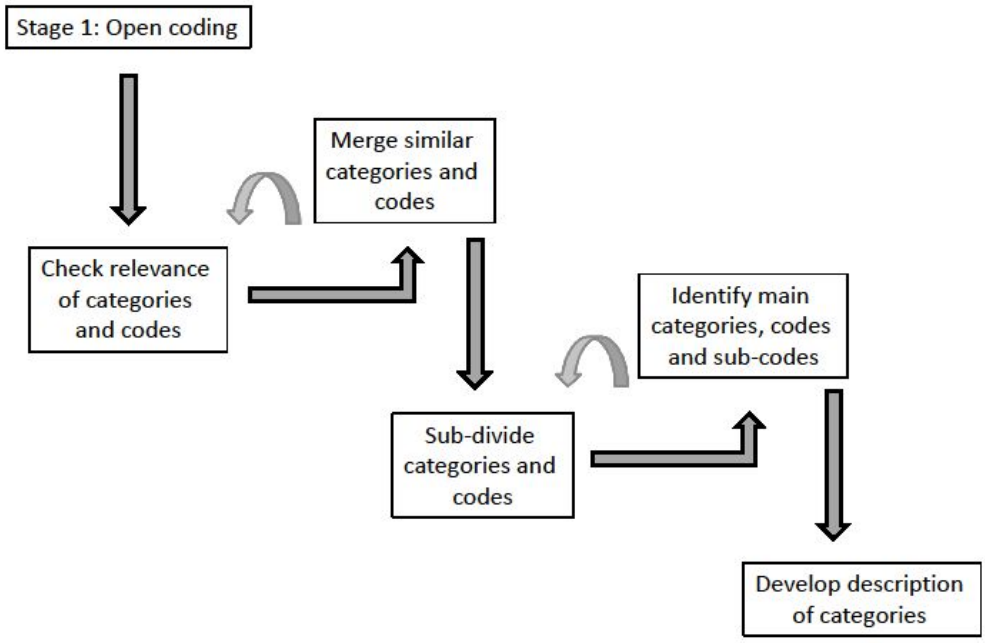


Figure 4.1: Axial coding technique

Through open coding it was clear that significant events were important to the initiation of the commissioning process that was followed during the data collection period and the commissioning process itself. Although each commissioning case study initially appeared to have broadly similar goals, the commissioning processes

that were used were complex and different, and ultimately led to different outcomes. The systematic process used during the axial coding stage (figure 4.1) was used reconfigure the codes generated in stage one into a meaningful explanation of the initiation, the commissioning process itself and the outcomes of commissioning in each case study site. This allowed the themes of each stage to be explored in detail before the third analytical stage was applied to understand how institutional logics may be influencing commissioning in each phase. An example of the output for axial coding of the commissioning process is given in table 4.4.

Table 4.4: Example of axial coding

Category	Sub-categories	Description	Example quote
Remaining CCGs attempt to progress towards new model through procurement of existing CST service	Plans on hold Poor communication Conversations inhibited	Contractual obligations for existing CST: Procurement exercise intended to result in lead provider model after the new contract is awarded but lead to break down in collaborative relationships	*'I have questioned why it's all gone off-the-boil in the last sort of six months. Meetings have been cancelled. We haven't carried it on and then all the services go out to tender. So I was confused by that because that's never been explained'* Wendy, General Manager, North Community Provider Westhall quote 18

The results of the axial coding phase formed the basis of the findings for each commissioning case study.

Step three: Selective coding using institutional logics framework

Selective coding refers to the process of looking for specific connections in the categories to make sense of what is happening in the field and is considered a logical step after data has been segmented using axial coding (Boeije, 2010). This phase of the analytical strategy aimed to incorporate the institutional logics

framework to allow theoretical concepts to be developed in response to the overarching research question.

Selective coding relies on the researchers understanding of theory as this influences how theory is applied to the data. Through the literature review of institutional logics (Chapter 3), ideal type logics were identified as the basis of the institutional logics framework which could be used for analysis of the data. Ideal type logics allow the boundaries of analysis to be systematically defined and identified in data. They assist the researcher to avoid mere reproducing an empirical situation by providing a rich but generalisable understanding of the varied processes that shape an observed institutional outcome (Thornton, Ocasio and Lounsbury, 2012).

Ideal type institutional logics for the healthcare field had been previously used but not in the analysis of a field were different types of organisations co-existed and worked alongside one another. Chapter 2 explored the NHS as the setting for this scenario and the institutional logics framework was applied to the understanding of commissioning and provider organisations to give a possible theoretical construct of the organisations using ideal types in Chapter3. To do this the researcher used the corporate, market, bureaucratic and professional logics known to be associated with healthcare and generated a theoretical ideal type for commissioning and healthcare provider organisations (table 4.5) that then formed the basis of the selective coding used in phase three of the analytical strategy.

Table 4.5: Ideal type Commissioning and Provider Organisations used for selective coding of data

	Ideal type Commissioning	Ideal type Provider
Root metaphor	**Market - bureaucratic** *State redistribution of resources with elements of a market system*	**Corporate - professional** *Relational transactions of professional knowledge in corporate hierarchy*
Source of legitimacy	**Market - professional** *Decisions legitimised through money and clinical evidence*	**Professional – corporate** *Specialist knowledge used to determine market position*
Source of authority	**Bureaucratic** *Action controlled through policy and governance structures*	**Corporate - professional** *Clinical standards enforced through top down management*
Source of identity	**Bureaucratic - market** *Defined by political party in power*	**Professional – corporate** *Professional reputation maintained through bureaucratic mechanisms*
Basis of norms	**Market - bureaucratic** *Citizenship for equitable access*	**Market - bureaucratic** *Citizenship for equitable access*
Basis of attention	**Bureaucratic** *Community rather and individual attention*	**Professional – bureaucratic** *Status in profession and community good*
Basis of strategy	**Market - bureaucratic** *Economic efficiency for community good*	**Market - corporate** *Reputation, efficiency and profit*
Control mechanism	**Bureaucratic – market** *Finite resource allocation*	**Corporate - professional** *Clinical and managerial hierarchy*
Economic system	**Market - bureaucratic** *Welfare and market capitalisation*	**Corporate- market** *Managerial and market capitalism*

To complete the selective coding phase, the categories and sub categories generated through axial coding in stage 2 were re-examined under the institutional logics lens to establish the logics at play in each commissioning case study. Using the example given in table 4.4, the commissioners were seen to be acting under the market logic by attempting to commission using a procurement process with elements of the bureaucratic logic as they attempted to implement new commissioning models (lead provider model) that had been suggested in the recent Five Year Forward View (NHS England *et al.*, 2014). In comparison, the providers were more closely aligned with the professional and bureaucratic logics as they were confused by the procurement process suggesting that there was a conflict between the logics that each organisation was working under.

The research question called to understand how inter-organisational working was influenced by institutional logics but existing knowledge suggested that the influence of logics goes beyond purely complementary or contradictory logics. To allow a deeper enquiry, the selective process also drew on the concept of goals and means (Pache and Santos, 2010) to understand how organisations operate. In combination with identifying ideal type logics in the data, the goal and means of establishing those goals were considered for each organisation to assist in establishing how organisations were working together in each commissioning case study. The findings were then used to allow the three case studies to be compared before a theoretical explanation for the findings was developed and presented in Chapter 8.

Quality

It is important to ensure that research is of a high quality and measures were taken to design and conduct the research to the highest quality standards possible. An important consideration was the trustworthiness of the research.

Trustworthiness of the research

Lincoln and Guba (1985) define trustworthiness as a researcher's ability to persuade their audience that their research is worth paying attention to and suggest four criteria that should be considered to determine the level of trustworthiness. Firstly

the *'truth value'* or confidence in the findings; secondly the *'applicability'* of the findings in other contexts; thirdly the *'consistency'* of the findings should the study be replicated with the same subjects in the same context; and finally the *'neutrality'* of the researcher and their ability to remove their own bias, motivation and perspective from the research (Lincoln and Guba, 1985).

The basis of constructionist case study research is that it builds an argument based on constructions of reality from multiple participants and data sources. To demonstrate the truth value in the findings, the researcher must demonstrate that they have represented the multiple constructions explored in the case study accurately to ensure that the final construction by the researcher is a credible refection of the original multiple realities investigated (Lincoln and Guba, 1985). To ensure a credible account of each case study was presented in the research, the researcher drew on multiple sources of empirical evidence. During the data collection period, data collection was guided by previous data sources with the aim of clarifying or disregarding findings through a process of triangulation (Silverman, 2013). To ensure trustworthiness in this process, multiple sources of this data was presented to reassure the reader in the process by which conclusions were made.

When considering the applicability of the findings, it has been suggested that the way in which findings can be transferred to other context can only be considered by those seeking to apply the findings elsewhere (Lincoln and Guba, 1985). Lincoln and Guba (1985) suggest that to aid this process, researchers should seek to provide as much description as possible in their findings. With that in mind, Chapters 5, 6 and 7 present a highly descriptive and detailed account of each case study. Each case study begins with a rich description of the case as it unfolded before the analysis is presented to allow the reader to understand the context in which the findings are presented. It is then for the reader to determine if they agree with the researchers interpretations.

Replication of a study to determine the consistency of findings relies on the assumption of naive realism or the assumption that there is something tangible and unchangeable in the context (Lincoln and Guba, 1985). As will be shown by this

research, this neglects the instability of the context and the constantly changing and adapting environment that influences a case in many ways. To overcome the problems of replication, the research focuses on three individual case studies within a broadly similar context in the same time point. It therefore makes an attempt to consider replication within its particular frame of reference. However the methodological approach may be replicated elsewhere in the future and it remains to be seen if results are similar or influenced by a new contextual situation.

Finally neutrality is said to occur when an appropriate methodology is employed that allows distance between the observed and the observer based on the notion that the observer is neither disturbing or disturbed (Lincoln and Guba, 1985). True neutrality is near impossible to achieve but acknowledgment of the researcher's frame of reference as they enter the research process in terms of their own epistemological assumptions and past experiences, allow the reader to appreciate how the research may have been shaped. The epistemological considerations for the research were outlined earlier in the chapter and the researcher reflections on the research process which follows explores past experiences.

Researcher's reflections on the research process

The research presented in this thesis is the end product of a four year PhD journey. Traditionally this journey is considered to comprise of distinct phases of planning, exploration and explanation but the process of completing a PhD rarely follows a pre-determined path. During this PhD I did complete all of these phases but the pathway was far from linear as it involved changes in perspectives as I began to challenge my own beliefs and behaviours.

Prior to starting this PhD, I was working as a senior neurological research physiotherapist with a special interest in community stroke rehabilitation. This was important as it influenced a number of decisions in how I would carry out the PhD. My previous experience had conditioned me to consider specialist CSTs an essential component of the stroke pathway. I felt strongly that CSTs made a real difference to the lives of stroke survivors but struggled to understand why such services were not more widely available and often considered the poor relation of their super-

specialised acute counterparts, especially when evidence was becoming increasingly in favour of commissioning specialist community stroke services.

As I began planning the research, I was initially focused on understanding how commissioning CSTs could be improved to increase the provision of such services. I was focused on a practical intention but neglecting that the research could have much wider implications that reached into theory and beyond. I was guided to expand my knowledge beyond stroke and commissioning in literal terms and conceptualise NHS commissioning as an organisational concept. Broadening the way I understood the NHS gave me scope to consider commissioning as an inter-organisational concept within a complex field. I began to appreciate the layers of complexity within the healthcare field and the contradictions that seemed to exist between different organisational components of the NHS system. As my knowledge deepened, I turned to institutional theory to help to explain the complexity I had not previously appreciated.

Through emersion in theory, I began to understand how considering stroke as a contextual example rather than the main focus of my research could result in findings that had further reaching consequences. I found institutional logics to be a promising perspective that could be used to understand why commissioning CSTs was so challenging. I developed a research question that satisfied both my theoretical and practical questions relating to institutional logics, NHS commissioning and stroke services.

As I began to design the research to answer my questions, I began to think about my role as a researcher. Reflective practice is commonplace for health professionals (Clouder and Sellars, 2004). Critical reflection is regularly used to consider how work was done and enhance patient care through retrospective observation. However moving into the role of researcher, I needed to develop my reflective skills to a more sophisticated and complex way of thinking. A reflexive researcher goes beyond merely observing ways of doing, and questions the basis of work and opens the opportunity for alternative thought processes and explanations (Hibbert et al., 2010).

Challenging my own assumptions and beliefs was an important process as I planned to use a predominantly inductive methodology, accepting that the phenomena I wanted to investigate was ambiguous and more than one line of inquiry could be explored (Alvesson, 2003). My previous position as a stroke healthcare professional had the potential to make this difficult. Past experience of being a health professional can be advantage when undertaking research in a health environment (Finlay, 2002) as tacit clinical knowledge of stroke rehabilitation could allow me to relate to the research environment.

An insider role could be considered problematic for inductive qualitative research as I could be prone to aligning my arguments within a particular standpoint and deductively seek to confirm my assumptions. I could feel compelled to support that case for commissioning specialist stroke care, and fail to see past this view to explore other decision making strategies and report other findings (McNair et al., 2008). However as I had started to become aware of the multiple perspectives that could be held by commissioning stakeholders, I realised that my clinical standpoint I may not be that held by commissioners. I started to see that my lack of experience and knowledge in commissioning could give me the perception of being an outsider. Researchers from one culture wishing to research another culture face the problem of having experience that does not equip them to make sense of event in the same way as an insider would (Easterby-Smith and Malina, 1999).

However there is a strong clinical aspect to commissioning and boundaries of my position could make me an insider to some and an outsider to others. Assuming multiple identities as an insider and outsider in the research context can enhance reflexivity (Easterby-Smith and Malina, 1999). I needed to consider how my position as an insider or outsider may influence data collection and my interpretations of what was found. Being explicit about identity position could be counterproductive as it may lead to responses being fixed too firmly (Alvesson, 2003) and I needed to be flexible with my position to ensure the data answered my questions. I concluded that my stance would be to conceal my clinical identity at least in the first instance, and to only reveal my knowledge of stroke if it may open new avenues of enquiry. As a researcher's personal knowledge about a particular world or subject in which

they are writing is thought to correlate with successful research (Hirsch, 1995) allowing discussion of my own experience as a stroke physiotherapist could help to facilitate discussions with commissioners and enhance my interpretation of why commissioning is practiced the way it is. It could help to legitimise my identity as a health professional alongside my identity as a student. Establishing a position of knowledgeable researcher or naive PhD student could have consequences for relationships formed as part of the research process (Duke, 2002).

Completing a PhD presents many opportunities to hone new skills and data collection was a new challenge. The majority of data was collected in interviews. An interview is a complex social situation where the interplay between two people, their personal characteristics and experience heavily imprints on the data collected (Alvesson, 2003). As a health professional I had experience of interviewing patients but this had a very objective focus. Clinically trained researchers are often skilled in interview techniques including observation, verbal and non-verbal communication and a range of questioning styles but can have a tendency to focus on objective fact finding rather than delving into more subjective topics (McNair et al., 2008). McNair et al (2008) found that novice GP researchers also fall into the same trap, feeling the need to follow a topic guide too rigorously and conclude discussions too quickly as they are used to working within strict time constraints. It is generally assumed that participants want to give a good reflection of themselves and their organisation and will often follow a script of official answers to questions (Alvesson, 2003). Developing rapport with participants helps to break through the official rhetoric of the organisations.

Finaly (2002) suggests that in being reflexive, researchers *are "damned if they do and damned if they don't"*. It is up to the researcher to decide how best to exploit reflexivity in their work and consider how it may enhance or hinder the knowledge they construct (Finlay, 2002). As the data collection progressed I became more confident in my own skills as a researcher. By the time data analysis was near competition, I considered that I identified more closely with the role of researcher rather than physiotherapist but had a broad set of skills that enhanced the case studies.

Chapter 5: Westhall case study: Competitive commissioning

Introduction

This chapter presents the empirical findings from the commissioning process followed in Westhall between March 2015 and March 2016. The commissioning process was initiated before this period in response to concerns that the way in which stroke services had been commissioned in the past had led to variation and inequality in the area. Westhall was recognised within the region as having pockets of excellent and comprehensive stroke services with the majority of required elements of the stroke pathway in place (Document 1, Provision of stroke care report, AHSN, June 2015). However the way in which providers were organised and funded had created a fragmented system (Document 8, Stroke services review, Westhall CCGs, September 2014) with two different stroke pathways emerging from one acute hospital (figure 5:1).

The differences in service providers, provision and quality of stroke services originated from the period when services were commissioned by Primary Care Trusts (PCTs). During this time two PCTs, North Westhall PCT and South Westhall PCT operated in the area and were responsible for delivering community services. This led to the development of two different stroke pathways for stroke survivors depending on if they lived in North or South Westhall. Initially this was not problematic as the two pathways were very similar. However overtime they became inequitable for patients as the two services developed and changed in different ways clinically, financially and contractually. The case study begins by exploring the drivers which initiated the process to change commissioning arrangements in Westhall, followed by the commissioning process itself and details of the commissioning outcome. The case study seeks to understand how organisations in a complex institutional field work together to achieve their goal. This is explored in the final section using the institutional logics framework.

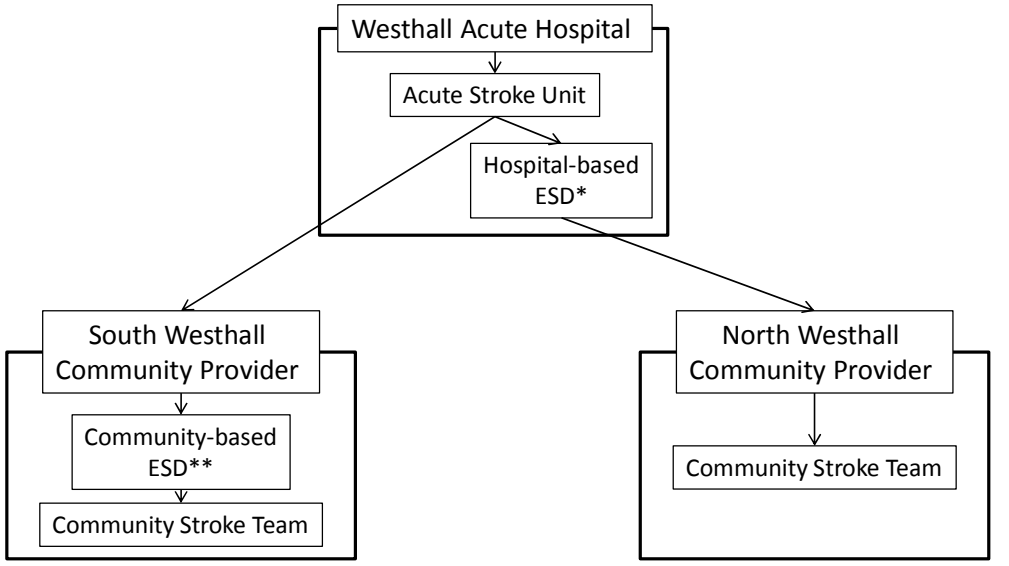


Figure 5:1: Westhall stroke pathways

Initiating change

The three case studies in this research were subject to similar regional and national policy drivers but the organisations and individuals in each case study site interpreted these differently. Each site had locally specific drivers that influenced the commissioning response. Although the drivers could only be explored retrospective through document analysis and interviews, they heavily influenced the initiation of the plans to change commissioning arrangements for stroke in Westhall and the commissioning process that followed.

Six main drivers for change (figure 5:2) were identified. These included Strategic Clinical Network (SCN) and Academic Health Science Network (AHSN) pressure, clinical policy, local and national policy, patient and public involvement and historical commissioning arrangements. The commissioning process sought to address the problems associated with historical commissioning arrangements for

stroke. These had led to the development of two different pathways in Westhall that were funded and delivered in different ways. This had created a fragmented system that was considered inequitable for patients and inefficient due to poor integration between the Acute Provider and the two Community Providers. The case for change was strengthened by the national transformation agenda to address problems the health service was facing with inefficiency and escalating costs. These problems were reflected in the problems stroke services were experiencing.

'If we don't transform our services across Health and Social Care, we'll have a £140m financial gap. At the moment Social Care's already got significant financial challenges. We've got a large acute hospital that's already got significant financial challenges, well millions of pounds. So we know that the model of care actually at the moment isn't sustainable'.

Sarah, Commissioning Director, Westhall Transformation Board

Westhall quote 1

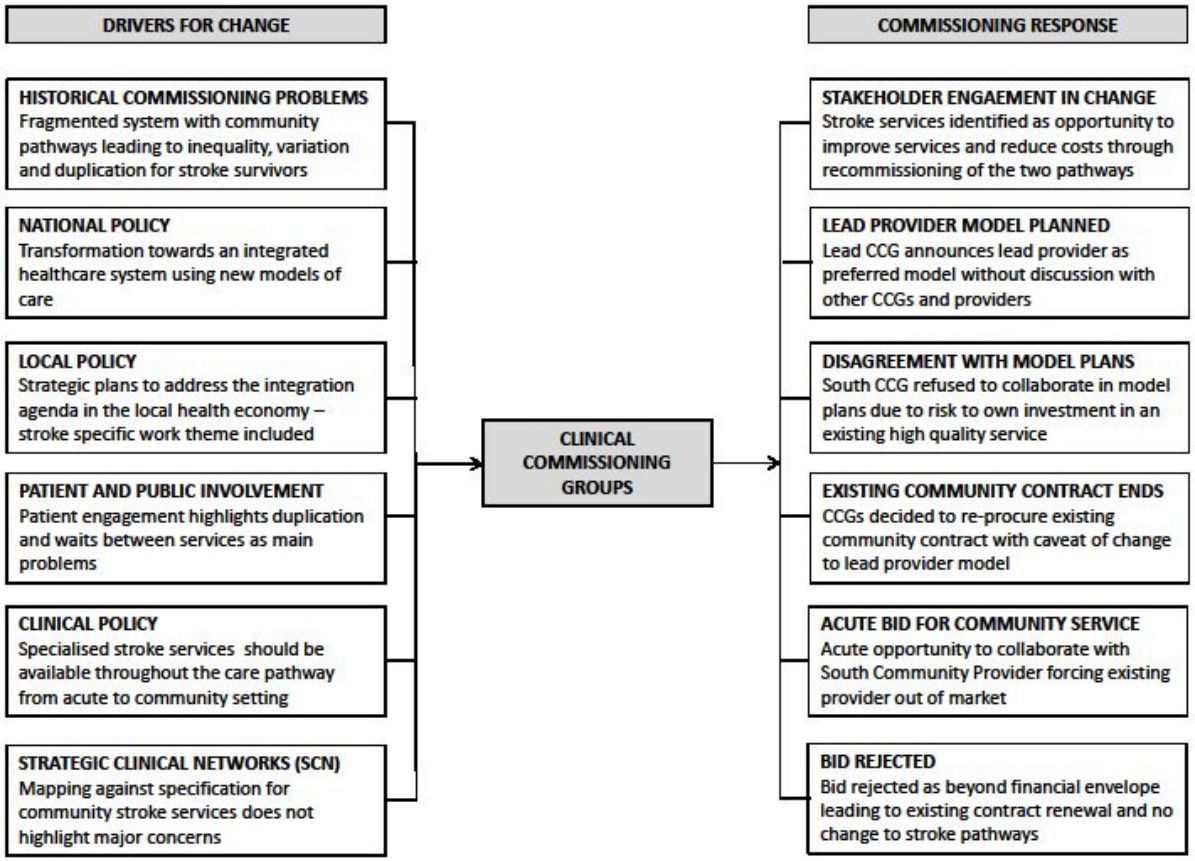


Figure 5:2: Westhall change drivers and commissioning response

Historical commissioning arrangements

Two stroke pathways in Westhall (figure 5:1) had existed for many years. The arrangement originated from the period when community services were commissioned and delivered by two PCTs in the area; North Westhall PCT and South Westhall PCT. Both PCTs commissioned and delivered a Community Stroke Team (CST) and initially there was little difference between the two pathways other than different provider organisations in the community. As evidence emerged to support reorganisation of acute stroke services and introduction of Early Supported Discharge (ESD) (see Chapter 2), South Westhall PCT took the opportunity to create a comprehensive stroke pathway to improve the quality of the care their stroke patients received. The South Westhall PCT won funding for a comprehensive ESD through a *'new investment funding pool'* (Liz, Business Manager, South Community Provider) offered by South Westhall PCT. North Westhall PCT was not in a position at that time to invest in an ESD. Tension emerged between the two Community Providers as two different pathways developed and the new ESD started to make positive improvements for the patients in the South Westhall by reducing length of acute hospital stay and overall outcomes.

'In the [South] at that time we were really fortunate that the investment was made into ESD and we could have an all singing, all dancing multidisciplinary team and obviously some of the issues perhaps are our counterparts in the [North] had is that they weren't in that position and they had to make the best of the resources available I guess'.

Liz, Business Manager, South Community Provider

Westhall quote 2

However the North PCT was interested in finding a cost effective solution to allow them to introduce ESD into their pathway. After the South ESD was implemented, new Payments by Results (PbR) guidance in 2008/09 suggested that the national stroke tariff could be split 55:45 to allow the rehabilitation component of the tariff to be released to fund ESD. The guidance acknowledged that splitting the tariff

could cause tension, but failed to give a definitive answer to how the tariff could be split leaving the tariff arrangements subject to negotiation by local organisations.

'The National Stroke Strategy (2007) raised the profile for stroke but few ESD services were established and the medical model of care, rather than therapy or rehabilitation prevailed. The rehabilitation costs were included within the acute tariff. However, where ESD services or stroke skilled community teams exist, patients are leaving the acute environment much earlier resulting in some tension around allocation of the resources currently contained within the tariff'.

Extract from 'Stroke rehabilitation in the Community: Commissioning for Improvement. Chapter 5: Commissioning stroke rehabilitation in the community'. NHS Stroke Improvement (2012)

Over time variation in community based stroke service provision and funding became increasingly problematic for Westhall's commissioners and providers. In the South, commissioners considered that the new PbR guidance suggested that they were *'double paying'* (Margo, Consultant, Public Health) for acute stroke rehabilitation because they were funding acute care through the tariff and paying for ESD in addition to the tariff. They considered that following the new guidance, the stroke tariff should be split to reimburse them for the reduction in costs the acute provider gained by being able to discharge stroke survivors earlier to the ESD service. In the North commissioners sought to implement their own ESD by releasing money from their tariff payments to the Acute Provider. The Acute Provider was reluctant to engage with either the North or the South commissioners to resolve the situation.

'In the [North], we haven't traditionally, we haven't had an ESD although we knew that was something we really wanted to do. And one of the discussions we had, and had many discussions, was we felt that the stroke tariff covered the ESD element as well as the hyper acute and so we were saying in order for us to actually afford an ESD we wanted to unbundle the stroke tariff. And we had many discussions with [the acute provider] and they were not happy to do that. So I think there is certainly a [North] view on that, that tariff should be unbundled'.

Sharon, Commissioning Manager, North CCGs

Westhall quote 3

The situation was not resolved before PCTs were abolished and replaced with CCGs in 2013. South Westhall PCT was replaced with one CCG and North Westhall PCT was replaced with 3 CCGs that worked together closely once the CCGs were established and the commissioning problems associated with stroke were revisited.

The North CCGs entered discussions with the Acute Provider but the Acute Provider was unwilling to release money from the tariff for an ESD in the North. However the CCGs *'managed to come to an agreement with [the Acute Provider] whereby we would [continue to] pay tariff but they would within [their existing service], they would provide an ESD service'* (Carol, Commissioning Director, North CCG). The result was a skeleton version of ESD delivered by the Acute Provider which addressed some of the variation across in stroke services across Westhall. This created further financial tension between the CCGs and Acute Provider.

'[The Acute Provider's ESD] was in theory funded by beds being closed down on the wards, so this is money that the CCG's have already paid the hospital for length of stay, and they discharge them earlier so they get more people through the beds, so they can get more income in at [the Acute Provider] so it actually pays them to close beds down from the service. I think, the [North] CCG's are laughing because in a way they are getting an ESD service provided for nothing. You know because, and you can understand the [South] thinking actually that's not fair because are we closing some of the beds because of our ESD but we are getting nothing for that, their

funding their whole service, commissioners are in the community. So it does seem unfair'.

Bob, Clinical Manager, North Community Provider
Westhall quote 4

The South CCG considered the arrangement to be unfair and exacerbate their double payments funding situation. The South CCG attempted to enter discussions with the Acute Provider in an attempt to release money to part fund their existing ESD but the Acute Provider refused to negotiate. The Acute Provider had discovered that their stroke services had been under funded because they were being paid using the wrong tariff and this had contributed to a large financial deficit. The Acute Provider demanded the CCGs *'put an extra £3.8 million into stroke services'* (Carol, CCG Director, North CCGs) and would not discuss any other issues until the tariff situation had been resolved.

'[The South CCG] said to us, 'We're paying for like nine hundred thousand pounds for ESD. You're paying for your own ESD and we believe, as per tariff guidance, you should actually be funding [South] ESD. So we want you to give us nine hundred thousand.' At the time when the [acute] service was making a five hundred million pound loss on seven million pounds worth of income, I said, 'If I give you that, we won't have a service'. We've got something systematically wrong with what we're doing. So that put it on hold and my work which is only shared with the Trust which said that we were not charging for the best part of three-and-a-half million, and their work kind of came to a head because we said, 'Hold on. We've got a problem here' and they said, 'Okay. Then maybe ours isn't such a big issue'.

Caroline, General Manager, Acute Provider
Westhall quote 5

This development had the effect of uniting the CCGs who were faced with the long term prospect of having to increase funding into stroke services across the whole stroke pathway. It provided motivation to address the problems with historical commissioning arrangements in stroke by recommissioning the whole pathway.

Academic Health Science Network and Strategic Clinical Network

The SCN and AHSN had recently reviewed stroke services in the area (Document 1, Provision of stroke care report, AHSN, June 2015) and aimed to influence provision with a regional commissioning guide for stroke services (Document 4, Community Stroke Specification, AHSN, 2013). In Westhall stroke services were not experiencing pressure from the AHSN and SCN to improve as they were considered to have one of the most comprehensive stroke pathways in the region (Document 1, Provision of stroke care report, AHSN, June 2015).

'Variation exists across the region in the models of service delivery for stroke patients. Currently, only [South Westhall] provides a complete stroke care pathway exactly as specified by the evidence-base'.

Extract from Document 1, Provision of stroke care report, AHSN, June 2015

However despite the perceived high quality service coverage, there was variation and inequality, depending on which stroke pathway stroke survivors were able to access. Although the pathway in South Westhall matched the regional Community Stroke Specification (Document 4, AHSN, 2013), in North Westhall services were less comprehensive with a skeleton ESD. Although the AHSN report did not highlight significant problems for North Westhall, a local report suggested duplication and a fragmented experience for those receiving care (Document 7, Public Engagement Report: Stroke Care, November 2014) which made stroke services a target for the Local Transformation Board.

Local Transformation Board and Patient and Public Involvement

The Local Transformation Board was tasked with addressing the national integration agenda which sought improve the working relationships between the different organisations administering and delivering clinical services. A local review of stroke services found that stroke services were *'commissioned from different organisations through different contracting arrangements and with individual service specifications, which providers have acknowledged leads to fragmentation'* (Document 8, Stroke services review, CCG, September 2014). It was suggested that

the multiple organisational boundaries that had been created in stroke and commissioning were responsible for the problems that services were experiencing.

'At the moment what we've got is four CCGs. So there was a policy that set up CCGs but very local organisations, and you know, everybody started to develop their own things and there's lots of things been happening here. So some have got more money than others. Some are very wedded to providers and that, but part of the work that we need to do is to start to bring all the pieces of the jigsaw back together again'

Sarah, Commissioning Director, Local Transformation Board

Westhall quote 6

Using the Five Year Forward View (NHS England *et al.*, 2014) as a guide, new models of care were being considered by the Local Transformation Board to improve the integration of health and social care services to address inadequate quality and efficiency of services. Working alongside the CCGs, Westhall Local Transformation Board had been working on the understanding the problems associated with stroke in the area through patient and public engagement which strengthened the case for change.

'We know that we're not completely meeting the needs of patients at the moment. So there's been a lot of work in Westhall working with local patients, service users, carers, citizens, to understand what their needs are. So people are telling us that services are too fragmented. They're having to repeat their story a number of times. For them it is too much of a hospital reactive bed-based model of care'.

Sarah, Commissioning Director, Local Transformation Board

Westhall quote 7

Stroke provided an opportunity to test new models of provision and encourage providers to work together to develop whole pathways of care. The regional community stroke service specification (Document 4, Community Stroke Specification, AHSN, 2013) provided a template to work towards in conjunction with

the new models of care suggested in the Five Year Forward View (NHS England *et al.*, 2014).The work done by the Local Transformation Board was designed to complement the CCGs and stimulate and support change to address problems associated with the existing healthcare system.

Change drivers stimulate a commissioning response

Westhall was known regionally for the high quality of it stroke services but the historical commissioning arrangements that had created two separate pathways and funding systems that had led to organisational tension between providers and CCGs, and fragmented services for patients. It was the historical commissioning arrangements that were the primary stimulus for change but nation and local policy informed the direction of change towards a more integrated healthcare system. Stroke was viewed as an ideal candidate for integration because services for stroke survivors were required in many different settings and strong clinical evidence already existed to support the care pathway approach to healthcare delivery. Together the change drivers were sufficiently aligned to create a commissioning response.

Commissioning process

The commissioning process (figure 5:3) had six different phases each with their own themes. The process began with CCGs engaging with providers in the Westhall to discuss the problems with the two stroke pathways and work on plans to reorganise and develop existing services an integrated stroke service across the whole area to address issues of fragmentation, variation and inequality. Once a plan was agreed in principle, the North CCGs announced that a lead provider model would be their preferred commissioning arrangement to standardise care across North and South Westhall.

However the South CCG disagreed with plans for a lead provider model as they were concerned that it risked the quality of existing services in South Westhall and subsequently left negotiations. The remaining North CCGs decided to continue with the plans for a new lead provider model for stroke services in North Westhall only but first needed to address the imminently expiring North CST contract.

The North CCGs entered a procurement exercise to re-establish the North Community Stroke contract with a tender caveat that the new North CST Provider would join a lead provider model with the Acute Provider at a later date. This confused the procurement process as providers considered that collaborations should be established before the new contract was awarded.

Unexpectedly, the Acute Provider bid for the CST contract as a joint venture with the South Community Provider rather than the existing North Community Provider. Their bid aimed to raise the quality of North community services provided to the standard of those in the South but was unable to do this within the financial envelope offered. As a result the bid was rejected and the commissioners abandoned plans to change commissioning arrangements. This process will now be explored in more detail.

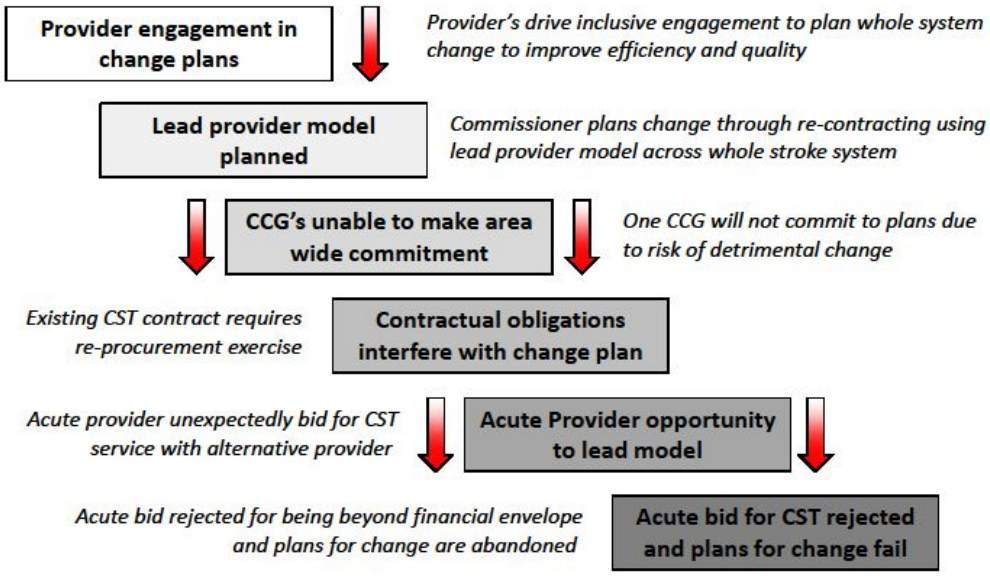


Figure 5:3: Westhall commissioning process

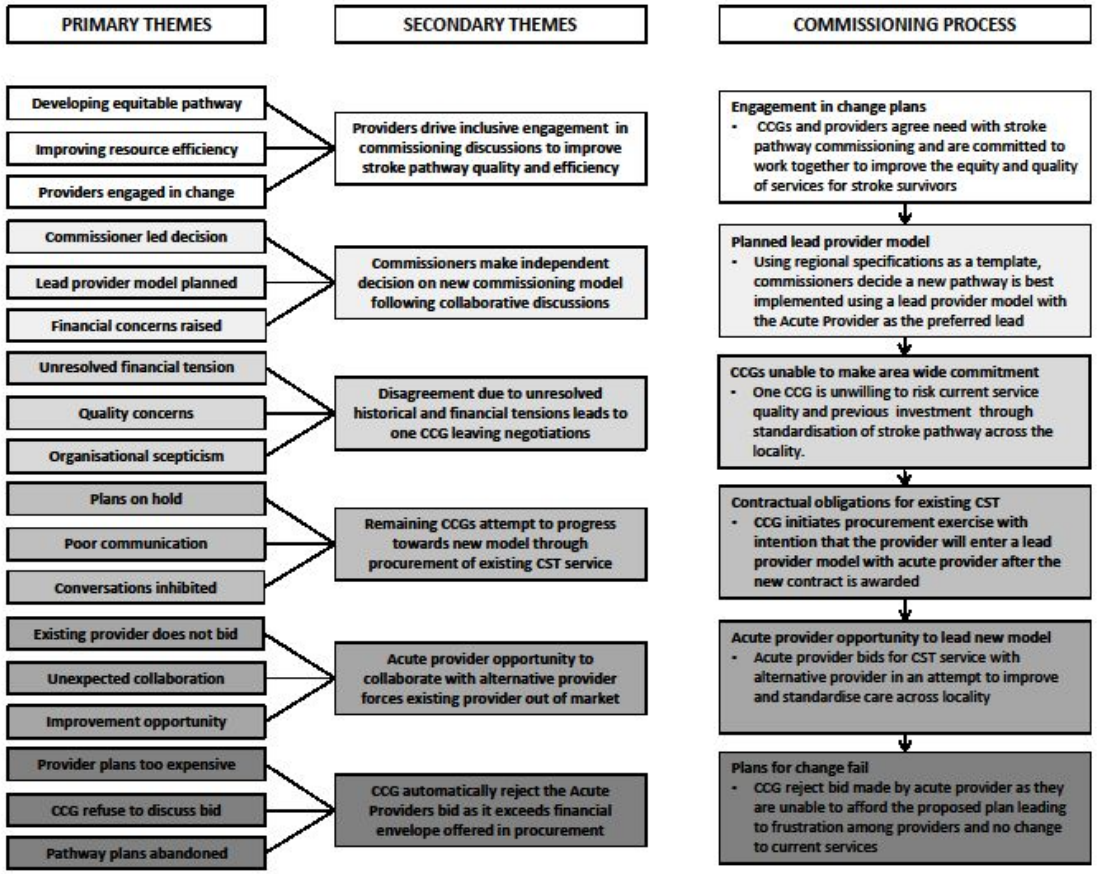


Figure 5:4: Westhall commissioning process themes

Provider engagement

Providers drive inclusive engagement in commissioning discussions to improve quality and efficiency: *Providers engaged in change plans to develop an equitable pathway and improve resource efficiency*

Although the South stroke pathway was well established and effective, it was generally agreed that without an equivalent North stroke pathway the system was inequitable for patients and made service delivery complicated for the Acute Provider. Providers were engaged and motivated to develop a more equitable pathway for the stroke survivors in Westhall.

'I think it's incredibly frustrating for staff because if you just think operationally on a day to day basis you can have two patients in beds next to each other that have to have very different care plans and discharge plans for them. That's very difficult for clinical staff to […] and I think that causes inefficiency in the system because they can't just process everybody through a pathway and so there's delays to discharge'.

Nadia, General Manager, Acute Provider

Westhall quote 8

As the stroke pathway in the South did not require change, there was little motivation for commissioners in the South CCG to lead change so it was the North CCGs that initiated the process. Initially the commissioners only approached the Acute Provider to discuss possible changes. However the Acute Provider did not want to proceed with discussions without the two Community Providers' and other experts in stroke services involvement.

'We started initially having discussions with the [Acute Provider] and it was them that said look actually, we needed [South Community Provider], [North Community Provider] around the table. We asked the Academic Health Science Network to join us, we had Public Health, we had commissioners around the table. So it grew quite quickly but I think that was very proactive in that everybody you know, was understanding that everybody wanted to work together'.

Sharon, Commissioning Manager, North CCGs

Westhall quote 9

Stakeholders were aware of the need to justify the use of scarce resources and agreed that increased efficiency could lead to better care for stroke survivors. Providers were motivated to engage in the discussions as they felt that the commissioners were approaching the plans in a different and more inclusive way and by working together, they were creating a realistic plan of how improvement could be made. There was a sense that the agenda had changed towards a collaborative approach which was welcomed.

'I think the best experience we've had of working properly together is around Stroke because we've met across the [South] and the [North], the clinicians, the managers, and I think it's been good really. We've all looked at how we could do things differently, where the gaps are, you know, there's lots of hand-offs for the Stroke patients which I've always questioned, 'Why do we do that?', and depending on how they're referred as to which pathway they get. Then there's gaps. So it produces its own gaps I think in the- So I think that's the best piece of work we've done'.

Wendy, General Manager, North Community Provider

Westhall quote 10

Through collaborative engagement, stakeholders were beginning to understand the changes that were needed and providers believed that there was a shared goal of developing an integrated service based on the existing pathway in South Westhall. However as the plans progressed communication from the commissioners became sporadic and the providers were left unclear as to what was planned.

Commissioning decision

Commissioners make an independent decision on a new commissioning model following collaborative discussions: *Commissioners announce plans for a lead provider model which raises financial concerns*

When the commissioners resumed communication with the providers, they announced that they considered the lead provider model recommended in the recent Five Year Forward View (NHS England *et al.*, 2014) to be the most appropriate commissioning arrangements for any changes to existing stroke service commissioning. The commissioners were interested in new commissioning models for stroke that reduced the need for separate contracts with different organisations to allow the delivery of care that was seamless for patients. However, rather than continue to work with providers to negotiate how the new pathway could be commissioned and delivered using the lead provider model, the commissioners made an independent decision on which new model to use with no discussion with the providers they expected to be involved.

'[Carol] and I came away and said we think it's an accountable care organisation[1] *that could help this and then it's up to providers how they deliver the service. As long as they deliver the outcomes it's up to them, to say there's the money, go away, with you know some guidelines in a service spec. So these are the elements that we expect it to cover, and these are the indicators we expect you to perform to, to give us the outcomes that we require'.*

Sharon, Commissioning Manager, North CCG

Westhall quote 11

'CCGs have decided to move away from a multiple *provider, activity based contracting model towards a model that incentivises outcomes, rewards the right behaviours and aligns risk with control and influence, giving providers across the*

[1] Respondent used 'accountable care organisation' and 'lead provider model' interchangeably to describe a commissioning model whereby a single contract is held by a single organisation and that organisation may then subcontract to other organisations to deliver sections of the care pathway.

system more flexibility to target resources and investment to better meet the needs of patients'.

Extract from proposed commissioning model document, November 2014

The commissioner-led decision to change the commissioning model and contracting arrangements marked a move away from the collaborative and inclusive approach that was initially taken to discuss plans to reconfigure the stroke pathway. The providers had demonstrated that they were willing to work in a collaboratively, but the lead commissioners imposed the plan on the providers and South CCG without any warning or discussion. This was problematic for the providers because they felt *'the people perhaps more distantly removed from the services [were] making decisions based on limited amount of information'* (Nancy, Community Clinical Manager, South Community Provider). The South CCG was also excluded from the decision which created tension between the North and South CCGs and this made the providers and South CCGs suspicious of the North CCG's motivations for using the lead provider model.

'[The South CCG] is small in comparison to them [North CCGs] and they [North CCG] lead on it, the [South CCG's] desires and wishes are always second'

(Liz, Business Manager, South Community Provider)

Westhall quote 12

The providers and South CCG suspected that the lead commissioners had realised that the plans that were developing for the new pathway were *'going from a financially unviable model to a very unviable model'* (Caroline, General Manager, Acute Provider) because the commissioners wanted to raise the standard of the whole pathway to that of the South without financial investment. They suspected that they were trying to control the situation by imposing a new model.

The Acute and North Community Providers were concerned that they would be expected to provide more for less money, and the South CCG and South Community Provider were concerned the new model could impact on the quality of the service

they already provided by spreading resources too thinly across a larger area. As the North CCG commissioners put forward their proposal to stakeholders, there was concern that there was no clear plan.

'From the meetings that I was involved in, there didn't seem to be a clear plan and there seemed to be a lack of finance. So the aspiration is something similar to [South Westhall] but there is big difference in what they want and what they can pay for that … we [South Westhall] are in the fortunate position that we have got all the services but it is different over at [North Westhall] and I think it could be better but it will be an impact on resources, you know they [CCGs] are going to have to put some more money into it.'

Nancy, Clinical Manager, South Community Provider

Westhall quote 13

Unresolved tension

Disagreement due to unresolved historical and financial tension leads to one CCG leaving negotiations: *Unresolved financial tension, quality concerns and organisational scepticism*

The South CCG were concerned that the proposed lead provider model risked the quality of their existing ESD and CST. They did not feel confident that their original investment would be protected even if the new arrangement stopped the 'double tariff payments' they were currently making. As a result the South CCG decided to leave negotiations.

'From a commissioning perspective there's a clash because people you know feel very passionate about that's their money and that's their investment and that's their platinum service that they've developed.'

Liz, Business Manager, South Community Provider

Westhall quote 14

The South CCG shared a close relationship with the South Community Provider and was keen to *'not destabilise'* (John, GP, South CCG) the services they already had. They preferred monitor the situation with a view of joining in the future if the change was successful. The other stakeholders found it difficult to understand why the South CCG would not join the plans which would resolve the double payment issue and were concerned it may cause problems in the future if they wanted to join at a later date. However the North CCG commissioners were not prepared to be held back by the South CCG's reluctance to commit.

'If [South CCG] bought into that it would resolve their issue of double paying but they seem determined not to for spurious quality reasons as far as I can see'.

Margo, Consultant, Westhall Public Health

Westhall quote 15

'They [South CCG] haven't said never. What they have said is that they will see how it goes. I think our concern for that is, if we have got two providers that are very willing to talk, we don't want that to hold us up'.

Carol, Commissioning Director, North CCG

Westhall quote 16

The North CCGs considered the Acute Provider the natural leader of a new lead provider model. This reinforced the South CCG's decision as they were sceptical about the Acute Providers ability to manage the whole pathway effectively and fairly. They were concerned that without a competitor in the market, the Acute Provider could *'hold the commissioners to ransom'* and '*suck resources out of the community [provider]'* (Liz, Business Manager, South Community Provider) making them more powerful in the healthcare system.

'I haven't got trust in them to deliver a full community stroke pathway. I'd rather retain that control'.

James, Commissioning Manager, South CCG

Westhall quote 17

Procurement of new model

Remaining CCGs attempt to progress towards new model through procurement of existing CST service: *Poor communication leads to conversations inhibited and plans put on hold by procurement exercise*

After the South CCG left negotiations, the North CCGs viewed the situation as less complicated as they had two existing providers who could form a lead provider model. The existing community contract with the North Community Provider was nearing its end and due to be put out to tender imminently. Rather than working on a new contracting model, the commissioners decided to retender the existing North CST with a caveat that the provider awarded the new contract would be expected to form a lead provider model with the Acute Provider. The commissioners did not consider this a problem as they expected the North Community Provider would bid to retain the service.

However, the commissioners did not inform providers of their intensions and the procurement exercise was viewed as a *'bit of a shock'* (Bob, Clinical Manager, North Community Provider). The tender package was seen as *'a really funny lot'* (Nadia, General Manager, Acute Provider) because the financial envelope for the service was small and the lead provider model arrangements were not clear. Poor communication from the commissioners on the intended procurement process left the providers feeling like the collaborative approach they had been taking was no longer appropriate because they were forced to cease conversations during the procurement period. Providers were frustrated that their collaborative plans appeared to be on hold during the procurement process and could not understand why the commissioners were approaching plans for an integrated model using procurement.

'I have questioned why it's all gone off-the-boil in the last sort of six months. Meetings have been cancelled. We haven't carried it on and then all the services go out to tender. So I was confused by that because that's never been explained'.

Wendy, General Manager, North Community Provider

Westhall quote 18

The procurement process caused the providers to *'believe themselves to be in competition around community stroke'* (Carol, Commissioning Director, North CCG). It appeared the commissioners did not anticipate that this would happen. The providers followed their understanding of the rules of procurement by ceasing inter-organisational conversations but the commissioners appeared to hold a different stance. The commissioners understood that with *'procurement there's various EU legislation that we've got to adhere to'* (Beth, Commissioning Manager, North CCG) but considered those rules to be flexible so they could alter the course of the process if it was not proceeding as anticipated and were prepared to withdraw the tender if necessary.

'We struggled with community stroke service in terms of the tender because of the timing of everything because we have to go out to tender because our contracts end and that is in one of our contracts. But actually we want to do something completely different around stroke and it's whether we went out to tender and got a new provider, and then they worked with the [Acute Provider] or whether we didn't go out to tender and asked our existing providers to work together. I think that's still undecided. We have gone out to tender but we still have the opportunity to withdraw if we think things aren't quite going as they are'.

Carol, Commissioning Director, North CCG

Unexpected bid

Acute Provider opportunity to collaborate with alternative provider forces existing provider out of the market: *Acute provider sees improvement opportunity and makes unexpected collaboration causing the existing provider to not make bid*

The commissioners had expected that the CST tender would only interest the existing North Community Provider. However the Acute Provider considered that the procurement exercise presented an opportunity for them to collaborate with their preferred community provider rather than being forced into a lead provider model with a provider they were not comfortable working with. The Acute Provider formed a collaboration with the South Westhall Community Provider who delivered

the high quality stroke pathway in South Westhall. They considered that the collaboration could allow the original plans for an improved pathway across Westhall to be realised.

The unexpected collaboration came as a surprise to both the North CCGs and the existing North Community Provider. The North Community Provider had anticipated that they would bid to retain the community stroke service but as the tender stated that the provider would be expected collaborate with the Acute Provider to work together to deliver the stroke pathway, the North Community Provider assumed the procurement process should involve collaboration discussions with the Acute Provider prior to submitting a bid.

The North Community Provider approached the Acute Provider to discuss the longer term plan for stroke but found that the Acute Provider was unwilling to collaborate with them as they had been working on a bid with the South Community Provider. As a result the North Community Provider did not consider the CST contract to be worth retaining because *'financially it's a small proportion [of their income]'* (Wendy, General Manager, North Community Provider) and decided not to bid for the service.

'Our impression was if we did need to tender, it would be a joint tender with [Acute Provider] and [North Community Provider] and so it became a shock when the Operational Manager of [North Community Provider] came to see us to say that they had been unable to get that agreement from the [Acute Provider].'

Bob, Clinical Manager, North Community Provider

Westhall quote 20

The Acute Provider was confident that their bid provided an opportunity to improve stroke services across the whole of Westhall up to the standard of the existing south pathway and *'nationally we could be seen as one of the leaders'* (Sophie, Clinical Manager, Acute Provider). However they were not able to do this within the financial envelope offered by the CCG and their bid exceeded this. The Acute Provider and South Community Provider considered that this reflected the true cost of delivering a high quality service and would create an opportunity for reassessing

the level of funding required for a high quality stroke service that they thought the commissioners wanted to commission.

'It felt really positive and it felt like we were trying to do this whole system model and try and get some equity for patient because we could use the [South Community Provider's] experience of having their community stroke team and what worked with it etc. and we tried to model that so that it would be the same experience for [North] patients.'

Nadia, General Manager, Acute Provider

Westhall quote 21

'It would be potentially an opportunity and an easy opportunity to start to work towards what potentially could have been a good model. So the [Acute Provider] went in partnership with the [South Community Provider] to bid for that service, and you know, in that respect, in the work that was done, it felt like there was less competition, there was more collaboration with [South Community Provider], there was more- it felt like a very positive thing, and that if the [Acute Provider] and [South Community Provider] won, then it could work within a primary provider model.'

Sophie, Clinical Manager, Acute Provider

Westhall quote 22

Bid rejection

CCG automatically reject the Acute Providers bud as it exceeded financial envelope offered in tender package: *Provider plans too expensive but CCG refuse to discuss and plans abandoned*

Despite the Acute Provider and South Community Provider's bid being very close to what the commissioners had set out to commission initially, the CCGs automatically rejected the Acute Providers bid as it exceeded the financial envelope offered in the tender package. The Acute Provider and South Community Provider had deliberately exceeded the value of the tender because they assumed it would have

to be considered despite it being too expensive. They considered their bid to be valid because it addressed the quality and financial issues that had existed around for many years and the providers *'didn't feel it could be done in the financial envelope'* (Nadia, General Manager, Acute Provider). However the bid was automatically rejected without further discussion.

'It was a really poor process because they didn't respond to questions in a very timely way. They say they did. And when the bid went in, we actually didn't know that we had been flatly refused on the finance part until a couple of months later they invited us to a debrief which was actually basically about the children's lots because they were the big million pound ones. Ours was only about £380,000 or something, it was tiny. So actually we were just point blank excluded based on the financial envelope. We had hoped that it would stimulate enough interest to have a conversation about would be done and what might be moved towards but there was no interest to do that'.

Nadia, General Manager, Acute Provider

Westhall quote 23

After rejecting the bid, the commissioners awarded the contract back to the existing North Community Provider that had not bid to retain the service. The Acute and South Community Provider found it troubling that a process designed to find the most appropriate provider for services, could award a service to a provider who had not even bid to retain it making it an *'unfair system'* (Sophie, Clinical Manager, Acute Provider), especially when they were viewed to be under delivering in their current service provision.

'I think there is a lot of frustrations there because it was awarded back to [North Community Provider], all be it temporarily and they hadn't put in for the tender etc. but a lot of the things that were in the tender we know they are not delivering'.

Nadia, General Manager, Acute Provider

Westhall quote 24

For the commissioners, the procurement process confirmed that the service they would like to commission was too expensive. Commissioners were in a difficult

position because *'as harsh as it sounds they have to think about the financial bottom line because there is only a finite resource'* (Cathy, Improvement Manager, SCN). However, the providers were financially very clear about how much the service they wanted would cost, because it was already operating in South Westhall effectively. The after the procurement process, the commissioners refused to enter further discussions about stroke commissioning and no changes were made to the provision of stroke services in South or North Westhall.

Commissioning process outcome

The outcome of the commissioning process in Westhall was that no changes were made despite initial collaborative discussions and a procurement process. The competitive commissioning strategy the lead commissioners used failed to make any improvement to the quality and equity of the stroke pathway in Westhall.

Relationships between the North CCGs, the Acute Provider and South CCG continued to be strained demonstrating how even when there is shared goal of an improved stroke pathway based on collaborative organisational work, it cannot be achieved if the organisations involved have incompatible beliefs.

In comparison, the relationship between the South CCG and the Acute Provider appeared to have strengthened based on the close working relationship the Acute Provider formed with the South Community Provider as they worked together to bid for the north community stroke service. The process allowed the two organisations to find common ground in their beliefs about what constitutes a quality service.

Where's the logic in Westhall's commissioning process?

The commissioning process in Westhall was initiated due to problems with historical commissioning arrangements and national and local policy drivers focused on developing a more integrated and efficient healthcare system. In Chapter 2, the organisation of the NHS administration was set out and found to be institutionally complex. As the commissioning and healthcare provider functions of the NHS are split, they follow two different representations of logics in the institutional system.

Using the ideal type logic typology set out in Chapter 3, a theoretical representation of commissioning and healthcare found that healthcare commissioning was predominantly influenced by market and bureaucratic logics, whereas healthcare provision tended to be influenced by corporate and professional logics. Ideal types follow a theoretical framework that can be used to characterise other contexts. Using the typology as a guide and based on the behaviours of the organisations in the case study, the theoretic representation of logics in the organisations in the Westhall case study is given in table 5:1.

The analysis shows that South CCG and North CCGs in Westhall attend to different logics in the institutional system and internally represent ideal type commissioning logics in different ways. The behaviour of the North CCGs suggests that they tend to follow logics more closely associated with the market logic, whereas the South CCG was more aligned with the bureaucratic logic.

While working through the commissioning process, the North CCGs appeared to closely follow market principles by using a procurement exercise as the basis of their attempt to implement a lead provider model as the contracting method for the reconfigured North Westhall stroke pathway. This suggests that the North CCG holds the market logic as their root metaphor.

In comparison the South CCG appeared to be more concerned with the fair distribution of resources. They demonstrated this by avoiding the unfair distribution of their own investment to populations they were not responsible for while at the same time protecting the quality of the services they provided for their own populations. This suggests that South CCG's root metaphor was based in the bureaucratic and professional logics.

The providers showed traits generally associated with their ideal type characterisation with strong links to the professional and corporate logics in their commitment to raising the standards of services for stroke survivors across the whole of Westhall while maintaining their share of the stroke healthcare provision market. However the Acute Provider and South Community Provider were more

closely aligned with ideal type provider organisations and with each other with stronger commitment to the corporate logic.

The Acute Provider and South Community Provider showed similar logics across more of the characteristics than the North Community Provider. The Acute Provider and South Community Provider's commitment to professional and corporate logics are demonstrated in their attempt to take over the North CST to bring it in line with the pathway in the South. They legitimised their actions using evidence to support the implementation of a high quality service and their position as market leaders to justify the higher cost of their proposal even though the approach was considered unusual and tactical across the stakeholders as a whole.

Rather than following a predominantly corporate-professional logic, the North Community Provider demonstrated more characteristics associated with the bureaucratic logic. The North Provider was more inclined to follow the established rule system for commissioning in the way that it had been approached in the past. With a bureaucratic logic root metaphor, the North Provider's approach to the procurement exercise was to follow the rule system for distribution of resources and attempted to legitimise their action through democratic actions by approaching the Acute Provider to establish an inter-organisational working relationship before making a bid for the North community Stroke service. When unable to establish agreement, they withdrew as they based their identity on collaborative relationships that were not able to establish.

The Westhall case study demonstrates how different organisations work together as they attempt to establish collaborative working. The difference in the representation of logics in each of the organisations and how that influenced their behaviour may have contributed to how the different organisations worked together towards the shared goal of an integrated stroke pathway. The different phases of the case study will now be explored in more detail using logics to understand how logics may be influencing how organisations collaborate and work together.

Table 5:1: Theoretical representation of logics in Westhall

	Ideal Type Commissioning	North CCGs	South CCG	Ideal type Provider	Acute Provider	North Community Provider	South Community Provider
Root metaphor	**Market - bureaucratic – market** *State redistribution of resources with elements of a market system*	**Market** *Transactional relationships with limited negotiation on terms of contract*	**Bureaucratic – professional** *Distribution of resources fairly through relational transactions*	**Corporate - professional** *Relational transactions of professional knowledge in corporate hierarchy*	**Professional – corporate** *Relational transactions of professional knowledge in corporate hierarchy*	**Bureaucratic** *Following rule system for redistribution of resources*	**Professional – corporate** *Relational transactions of professional knowledge in corporate hierarchy*
Source of legitimacy	**Market - professional** *Decisions legitimised through money and clinical evidence*	**Market** *Decisions legitimised through economic reasoning*	**Professional** *Decisions legitimised through clinical evidence and specialist knowledge*	**Professional – corporate** *Specialist knowledge used to determine market position*	**Professional – corporate** *Specialist knowledge used to determine market position*	**Bureaucratic** *Decisions legitimised through democracy*	**Professional – corporate** *Specialist knowledge used to determine market position*

Source of authority	**Bureaucratic** *Action controlled through policy and governance structures*	**Bureaucratic - market** *Domination through policy and governance structures of market systems*	**Bureaucratic** *Action controlled through policy and governance structures*	**Corporate - professional** *Clinical standards enforced through top down management*	**Professional – corporate** *Clinical standards enforced through top down management*	**Bureaucratic – corporate** *Bureaucratic domination enforced through top down management*	**Professional – corporate** *Clinical standards enforced through top down management*
Source of identity	**Bureaucratic - market** *Defined by political party in power*	**Bureaucratic – market** *Defined by faceless control of the healthcare market*	**Bureaucratic** *Defined through collaborative relationships with partners*	**Professional – corporate** *Professional reputation maintained through bureaucratic mechanisms*	**Professional – corporate** *Professional reputation maintained through bureaucratic mechanisms*	**Bureaucratic – corporate** *Defined through collaborative relationships with partners and bureaucratic mechanisms*	**Professional – corporate** *Professional reputation maintained through bureaucratic mechanisms*
Basis of norms	**Market - bureaucratic** *Citizenship for equitable access*	**Market** *Self interest in managing budgets*	**Bureaucratic** *Citizenship for equitable access*	**Market - bureaucratic** *Citizenship for equitable access*	**Professional – corporate** *Delivery of professional service*	**Professional – corporate** *Delivery of professional service*	**Professional – corporate** *Delivery of professional service*

Basis of attention	**Bureaucratic** *Community rather and individual attention*	**Market** *Status in market as controller of budgets*	**Bureaucratic** *Community rather and individual attention*	**Professional – bureaucratic** *Status in profession and community good*	**Professional – market** *Status in profession and position in market*	**Professional – bureaucratic** *Status in profession and community good*	**Professional – market** *Status in profession and position in market*
Basis of strategy	**Market - bureaucratic** *Economic efficiency for community good*	**Bureaucratic – market** *Economic efficiency for community good*	**Bureaucratic-professional** *Increased community good through reputation*	**Market - corporate** *Reputation, efficiency and profit*	**Professional – market** *Reputation, efficiency and profit*	**Professional – market** *Reputation, efficiency and profit*	**Professional – market** *Reputation, efficiency and profit*
Control mechanism	**Bureaucratic – market** *Finite resource allocation*	**Bureaucratic – market** *Finite resource allocation*	**Bureaucratic** *Organisation administration*	**Corporate - professional** *Clinical and managerial hierarchy*	**Professional – corporate** *Clinical and managerial hierarchy*	**Professional – corporate** *Clinical and managerial hierarchy*	**Professional – corporate** *Clinical and managerial hierarchy*
Economic system	**Market - bureaucratic** *Welfare and market capitalisation*	**Bureaucratic – market** *Welfare and market capitalisation*	**Bureaucratic** *Welfare capitalism*	**Corporate-market** *Managerial and market capitalism*	**Corporate-market** *Managerial and market capitalism*	**Corporate-market** *Managerial and market capitalism*	**Corporate-market** *Managerial and market capitalism*

Negotiating the goal of the commissioning process

The case study started with the commissioners wanting to address problems with the two highly regarded stroke pathways in Westhall. Despite regional recognition of quality (Document 1, Provision of stroke care report, AHSN, June 2015), local reports raised concerns of fragmentation and inequality which required improved integration (see quote 7).

The principles of integrated care are rooted in the concept of collaboration but the North CCGs set about negotiating a goal of the commissioning process by just approaching the Acute Provider initially (see quote 9). This suggests that the commissioners may not have appreciated the collaboration that was required between the different organisations to allow an integrated pathway to be successful or that their historical experience of working with Acute Provider had conditioned them to assume that the Acute Provider would control any change plans.

The North CCG's basis of attention was rooted in the market logic as the controller of the budget and in the past the North CCG had struggled to maintain this control with the Acute Provider's approach to stroke services (see quotes 3, 4 and 5) but were open to discussions to try to address the problems of the past through development of an area wide integrated stroke pathway (see quotes 6 and 7).

Although the Acute Provider was in agreement with the goal, their source of legitimacy was based on the professional and corporate logics which allowed them to use specialist knowledge to determine their position in the market. The Acute Provider recognised that whole system change towards integrated care pathways required input from the other organisations (see quote 9). After other stakeholders were invited to discussions, it was clear that the majority of stakeholders held the view that change was required and welcomed the opportunity to work together on new commissioning arrangements (see quote 10).

However, there was an assumption among the provider organisations that the goal of the commissioning process was to improve the quality of services for patients and to raise standards across the Westhall area to that of the South Westhall

pathway. This suggests that provider organisations were drawing on the professional logic to establish the changes that were required but as discussions progressed, the North CCG commissioners began to distance themselves. This suggests that they were uncomfortable with how plans were progressing under the professional logic which contradicted their basis of attention which was firmly rooted in the market logic.

The North CCGs viewed themselves as the controller of the budget and there was a mismatch between the overall goal of the stakeholder organisations to improve quality, and their goal of reducing costs. To resolve the situation, the North CCG reverted to their bureaucratic and market control mechanism by forcing finite resource allocation through procurement.

Overall analysis suggests a perceived shared goal between stakeholders of improving quality and provision for the stroke pathway across Westhall, but this was not the overarching goal of the North CCG who initiated the process. This suggests that the organisations had a shared goal of reorganisation but the rationale for the change was different for each organisation. Ultimately this meant that they had conflicting goals at the start of the process (see quote 13). The North CCGs commissioner's behaviour suggest that they were aware of the situation but as they identified as the faceless controller of healthcare through the bureaucratic and market logics, they actively avoided communication of the problem to the other stakeholder in their own attempt to regain control of the commissioning process that followed (see quote 11).

Implementing the goal of the commissioning process

In an attempt to overcome the differences in the goal of the commissioning process between the North CCG and the other stakeholder organisations, the North CCG's commissioners announced that their means to implement their goal was to implement a lead provider model as the commissioning mechanism (see quote 11). This attended to institutional demands in the wider healthcare system as it followed the views expressed in the Five Year Forward View (NHS England *et al.*, 2014) and the Local Transformation Board who were interested in more sustainable models of

care (see quote 1). However in this situation it appears that that strategy was focused on regaining overall control of the commissioning process rather than attending to wider institutional demands.

Although the lead provider model satisfied the requirements of the goal from the provider's perspective, the decision was made without their involvement. The approach contradicted the collaborative approach the stakeholders had taken to agree their goal and risked the organisational relationships that had been established. The stakeholders started to recognise that the goals of the commissioning process may be different for the North CCG and suspected that the basis of the difference was money (see quote 13) and this had the potential to risk the investment that had already been made in the South (see quote 14). As a result, the South CCG left discussions suggesting that they viewed the North CCG's logic to incompatible with their own and therefore inter-organisational working was not possible.

With reduced commitment from the South CCG, the North CCG decided to proceed with their plans and initiated an unexpected competitive procurement exercise for the CST element of the North stroke pathway (see quote 18 and 19), again suggesting their commitment to the market logic and attempts to control the commissioning process. The other stakeholders considered that this approach again contradicted the collaborative approach that had been embraced by the providers but forced the providers to respond to the market logic. All the providers were accustomed to this process and responded using institutionalised behaviour and following the legal rules of procurement. The market logic forced providers to respond in a manner that the commissioners considered to be more predictable and would force them to attend to the commissioners goal rather than their own.

It was anticipated that the existing North Community Provider would bid to retain the CST they delivered. As the tender package suggested future collaboration with the Acute Provider, the existing Community Provider considered that this should be established before a bid was made. However, the Acute Provider had unexpectedly established a collaboration with the South Community Provider and the analysis of

logic characteristics suggests that this may because they shared common values. The Acute Provider and South Community Provider generally followed a professional and corporate logic, whereas the North Community Provider had more bureaucratic tendencies. The strong professional and corporate logics suggest that the two providers considered that that were stronger together and better equipped to achieve the original goal of a comprehensive stroke pathway.

This suggested that they were using different logics in an attempt to defy the logics that were imposed on them by the North CCG. However the bid failed with the North CCG using their authority prevent the bid by implementing the governance structures of the market and legitimising their control of the budget through economic reasoning based on not having enough money available to implement the bid. Throughout the process, the North CCGs logic was incompatible with the other organisations in the commissioning process but this allowed them to maintain control.

Conclusion: Incompatible goals, incompatible means

Although initially all the stakeholders in the commissioning process appeared to have a shared goal, ultimately the goal was unachievable because the North CCG and the other stakeholder organisations had different versions of the goal that were ultimately incompatible. This suggested that each organisation had their own version of the goal that was influenced by their internal representation of the complex institutional system in which they operated.

The North CCG showed a strong allegiance to the market logic and used this to attempt to force the other organisations in the system to behave as required to achieve their goal. This suggests they were using the market logic to regain control the healthcare system that had been lost through historical commissioning arrangements that had placed the Acute Provider in the position of power in the system. However, the providers did not behave as the commissioners expected with the Acute Provider and South Provider using defiant tactic in an attempt to implement their own goal.

In this case study, some organisations appeared to find common ground to enable them to work together collaborative. This was demonstrated by the Acute Provider and South Community Provider who had similar internal representations of the institutional system, and also with the North Community Provider who shared the goal of an improved stroke pathway for Westhall. However, despite the providers' openness to collaboration and development of a shared goal, the goal they formed was incompatible with that of the commissioners. The North CCGs were hindered by a lack of finance that forced them to rely on the market and bureaucratic logic to ensure that their finite resources were allocated fairly. However, their commitment to the market logic ultimately led to no change in the system and the commissioning process failed.

Chapter 6: Edgeham case study: Collaborative commissioning

Introduction

This chapter presents the empirical findings from the commissioning process followed in Edgeham between April 2015 and March 2016. The commissioning process was initiated in response to early feedback from reports published highlighting inadequacies in the community aspects of the stroke pathway (Document 1, Provision of stroke care report, AHSN, June 2015) and failings in community neurology services (Document 2, Provision of neurology care report, SCN, January 2015) across the whole of the Edgeham area.

The three CCGs in Edgeham were open to working collaboratively to review arrangements for community based stroke and neurology services. They planned to benchmark existing stroke provision against the community stroke service regional specification (Document 4, Community Stroke Specification, AHSN, 2013), and review community based neurology services. Together these provided drivers to support a case for change which in turn led to a joint community stroke and neurology commissioning process to develop a new service to support acute care.

Existing stroke and neurology services in Edgeham were delivered by two well established providers; an Acute Provider and a Community Provider (figure 6:1). Both stroke and neurology patients had good access to acute hospital services but rehabilitation provision was fragmented and inadequate. The Acute Provider offered an Early Supported Discharge (ESD) to eligible patients and outpatient rehabilitation services to both stroke and neurology patients. No specialist community stroke or neurology services were available with the Community Provider only commissioned to provide a generic community service. However the Community Provider did provide some specialist inpatient rehabilitation in community hospitals. Historically, attempts had been made to commission specialist community stroke and neurology services but these had failed.

Beyond stroke and neurology, the Edgeham health service was facing significant quality and financial problems and was under pressure to transform its entire healthcare system. This contributed to the initiation of the stroke and neurology commissioning process and the case study begins by exploring the drivers that led to this in Edgeham, followed by the commissioning process itself and the commissioning outcome. The case study seeks to understand how organisations in a complex institutional field work together to achieve a shared goal and negotiate institutional demands to achieve the goal. This is explored in the final section of this chapter using the institutional logics framework and empirical evidence to illustrate how logics influence inter-institutional behaviours.

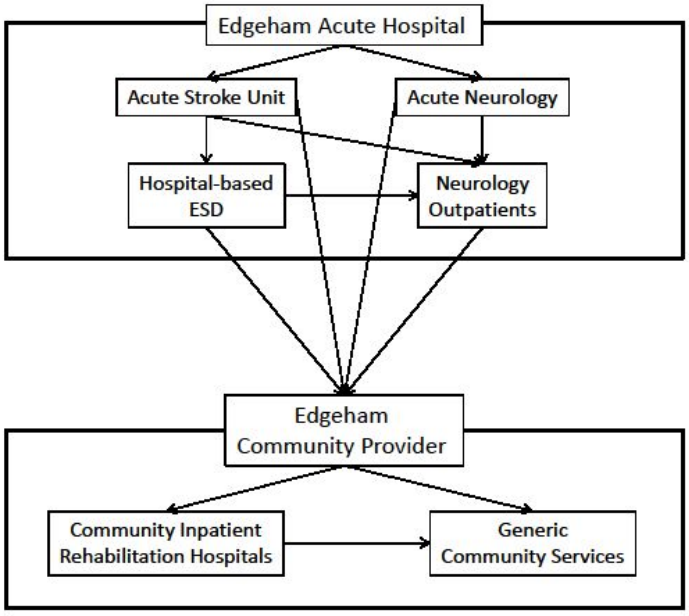


Figure 6:1: Edgeham stroke and neurology service providers and pathways

Initiating a commissioning process in Edgeham

The three case studies in this research were subject to similar regional and national policy drivers for commissioning, stroke and neurology. Each case study site interpreted these differently and had locally specific drivers that influenced the commissioning response. Although the drivers could only be explored

retrospectively through document analysis and interviews, they are important as they influenced the initiation and course of the commissioning process that followed.

Six main drivers for change (figure 6:2) were identified. These included Strategic Clinical Network (SCN) and Academic Health Science Network (AHSN) pressure, clinical policy, local and national policy, patient and public involvement and historical commissioning arrangements. Although improving services in the community for stroke and neurology patients was a priority, a significant driver for the commissioning process was the change that was required to address financial difficulties the Edgeham health economy was experiencing. The inadequacy of community stroke and neurology services provided an opportunity to test transformation plans but previous historical commissioning experience in this area contributed to the approach taken to initiate the commissioning process.

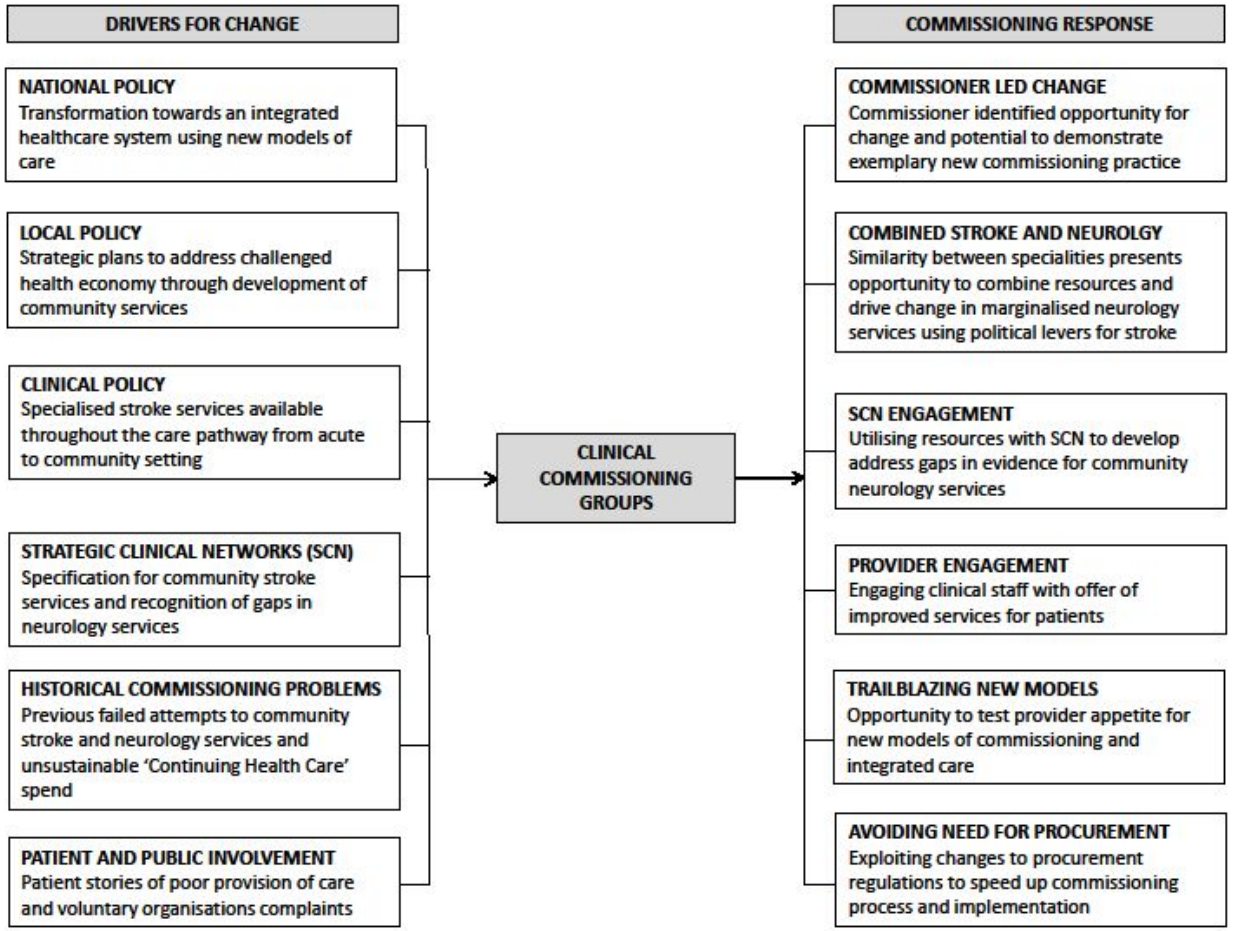


Figure 6:2: Change drivers and commissioning responses for Edgeham CCGs

Historical commissioning problems

Healthcare for people in the community with stroke and neurology conditions was inadequate, over stretched and under resourced in Edgeham (Document 1, Provision of stroke care report, AHSN, June 2015; Document 2, Provision of neurology care report, SCN, January 2015). After discharge from hospital, specialist stroke and neurology rehabilitation was only available in under resourced out-patient clinics delivered by the Acute Provider or as an in-patient in community hospitals delivered by the Community Provider, and these did not meet standards set out by clinical guidelines (Department of Health, 2005b; Royal College of Physicians, 2012; NICE, 2013) .

'For the last ten-ish years we've not been providing an effective service for patients with long-term neurological and short to medium term stroke challenges, and in essence it's been the backlog in outpatient appointments. So effectively the time it takes to get outpatient appointments is drifting. So in many cases it can be the best part of a year or even never seen, and on top of that, when we are delivering care to patients, actually we're rationing the care that we deliver. So we're not delivering currently the full spectrum of therapeutic services and we're reducing it to try and see as many people as we can. So all in all, if you're a stroke or neurological patient in Edgeham, it's not a very good experience.'

Toby, General Manager, Acute Provider
Edgeham quote 1

Previous attempts to commission community stroke and neurology services had failed. Commissioning an ESD service had taken six years and almost failed due to a lack of funding. Plans were only realised because national guidance was given on how to release money by *'unbundling the acute tariff'* (Jill, Stroke Consultant) which allowed the plans to be funded. Complimentary plans for a community stroke team (CST) failed as no additional money could be found.

Neurology experienced similar problems with several previous failed attempts to commission a community neurology service due to lack of resources. This had left clinicians feeling frustrated and sceptical about how plans for commissioning a new community stroke and neurology service would result in tangible change.

'They said, in an old document, that, 'By this time next year we will be having a Community Neuro Rehab Team', and they called for tenders and our hospital bid for the thing, but around 2009 when we sent them the costings, they said they didn't have money. So it fell apart'

Sam, Neurology Consultant, Acute Provider
Edgeham quote 2

'There's a little bit of history, little bit of like we almost got there then and it actually didn't quite work out. So for me it's a little bit like, 'Is this going to work out this time? Is it going to happen?' [laughs] So a little bit of apprehension for me personally'.

Lynn, Clinical Manager, Community Provider
Edgeham quote 3

The commissioners were aware of the fatigued attitude to commissioning among providers. The lead commissioner's approach focused on *'good old fashioned engagement work'* (Jane, Commissioning Manager, CCG) to build a collaborative environment but emphasised that resources would be limited to ensure expectations were realistic.

'Being absolutely honest from the outset, saying things like, 'This will mean fundamental changes with how you work. This isn't about let's identify how much this team will cost and look at investing huge amounts of money into a brand new team out into the community and you all stay as you are.' So it was a really open transparent process from the off-set'.

Jane, Commissioning Manager, CCG
Edgeham quote 4

Historical approaches to commissioning had created a situation where clinicians and providers did not trust commissioners to support the implementation of required clinical services. Aware of this, the commissioners appeared incentivised to take a new approach that would build provider engagement using a new strategy to approach the commissioning process. Key to this strategy was recent local transformation recommendations (Document 3, Health economy report, July 2014) and national and local policy drivers that emphasised the requirement for integration and collaboration.

National and local policy drivers

Problems associated with stroke and neurology services reflected problems across the whole of the health system in Edgeham. Edgeham was *'a challenged economy*' (Jess, Strategic Director, Acute Provider) with significant financial and quality problems that required major reorganisation to address a predicted financial gap of £398 million by 2020 if no changes were made (Document 3, Health economy report, July 2014).

'We were kind of looking at a position of going bankrupt very quickly, very significant health and social care demands, and a history and legacy of health within health of organisations not working particularly effectively together between providers and commissioners and that to be honest there had been very limited work between health and social care, so for a number of parameters we were defined as a challenged economy. So we had some external help to try and get to agree a joint plan that would seek to address our forecast position which was a £398 million financial gap by 2018/19 if we do nothing.'

Jess, Strategic Director, Acute Provider

Edgeham quote 5

An independent review recommended *'clear leadership across the system, representing a balance of providers and commissioners, which is built on delivering some quick wins to build confidence in delivery'* (Document 3, Health economy

report, July 2014). Stroke and neurology services were considered an area that could be targeted quickly and it was intended that the work could be used as *'an exemplar of how [they] can look at team integration across a number of other areas'* (Jess, Strategic Director, Acute Provider). This increased pressure to succeed and motivated the commissioners take a different approach to increase the chance of success.

The approach was to jointly commission community stroke and neurology services rather than commission services in isolation. This would allow the political weight of stroke (see Chapter 2) to be used as a catalyst to drive change in neurology that had not been achieved in the past (Document 2, Provision of neurology care report, SCN, January 2015). The opportunity to streamline both services into one funding stream also created potential to make efficiency savings.

'[Neurology] had never been managed in this way, had never been incorporated into the stroke agenda. It was always in isolation, you know, and I think that's probably why it didn't have the weight and the political momentum that it possibly has now because whether we like it or not, neurology's just not up there on its own.'

Jane, Commissioning Manager, CCG

Edgeham quote 6

The local transformation strategy (Document 3, Health economy report, July 2014) reflected quality and efficiency problems being experienced in the NHS across the whole country. The NHS's Five Year Forward View (NHS England *et al.*, 2014) outlined how the required transformation may be achieved using new models of provision (see Chapter 2).

Commissioners were particularly in interested in the new models of provision outlined in the Five Year Forward View (NHS England *et al.*, 2014) that were specifically aimed at developing community services to reduce demand on hospital services (NHS England *et al.*, 2014). However commissioners were frustrated that they were under resourced from central government to act on strategic plans which limited their ability to commit to change programmes. This emphasised the need to reduce spending and justify where resources were spent. To justify decision making,

commissioners turned to the SCN and AHSN to support commissioning and to ensure that plans were robust.

'So there's Five Year Forward View which is our national strategy policy document. So the five year strategy for Edgeham is aligned with that. … It's influencing [the transformation programme, but it doesn't seem to be influencing what the Government gives to the commissioners'.

Hannah, Commissioning Manager, CCG

Edgeham quote 7

Strategic Clinical Network and Academic Health Science Network

The SCN and AHSN played an important role in Edgeham in helping commissioners understand '*What would a good stroke rehabilitation service look like, that was evidence-based and how would [CCG's] go about commissioning?*' (Jane, Commissioning Manager, CCG) and providing service reviews to highlight gaps (Document 1, Provision of stroke care report, June 2015). The *Provision of stroke care report* (Document 1, June 2015) allowed Edgham's CCGs to prioritise community stroke commissioning as a priority area for change.

Although located within a different department within the SCN, neurology services were also receiving attention to raise their commissioning profile (Document 2, Provision of neurology care report, SCN, January 2015). The concurrent timing of the two reports for stroke and neurology gave the opportunity for similarities between the two specialities to be recognised. Joint commissioning of community stroke and neurology services had never been considered or attempted in Edgeham before but the commissioners recognised that the similarities between the two specialities could allow community services to be delivered by the same clinical team.

'In doing the needs analysis it was recognised that when we're looking at stroke rehabilitation, the needs and the approach for those patients is very similar to those who need rehabilitation who have a neurological deficit. Stroke is a neurological event. So, for that reason, what we've tried to do as a primary focus is say, "Is there

opportunity to increase community based rehabilitation by developing an integrated stroke and neuro rehabilitation team who would help and support patients with stroke or a neurological disorder?"'

Jess, Strategic Director, Acute Provider

Edgeham quote 8

The clinical community confirmed that similarities between the clinical needs of the stroke and neurology patients existed. However, their acceptance that there could be a jointly commissioned service appeared to be based on the failure of separate commissioning in the past rather than it being an ideal model. Providers recognised that *'if you're looking for two pots of money you're probably not going to get most of what you want in each pot, whereas if you're talking about bigger pot of money to do both you might have flexibility'* (Denise, Acute Clinical Manager). This viewpoint was not completely supported by the SCN and AHSN, in particular those associated with stroke, who were concerned that a combined service may *'dilute the stroke evidence base'* (Joanna, AHSN).

'I think everybody who's involved is so desperate to get something up and running, that they will clutch at anything that is offered. So the fact that commissioners are looking and doing stroke and neuro together. Yes. Fine. We'll be in because there is such a need for both services'

Anne, Acute Clinical Manger

Edgeham quote 9

Patient and Public Involvement

In Edgeham the SCN and AHSN played an important role in exposing commissioners to patient and carer feedback. An individual patient and their carer played an important role in driving change by speaking at a SCN event to raise the profile of neurology services. The commissioner responsible for stroke and neurology was at the event and hearing the experience of neurology patients added further motivation to drive change using a joint commissioning approach.

'So I just literally went to an event, heard this carer where he was telling his story and he happened to be a patient from Edgeham, and he was telling a story about his wife who's got MND and his son that's got MND and the difficulties he's had navigating the services and the inordinate amounts of waits that he's had and that provision has in effect stopped for his family members and his family members are technically at home just degenerating having no intervention whatsoever. I suppose that was the big catalyst for trying to maybe look at a different way of getting this on the radar. So I took this back and then had a little think about how we could test the waters with our existing stroke audience for looking at neurology at the same time.'

Jane, Commissioning Manager, CCG

Edgeham quote 10

Change divers stimulate a commissioning response

Edgeham had known problems with existing community stroke and neurology services that were highlighted by the SCN and AHSN and poor patient experiences. Local policy was influential in stimulating change as there was drive across the whole health economy to transform and improve services. Stroke and neurology presented an opportunity for transformation using a streamlined approach to combine the resources and political momentum of two specialities rather than commissioning each in isolation.

The Five Year Forward View (2014) provided new models of provision for community based services that could be used as a blueprint for change and an opportunity for an exemplar of new commissioning approaches that could be used in other aspects of the health system in Edgeham. Together the drivers combined to initiate and inform the direction of the commissioning process that followed. The three CCGs in Edgeham jointly entered the commissioning process for a new community stroke and neurology service to achieve *'consistent care'* (Jess, Strategic Manager, Acute Provider) and make the service more economically viable because if you *'commission the same thing, you've got economies of scale'* (Angela, Contracts Manager, CCG).

The commissioning process

The commissioning process (figure 6:3) had six phases each with their own themes (figure 6:4). It began with the commissioners intending to use an existing regional community stroke service specification (Document 4, Community Stroke Specification, SCN 2013) to guide the service requirements for stroke patients in the community. The same level of guidance was not available for community neurology services so the commissioners approached the SCN to request they develop a similar community neurology specification (Document 9, Community Neurology Specification, SCN 2015). Once two specifications were available, the commissioners began to work on adapting the two specifications to the local context by engaging clinicians from Acute Provider and Community Provider in Edgeham to co-design a joint community stroke and neurology service.

The commissioners introduced the lead provider model from the Five Year Forward View (NHS England *et al.*, 2014) as a contracting mechanism for the new service which was welcomed by the providers. To avoid the need to enter a procurement exercise to commission the new service, the commissioners marketed the plans to the CCGs as a service redesign based on reallocation of existing resources and limited investment. After a business case was developed and agreed, the commissioners steered providers towards agreeing to the Community Provider leading the new service with the CCG managing contract negotiations as they worked towards implementation. This process will now be explored in more detail.

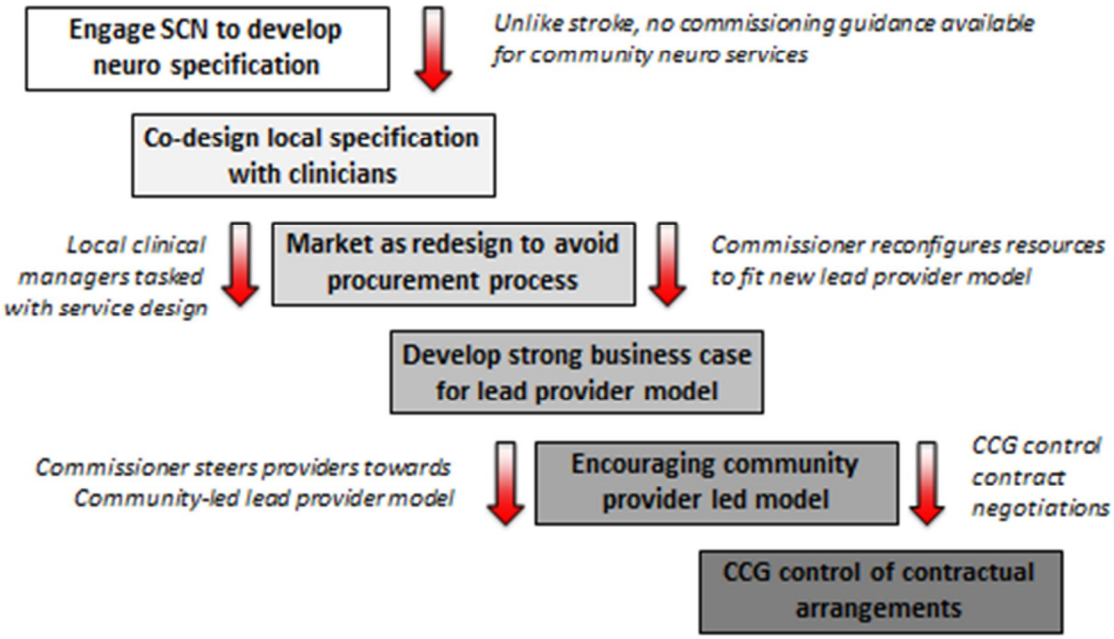


Figure 6:3: Summary of the commissioning process

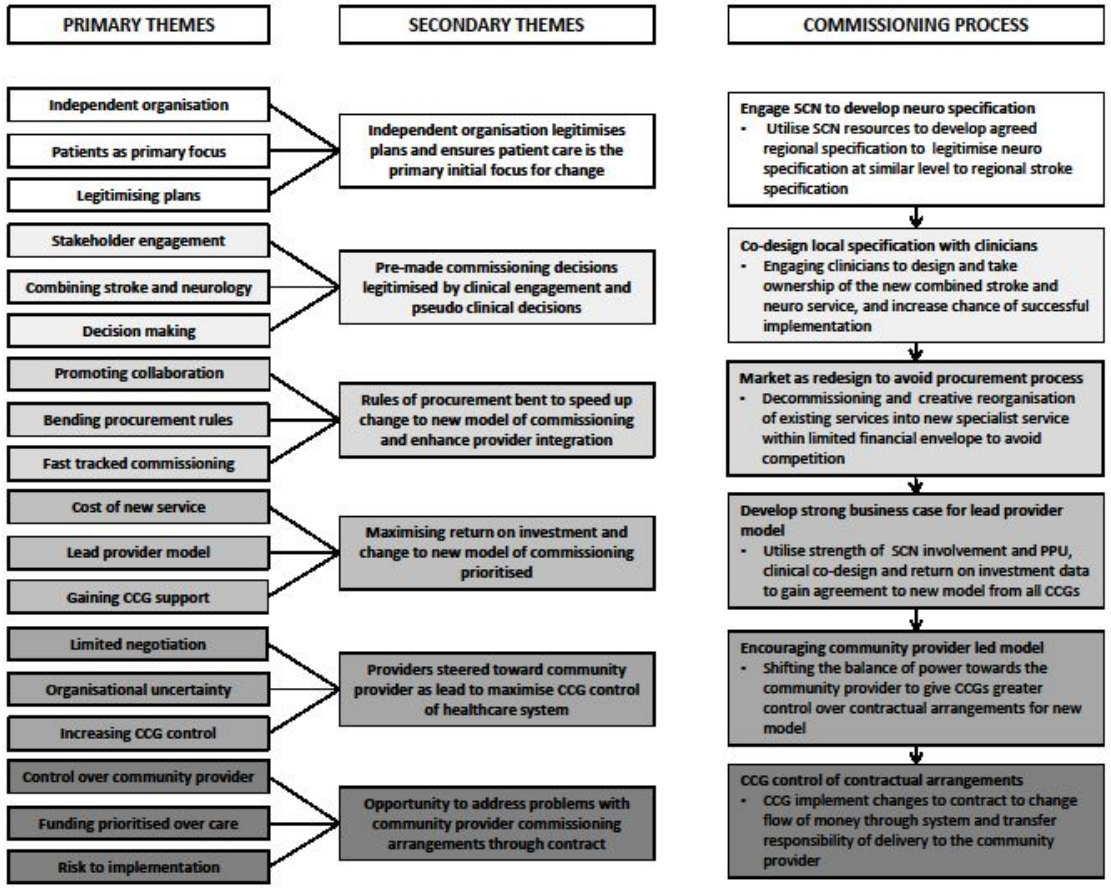


Figure 6:4: Phases of the Edgeham commissioning process and related themes

Engaging stakeholders

Engaging the SCN to develop a neurological specification: *Independent organisation legitimises plans and ensures patient care is the primary initial focus for change*

The Community Stroke Specification (Document 4, Community stroke specification SCN 2013) provided commissioners with non-obligatory guidance for community stroke services and an understanding of *'what a good looked like'* (Jane, Commissioning Manager, CCG). No similar guidance was available for neurology services other than the National Service Framework for Long Term Conditions (Department of Health, 2005b) which recommended *'people with long term neurological conditions living at home are to have ongoing access to a comprehensive range of rehabilitation, advice and support to meet their continuing and changing needs'*. Both documents focused on high quality patient care as the basis of commissioning. The commissioners approached the SCN and ASHN, and encouraged them to develop a specification that could be used as a commissioning tool to guide the development of a new community neurology service.

'We had been involved with the Strategic Clinical Network and the Academic Health Science Network to look at how we could- What would a good stroke rehabilitation service look like that was evidence-based and how would be go about commissioning? And we were at a point at which we knew what we needed to commission [in stroke] … We don't know what good looks like for neurology in the community because it's a little bit of a grey area, and what we've done is had a workshop where we brought together about eighty-five stakeholders, clinicians, patients, carers, so on and so forth, from all over the system, to come together to help us define what actually a good neurology service looks like'.

Jane, Commissioning Manager, CCG

Edgeham quote 11

To develop a regional community neurological service specification, a series of region wide stakeholder workshops were run by the SCN. This resulted in the

production of a consensus specification based on clinical, professional and personal expertise rather than peer reviewed academic evidence which was used to inform the community stroke specification (Document 4, Community stroke specification SCN 2013). However the commissioners considered that involving the SCN and AHSN as independent organisations legitimised the community neurology specification (Document 9, Community neurology specification, SCN, 2015) even though the SCN had *'no power or teeth as an organisation*' (Cathy, QI Manger, SCN). The specification was viewed by commissioners as a credible source of evidence that would be accepted at the CCG Board as robust evidence.

'[The SCN] have developed service specifications. So what would the ideal Community Stroke Rehab Team look like? What would the ideal Community Neurology Rehab Team look like? So to have those documents coming on an [regional] scale is really robust actually and it had a lot of strong clinical and patient input so I understand. So that is a great foundation really for this group to work from'.

Hannah, Commissioning Manager, CCG

Edgeham quote 12

Not all stakeholders were comfortable with the Community Neurology Specification (Document 9, Community neurology specification, SCN, 2015) as it was not considered to be strong evidence by the academic community and *'risked diluting the evidence'* (Joanna, Stroke Expert, AHSN). However the new approach from commissioners was welcomed as it was considered a move away from the '*days when commissioners just develop the specification in the four walls and say this is what we want to commission'* (Joanna, AHSN).

'What ended up happening was that it was more a case of informed by a team on the ground that was operating as opposed to the evidence that you should have this, this and this which was better than nothing but again I do worry.'

Joanna, Stroke Expert, AHSN

Edgeham quote 13

Once the Community Neurology Specification (Document 9, Community neurology specification, SCN, 2015) was completed, the commissioners intended to use the document alongside the Community Stroke Specification (Document 4, Community stroke specification SCN 2013) to develop a local specification for the new community stroke and neurology service. It is not clear if the SCN were aware that the commissioners intended to use the two specifications in this way when they were approached to develop the Community Neurology Specification (Document 9, Community neurology specification, SCN, 2015), or if they had known, would they would have been so willing to engage in the work.

Co-design plans

Co-design local specification with clinicians: *Premade commissioning decisions legitimised by clinical engagement and pseudo clinical decisions.*

Despite local policy directing the need for change in stroke (Document 1, Provision of stroke care report, AHSN, June 2015), neurology (Document 2, Provision of neurology care report, SCN, January 2015) and the wider health system (Document 3, Health economy report, July 2014) Edgeham CCGs did not have the resources to commission two separate community stroke and neurology services. The commissioners approached the idea of a combined service cautiously as they were concerned the providers were very *'blinkered [about] stroke/neuro'* (Denise, Clinical Manager, Acute Provider) and considered that they should be *'two separate teams'* (Lynn, Clinical Manager, Community Provider). However, the clinicians recognised that finance played a major role in what was realistically achievable and previous commissioning attempts had failed due to lack of finance and accepted that they had to compromise.

'I think some of us saw that was going to be a funding issue, because if you're looking for two pots of money you're probably not going to get most of what you want in each pot. Whereas, if you're talking about bigger pot of money to do both you might have flexibility'.

Denise, Clinical Manager, Acute Provider

Edgeham quote 14

'*I think everybody who's involved is so desperate to get something up and running, that they will clutch at anything that is offered'.*

Anne, Clinical Manager, Acute Provider

Edgeham quote 15

The commissioners built on the provider's acceptance of the plans by involving the provider's lead clinicians in the design process of the new service. Clinical managers attended a series of design workshops with the commissioners and were tasked with using the two regional specifications for community stroke and neurology services (Document 4, Community Stroke Specification, ASHN 2013, Document 9, Community Neurology Specification, SCN 2015) to design a local combined specification. This was considered to be a new way of commissioning because it was one of the *'first examples of how commissioners and providers can work together without creating any conflict of interest'* to *'co-produce and develop the vision*' (Jess, Strategic Manager, Acute Provider). This was viewed to have a greater chance of success.

'…the clinicians themselves are happy that they have designed it and [because] they have designed it, it works better, because even if the system is perfect and people feel that it's being imposed on them, sometimes there is a bit of resistance and all of that, you know, so they have ownership and they have responsibility and commitment to make it work'.

Tim, Contracts Manager, Community Provider

Edgeham quote 16

However the design process was closely managed by the commissioners. The clinicians found the initial workshops *'really positive and really useful'* but as they progressed they became *'bogged down in detail*' (Anne, Clinical Manager, Acute Provider). As the task progressed, commissioners took control of the specification

design to speed up the process. Rather than allowing clinical staff to make decisions about the important aspects of each specification, a CCG administrator compared the two specification documents and compiled a new specification based on the common features only. The clinical staff did not consider this problematic and complemented the administrator on doing *a 'really good job at sort of bringing in the two specifications more or less into one and highlighting where there were differences'* (Jill, Stroke Consultant, Acute Provider).

The clinicians were willing to relinquish control of content of the final specification, but by remaining involved in the pseudo-co-design process they legitimised the decision making process. However when pushed to critique the content of the new specification away from the workshops, concerns were raised that the specification was moving away from the integrated service that was initially promised and key elements of the service had been omitted. The clinicians did not challenge the commissioners on their concerns in any of the meetings even when they were concerned that they were being excluded from key clinical decisions.

'I was very disappointed by that to be honest because I think I was kind of seeing a service that was more seamless, but it seems like now we're kind of going down the route of we've got a very designated team that will work kind of on its own but then refer in to other services and there's always barriers when it works like that and gaps and people fall through'.

Anne, Clinical Manager, Acute Provider

Edgeham quote 17

'There's obviously been some conversations somewhere because that just seems to have just happened. […] So I think there's been some other conversations where decisions have been made that are perhaps not as transparent as- Or they think they know. Jane maybe thinks we know. I'm not sure'.

Lynn, Clinical Manager, Community Provider

Edgeham quote 18

Avoiding procurement

Market new service as redesign to avoid procurement: *Rules of procurement bent to speed up change to new model of commissioning and enhance provider integration.*

To proceed to the next phase of the commissioning process and promote the collaborative approach being taken, the commissioners had to consider how the new service was most likely to be agreed by the Clinical Commissioning Board. As some provision for stroke and neurology rehabilitation existed within the existing system, the commissioning process needed to involve decommissioning of existing services and channelling of released resources to fund the new service. This allowed the new service to be considered a redesign and if further investment was limited to less than £160,000 per CCG, the new service would be exempt from procurement under NHS competition regulations (Monitor, 2013). This dictated the budget for the service meaning the specification had to fit the available resources, or the CCG would be forced to enter a procurement process.

Procurement was unappealing as it required '*at least nine months to do a proper procurement*' (Geoff, Commissioning Manager, CCG). As commissioners were under pressure to demonstrate a *'quick win'* (Document 3, Health economy report, July 2014) they encouraged providers to work towards a collaborative agreement and avoid the need to tender to fast track the commissioning process. However there was uncertainty if competition law would be broken by proceeding in this way but it was implied that bending the rules for procurement was common practice within the CCG because there was *'always a way around'* (Angela, Contracts Manager, CCG) the rules.

'Given the overall value of this business, are we at risk of being challenged in so much of the competition law? So legal advice was taken and what they were able to say is, if there is a collaborative framework and we're able to show that in essence whatever option would be put out to the market, you need to engage [Community Provider] and [Acute Provider] in it, well, is that really going to be, you know, attractive to the market? And therefore it was handled very, very carefully in line

with the legal advice so that we weren't breaking any competition law. But based on the fact there was overall commitment to a collaborative framework, it was already established, this was about, you know, kind of making sure we can deliver the outcomes in the timescales we said. The legal advice was that we were able to proceed on that basis and not have to do it, go through full market testing.'

Jess, Strategic Manager, Acute Provider
Edgeham quote 19

The decision to avoid procurement was mutually beneficial for the commissioners and the providers as it reduced wasted resources on the process and allowed the commissioners to set the financial envelope for the new service while preventing the need for further investment. Although procurement was avoided, the new service required a strong business case to progress.

Commissioning decision

Develop strong business case for lead provider model: *Maximising return on investment and change to new model of commissioning prioritised.*

The business case outlined how the cost of the service would yield a return on any investment and needed to be agreed by all three CCG Boards before plans could proceed (Document 10, Business case, Edgeham CCGs, September 2015). The existing cost of services provided to stroke and neurology patients was used as a baseline to model the cost of the new service specification. This data was obtained from the Acute and Community Providers but data was incomplete and did not reflect true supply and demand meaning the business case was based on an estimate.

'We then tried to find out what will this proposed model cost? … Once we know the baseline of what patients we have going into the system, how much it's costing us and what whole-time equivalents we have managing that service at the moment, we can then use that as a proxy between what we think we should have, what we think we have and see what the commissioning gap is. Quite crudely that's the only

logical way we have found or I have found to get to a point to understand what's the cost of the service'

Jane, CCG Commissioning Manager
Edgeham quote 20

The business case presented different options for the new service which outlined expected return on investment in each scenario compared with no change (Document 10, Business case, Edgeham CCGs, September 2015). The commissioner had expected that the three CCGs would commit to a small additional investment to support the reorganisation of current services. However one CCG considered that a larger investment would allow greater change to occur which in turn forced the other CCG increase their financial commitment.

'It was quite a positive impact that my organisation has had on it because it has kind of pushed that return on investment in order to see the benefit that we want for our patients so we actually get that transacted and have some change. So what that has enabled my CCG to do is actually be a little bit more ambitious about what it wants to invest into this service to get more benefit for our patients. So it actually meant that the other CCGs had to reconsider their investment and kind of be a bit more ambitious with their plans, which is great for this piece of work actually.'

Hannah, CCG Commissioning Manager
Edgeham quote 21

The commissioners planned to contract the new service using the lead provider model suggested in the Five Year Forward View (NHS England *et al.*, 2014) to force one provider '*to take accountability, to be held to account for the outcomes*' (Holly, Strategic Manager, Community Provider). The CCG Boards agreed this approach and were in support of the Community Provider leading the model, as the service would be based within their field of expertise.

Commissioner control

Encourage community provider led model: *Providers steered towards Community Provider as lead to maximise CCG control in the healthcare system.*

The Community Provider was considered by the CCGs to have '*most of the workforce and most of the experience in delivering services in the community. So it's likely that [Community Provider] would be a lead provider*' (Hannah, Commissioning Manager, CCG). This was not discussed directly with either the Acute Provider or Community Provider before a meeting was called between the CCGs and the providers to discuss the contracting arrangements. Senior management from each provider were invited to the meeting and the management representatives from both providers assumed that the aim of the meeting was to negotiate which provider would be appointed the lead provider.

The Community Provider considered that they were well placed to lead the new service as they were *'good at community-based* services' (Holly, Strategic Manager, Community Provider). During the meeting the Community Provider confirmed their interest in leading the model but wanted opportunity to discuss it further and make a formal decision at a later date. The Acute Provider also expressed their interest in leading the model, as they considered themselves better equipped as an organisation to deliver the service as they had a better reputation for service delivery and strategy. As the meeting progressed the Acute Provider was surprised that the Community Provider leading the model came across as a *'done-deal'* (Toby, General Manager, Acute Provider) with limited negotiation. This led to organisational uncertainty about the suitability of the plans.

'*There was a desire for [Acute Provider] to provide it, because [Community Provider] at the time were having some CQC challenges; reputationally it wasn't very high. [Acute Provider] always finds it easier to recruit, and although it didn't necessarily fit with the broader strategy of becoming more specialised and smaller, I thought there was an appetite for [Acute Provider] to provide it. So I was slightly surprised when the overwhelming consensus in the room was that [Community Provider] would provide it'.*

Toby, General Manager, Acute Provider

Edgeham quote 22

Both providers felt that they should '*have some conversations*' (Holly, Strategic Manager, Community Provider) about contracts but the commissioner stated that CCG wanted a *'decision today'* (Jane, Commissioning Manger, CCG) and their preferred option was the Community Provider. By the end of the meeting, the Acute Provider accepted the decision because the financial incentive to lead the model was small and they were motivated to make improvements to overall patient services.

'*It's only £140,000 worth of income. So the clinical and the patient impact value is a lot higher than the financial, which is one of the reasons why actually I think we haven't involved contracts before or commissioners haven't, because for [the Acute Provider] it's only a small financial. The fact that, you know, we're a £800m organisation, £120,000 is relatively small-fry, but the patient impact is a lot higher than that'.*

Toby, Acute Provider General Manager

Edgeham quote 23

Contractual negotiations

CCG control of contractual arrangements: *Opportunity to address problems with Community Provider commissioning arrangements through contract.*

After it was agreed that the Community Provider would lead the new lead provider model, the CCG began working on a new contract with funding prioritised over care

specifications. This increased the CCGs control over the Community Provider and gave the CCG the opportunity to address some of the problems they had experienced with the Community Provider in the past by using contracts and money as levers for change.

'The history with [Community Provider] is that things are not delivered. They are always demanding more money for things […] The project management and mobilisation has got to happen and it's got to be so firmly controlled which is what we're trying to write into the contract variation to make sure that we still get the information we need and it's [Community Provider] who delivers it. We're very worried that they will slip and not deliver what we need'.

Angela, CCG Contracts Manager
Edgeham quote 24

The priority for the contracting process was ensuring affordability of the plan, which risked implementation of the agreed model. There were concerns that the *'original vision created by the clinical staff would be lost when the tricky conversations about contracts and money were addressed'* (Jackie, Strategic Manager, Community Provider).

During the contractual phase there was a high risk that the service could not be contracted and financed. It was intended that commissioning process was an exemplar of practice with the commissioners working with providers to co-design a new service but the contractual phase highlighted flaws within the design process. The commissioners had made assumptions about how the new service could be financed based on how they expected the new service to reduce overall care costs in the wider healthcare system through decommissioning of an Acute Provider service and a reduction on Continuing Health Care (CHC) spend for care support for stroke and neurology patients living in the community. As contract negotiations progressed, it became clear that there were fundamental problems with the business case.

'In the business case there is information about a service coming out of [the Acute Provider] and being then subcontracted through [the Community Provider]. I didn't know how that was contracted in in the first place, therefore it's been a case of unpicking how we contract it into [the Community Provider], but it's also been about getting confirmation that we won't commission it from [the Acute Provider] anymore and that's been quite complex. Another part of the business case gives you savings that are going to come from Continuing Health Care (CHC), and where we sit, we have the CHC Team next to us and in just chatting, it didn't appear that they actually knew they had to take money out or divert money. So it's been trying to make sure there's an understanding there that what we commit to in a contracts variation and the funds that go to buy things actually have to come out of there to make the books balance, and that complexity has been quite difficult'.

Angela, CCG Contracts Manager
Edgeham quote 25

The return on investment outlined in the business case had been calculated using predicted savings in the CHC budget directly associated with the new service. It had been assumed that providing a community stroke and neurology service would reduce spending on CHC and release £600,000 for the new service. However during the contractual phase the actual CHC spend reduction was found to be *'only £89,000'* (Amy, Commissioning Manager, CCG) because there was confusion around what the CHC budget provided for. Contracting therefore continued with the aim of limiting additional costs as much as possible to address the mistakes that were made, even if that meant risking the service specification that had been originally agreed in the business case.

'The assumption was for this project was that patients were choosing private [rehabilitation] providers, using the [supported care] funding but what actually, which is why it was such as substantial amount of money but what we have found out is that it wasn't rehab, it included a very small amount of rehab. It was all nursing care, domiciliary care and so that funding that we thought, that saving sorry

that we thought would be quite large is actually a very small amount in terms of rehab'.

Amy, CCG Commissioning Manager

Edgeham quote 26

Commissioning process outcome

The case study concluded at the point of intended implementation of the new service in April 2016 but the problems experienced in the contracting phase meant that it was necessary to delay implementation as it was not possible resolve the funding issues immediately. The CCG intended to continue with the plan but were working on the financial arrangements to ensure that the service would be cost neutral rather than achieving the return on investment they had originally hoped for. The CCG intended to do this by remodelling the long term cost savings on the supported care budget, as they assumed that the Community Stroke and Neurology service would have a positive impact on patient's independence and reduce the need for additional personal care.

'What we probably didn't do is get the supported care contracting team fully engaged and even though they were included in all of these business cases, all of this, they probably didn't get engaged at the right time so when they have had chance to look at it, it's been February when we needed them to look at it in November and consequently it has gone though and rolled on assuming that everything is fine and actually it wasn't so what lessons we've learnt are, and I'm sure Jane would agree with this, is that she should have got our lead supported care Finance Lead to have authorised those assumptions and said yes, completely agree. And that didn't happen'.

Amy, CCG Commissioning Manager

Edgeham quote 27

However, the CCG were not clear exactly how this could be calculated as the data available continued to be problematic. The commissioners recognised that they had made mistakes in the process and made assumptions that ultimately risked the implementation of the new service. Although plans to commission the new service

continued, the process failed to provide the commissioners with the quick win they were hoping for.

Where's the logic in Edgeham's commissioning process?

The commissioning process in Edgeham was initiated due concerns about the poor community service provision for stroke and neurology patients, and a local drive to transform the failing healthcare system in the area. In Chapter 2, the problems facing the NHS were highlighted and Edgeham represents an example of how services are struggling to meet demand, and organisations are poorly integrated (Document 3, Health economy report, July 2014). The current administrative system in the NHS relies on commissioners to work with providers to address these problems but the two types of organisation follow two different representations of logics in the institutional system.

Using the ideal type logic typology set out in Chapter 2, a theoretical representation of commissioning and healthcare found that healthcare commissioning was predominantly influenced by market and bureaucratic logics, whereas healthcare provision was more influenced by corporate and professional logics. Ideal types follow a theoretical framework that can be used to characterise other contexts. Using the typology as a guide and based on the behaviours of the organisations in the case study, the theoretic representation of logics in the organisations in the Edgeham case study are given in table 6:1.

The analysis shows that the CCGs in Edgeham are characterised in a very similar way to ideal type commissioning organisation with the exception of increased professional logic influences in their source of identity. This suggests that the commissioning organisation in Edgeham are following the beliefs and behaviours about commissioning that are found in the wider healthcare field. For example, commissioning organisations legitimise their behaviour through the market and professional logics (table 6:1), using clinical evidence to make decisions about the services that are required and rational economics to distribute money efficiently. In Edgeham, commissioners demonstrated the same logics as they sought to legitimise their decision making through a need to balance spending and efficiency savings

with justification of those decisions by generating evidence rooted in the professional logic (see quotes 5, 11 and 12).

Similarly, the Acute Provider shows characteristics in line with ideal type provider organisations. However the Acute Provider based their norms on a professional corporate logic through delivery of a professional service rather the bureaucratic logic that would demand an equitable service. The Acute Provider acknowledged that quality improvements were needed to improve the patient's experience of community stroke and neurology services but not at the expense of their own business structure. The decision to not contest the CCGs and Community Provider's desire for the Community Provider to lead the new service was driven by the corporate logic that acknowledged that small value of the service did not make it worth fighting to retain their position in the market (see quote 23).

In comparison, the Community Provider was characterised in a different way. The Community Provider showed closer alignment with the bureaucratic logic across many of the logic characteristics with a focus on creating community good with influences from the professional logic rather than a successful business that would be seen through attention to the corporate logic. For example, the Community Provider identified as a bureaucratic organisation; they considered themselves best placed to deliver community based services because that was the type of service their organisational structure was designed to deliver despite wider reputational concerns both formally and informally (see quote 22).

The difference in the representation of logics in the organisations behaviour may have contributed to how the different organisations worked together towards the shared goal of an integrated community stroke pathway. The different phases of the case study will now be explored in more detail using logics to understand how logics may be influencing how organisations collaborate and work together.

Table 6:1: Theoretical representation of logics in Edgeham					
	Ideal Type Commissioning	**CCGs**	**Ideal type Provider**	**Acute Provider**	**Community Provider**
Root metaphor	**Market - bureaucratic** *State redistribution of resources with elements of a market system*	**Bureaucratic - professional** *Redistribution of resources with influences from professional networks*	**Corporate - professional** *Relational transactions of professional knowledge in corporate hierarchy*	**Professional – corporate** *Relational transactions of professional knowledge in corporate hierarchy*	**Bureaucratic** *Following rule system for redistribution of resources*
Source of legitimacy	**Market - professional** *Decisions legitimised through money and clinical evidence*	**Market - professional** *Decisions legitimised through money and clinical evidence*	**Corporate - professional** *Specialist knowledge used to determine market position*	**Professional – corporate** *Specialist knowledge used to determine market position*	**Bureaucratic - professional** *Decisions legitimised through democracy and specialist knowledge*
Source of authority	**Bureaucratic** *Action controlled through policy and governance structures*	**Bureaucratic** *Action controlled through policy and governance structures*	**Corporate - professional** *Clinical standards enforced through top down management*	**Professional – corporate** *Clinical standards enforced through top down management*	**Bureaucratic – corporate** *Bureaucratic domination enforced through top down management*
Source of identity	**Bureaucratic - market** *Defined by political party in power*	**Bureaucratic – professional** *Defined by bureaucracy and professional*	**Professional – corporate** *Professional reputation maintained through*	**Professional – corporate** *Professional reputation maintained through*	**Bureaucratic – professional** *Defined by bureaucracy and professional*

		reputation	*bureaucratic mechanisms*	*bureaucratic mechanisms*	*reputation*
Basis of norms	**Market - bureaucratic** *Citizenship for equitable access*	**Bureaucratic - Market** *Equitable access with self interest in managing budgets*	**Market - bureaucratic** *Citizenship for equitable access*	**Professional – corporate** *Delivery of professional service*	**Bureaucratic** *Citizenship for equitable access*
Basis of attention	**Bureaucratic** *Community rather and individual attention*	**Market** *Status in market as controller of budgets*	**Professional – bureaucratic** *Status in profession and community good*	**Professional – market** *Status in profession and position in market*	**Professional – bureaucratic** *Status in profession and community good*
Basis of strategy	**Market - bureaucratic** *Economic efficiency for community good*	**Bureaucratic – market** *Economic efficiency for community good*	**Market - corporate** *Reputation, efficiency and profit*	**Professional – market** *Reputation, efficiency and profit*	**Bureaucratic** *Increased community good*
Control mechanism	**Bureaucratic – market** *Finite resource allocation*	**Bureaucratic – market** *Finite resource allocation*	**Corporate - professional** *Clinical and managerial hierarchy*	**Professional – corporate** *Clinical and managerial hierarchy*	**Professional – corporate** *Clinical and managerial hierarchy*
Economic system	**Market - bureaucratic – market** *Welfare and market capitalisation*	**Bureaucratic – market** *Welfare and market capitalisation*	**Corporate- market** *Managerial and market capitalism*	**Corporate- market** *Managerial and market capitalism*	**Corporate- market** *Managerial and market capitalism*

Negotiating the goal of the commissioning process

The case study began as the commissioners were making plans to address problems in the healthcare system from an economic and clinical perspective by looking specifically at stroke and neurology services in the community. Within the wider system, the commissioners were under pressure to address problems of poor integration (Document 3, Health economy report, July 2014) and the issues associated with stroke (Document 1, Provision of stroke care report, June 2015) and neurology (Document 2, Provision of neurology care report, SCN, January 2015) presented an opportunity to create an exemplar for change using a *'quick win'* (Document 3, Health economy report, July 2014) approach.

Ideal type commissioning attends to the market and bureaucratic logics to reallocate resources equitably for the good of the community through the market but in this case study the commissioners were under pressure to act quickly. The 'Health economy report' (Document 3, Health economy report, July 2014) was conducted by an independent private sector organisation more likely to follow a corporate logic meaning the commissioners were faced with a different set of demands to those usually experienced from central policy. Under the bureaucratic logic, commissioners usually respond to command and control from the centre which is slow to filter through the NHS field but in this case study the commissioners required an alternative approach.

In Edgeham the CCGs' root metaphor of bureaucracy was combined with a professional logic to allow for the redistribution of resources with influences from professional networks. An openness to connect with the professional logic and recognise the benefit of clinical evidence guided the commissioners towards seeking support from clinical networks (see quote 11). Engaging with clinical networks had the benefit of strengthening the case for change and legitimising their action. The professional logic appeared to be co-opted as part of the CCGs identity and legitimacy which was important during the negotiation of the shared goal of the commissioning process between the different representatives of the organisations involved. This suggests that the commissioners recognised that they required the

providers to engage with commissioning plans and they needed to identify as an organisation with similar beliefs and values. The clinicians involved in the design process followed the professional logic strongly in their desire to improve patient care and working with commissioners who appeared to hold the same values allowed collaboration to be enhanced (see quotes 11, 12 and 16).

However, during the course of the process to design a new neurology specification, some tension was evident about how evidence was generated and used, suggesting the commissioners sought legitimacy through alignment with the professional logic but were not concerned if they did not follow it closely. They used the professional logic to achieve engagement and collaboration but it not follow the norms of the logic which demands knowledge is attained through experience, qualification and professional membership (see Chapter 3) with decisions based on sound clinical evidence (see quotes 13, 17 and 18). Alternatively they misinterpreted the principles of the professional logic and rather than challenge the commissioner, the clinical community compromised their values to ensure that change occurred (see quote 18).

This suggests that the boundaries of logics are blurred and organisations may be willing to utilise logics in different ways to allow goals to be achieved if they are mutually agreeable. In this case study the organisations established a shared goal of developing a new community stroke and neurology service base predominantly on the professional logic but each organisation followed their own interpretation of the rules of that logic. Although this strategy may have consequences for the outcome of the commissioning process, it was successful in achieving a shared goal at the outset.

Implementing the goal of the commissioning process

With a shared goal of developing a combined community stroke and neurology service in place, the commissioners set about implementing the design and delivery of the service through the commissioning process. The ideal type characteristics of the commissioning organisation would suggest a bureaucratic and market logic

would be followed, with the commissioners determining the services they wanted and procuring that service using market principles.

The market logic in commissioning is closely associated and intertwined with the bureaucratic logic that demands that the NHS operates as an internal market. However the commissioners adopted elements of the professional logic to engage the provider's clinicians to co-design the new service and then actively avoided the market logic that they usually followed as they attempted to commissioning the plans for the new service. This suggests that the commissioners in Edgeham were avoiding the institutional demands of central policy by finding an alternative strategy. The commissioners found loopholes in procurement regulations to allow them to commission the community stroke and neurology service as a perceived redesign rather than a new service (see quote 19).

As the commissioning process progressed, it appeared that the commissioner's initial use of the professional logic may have weakened as they moved into the contracting and implementation phases and they returned to logics more closely aligned with ideal type commissioning characteristics. The commissioners co-opted the professional logic to engage the clinicians to work with them and collaborate. Once they secured engagement the commissioners reverted back to their ideal type market and bureaucratic logic behaviours using a command and control style to implement a new model of commissioning. This was first evident as the commissioners took control of the specification design phase with clinicians being excluded from a number of clinical decisions (see quote 18), followed by the decision to use a lead provider model as the new commissioning mechanism. This placed the commissioners in a position of power over the providers as they returned to more normal commissioning activities because they had manipulated the providers into agreeing to the new plans.

The shift in the balance of power away from the providers as the commissioners attended to bureaucratic institutional demands allowed the commissioners to take control of the healthcare system in an area where they had previously failed and lost the providers confidence (see quotes 2 and 3). This was important as it

strengthened the possibility of the process being used as an exemplar for change across the wider system.

The providers recognised that they had not actually been as influential in the design process than it would seem on the surface, but did not challenge the commissioners as they were motivated by the professional logic to achieve tangible change for patients (see quote 9) during the design phase where they demonstrated their commitment to the project. Changing the balance of power gave the commissioners the opportunity to gain further control over the how the community stroke and neurology service was contracted and who would lead the new lead provider model. By rejecting the market logic and attending to the bureaucratic logic, it gave the commissioners the opportunity to dictate that their preferred lead provider would be the Community Provider, which may not have been possible had they followed the standard procurement process. Again, to the providers this appeared to be the commissioner's professional logic that was driving the decision making.

The Community Provider was motivated to lead the model because it aligned with their professional logic which legitimised them as the most qualified provider to lead a community based service. However the commissioners were motivated by the bureaucratic logic as it gave them the opportunity to monitor the Community Provider's activity more closely and ensure that they were delivering the services they wanted (see quote 24). Although the Acute Provider questioned the rationale of the decision, their corporate logic allowed them to accept the decision as the new service did not align closely with their overall organisational goals (see quote 23).

The commissioner's strategy was effective in achieving their goal until the final phase of the commissioning process which involved detailed contracting and reallocation of funds within the system. At this point in the case study, problems were emerging with the commissioning process that had the potential to cause the plans to fail. Assumptions and miscalculations for funding made by the commissioners suggest that internal organisational relationships were weak, leading to mistakes that threatened the integrity of the CCG. This aspect was not explored

in detail as part of the case study but suggests that conflicting internal logics could impact on external inter-organisation relationships.

Conclusion: Shared goal, manipulated means

In this case study the commissioners appear to attend to different logics in the institutional system depending on what they want to achieve. This could be a key characteristic of how organisations are able to work together effectively. At the outset of the case study, the commissioners co-opted a professional logic to stimulate engagement in change plans with the provider organisations in an attempt to overcome the failure of commissioning in the past. The strategy aligned with institutional demands in the field which called for collaboration but allowed the commissioners to maintain control of the commissioning process by continuing to attend to ideal type commissioning logics while hiding behind the veil of the professional logic.

For this to be effective the collaborating organisations need to be open to manipulation. In this case study, the commissioner engaged with clinical leads to develop plans before approaching senior management to finalise plans. By the time this occurred, specifications and funding had been agreed, and the provider organisations did not challenge the commissioner's plans. This suggests that the legitimacy of the professional logic makes it a powerful logic to co-opt when organisations attempt to stimulate inter-organisational relationships.

Organisations may be less likely to challenge plans associated with the professional logic as they are assumed to be based on sound knowledge and evidence. By involving clinical staff with less operational influence in the organisation from the outset, the commissioners were able to manipulate their behaviour to achieve their version of the shared goal on the premise that it followed the professional logic. This gave the provider organisations confidence to continue to engage in plans. Overall this appeared to be a successful strategy for the commissioners to develop an inter-organisation relationship that ultimately gave them regained control of a struggling healthcare system.

Chapter 7: Oldville case study: Passive commissioning

Introduction

This chapter presents the empirical findings from the commissioning process followed in Oldville between November 2015 and April 2016. A commissioning process was initiated before this period due to concerns about variation and inequality in community stroke services the area. Oldville had been identified as having inadequate community stroke based stroke services (Document 1, Provision of stroke care report, AHSN, June 2015), and a fragmented healthcare system with poor integration. The commissioners and providers in the area were engaged in discussions to address the problems they were experiencing with stroke services and interested in reorganising services to address the problems with current commissioning arrangements.

In Oldville there was an Acute Provider that delivered well-established acute stroke services, and a Community Provider that was commissioned to deliver an Early Supported Discharge (ESD) and other community based generic rehabilitation services (figure 7:1). The community based services were not in line with national clinical guidelines for stroke (NICE, 2013; Royal College of Physicians, 2016b) and had been highlighted by the Strategic Clinical Network (SCN) and Academic Health Science Network (AHSN) as area that needed to be addressed (Document 1, Provision of stroke care report, AHSN, June 2015).

The case study begins by exploring the drivers that led to the initiation of the commissioning process in Oldville, followed by the commissioning process itself and the commissioning outcome. The case study seeks to understand how organisations in a complex institutional field work together to achieve their goal. This is explored in the final section using the institutional logics framework.

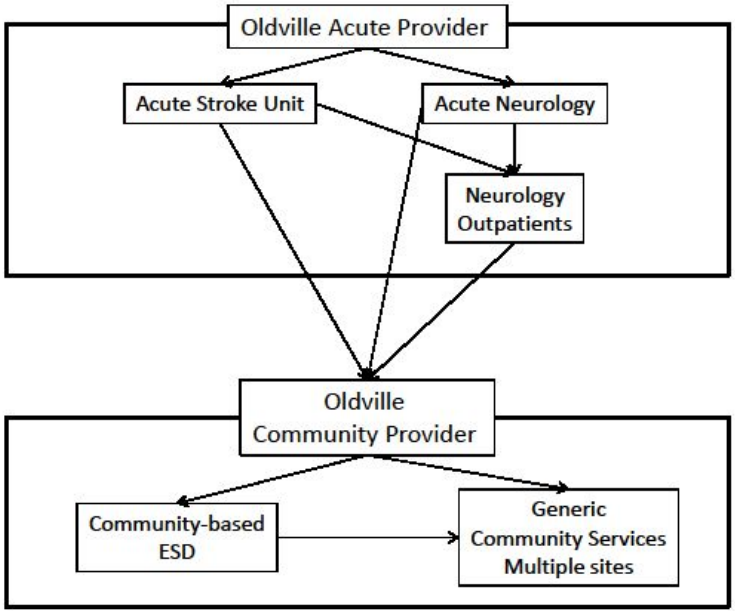


Figure 7:1: Oldville stroke and neurology service providers and pathways

Initiating change

The three case studies in this research were subject to similar regional and national policy drivers but each case study site interpreted these differently and had locally specific drivers that influenced the commissioning response. Although the drivers could only be explored retrospectively through document analysis and interviews, they heavily influenced the initiation of the plans to change commissioning arrangements for stroke in Oldville and the commissioning process that followed.

Five main drivers for change (figure 6:2) were identified. These included SCN and AHSN pressure, clinical policy, local policy, patient and public involvement and historical commissioning arrangements. The main aim of the commissioning process was to address the shortcomings of existing community services for stroke patients and consider how services may need to be commissioned differently in the future.

In Oldville the SCN and AHSN played an important role in keeping stroke services on the local commissioning agenda by highlighting variation in services across the

region (Document 1, Provision of stroke care report, AHSN, June 2015). Oldville was specifically highlighted as it lacked any specialised community stroke services beyond ESD. In the existing generic community services, historical commissioning arrangements had created a fragmented community health service across many specialities and locations. These were failing to adequately support the Acute Provider as services were sporadic and poorly integrated.

To address the wider issues with community based services a local transformation board was tasked with developing plans to improve integration between the different provider organisations. The wider integration plans and local policy were important in informing potential plans to develop a community stroke service as any changes were required to fit with other changes to the healthcare system in Oldville (Document 6, CST project scoping document, CCG, Jan 2016).

Historical commissioning arrangements

It was acknowledged that the historical commissioning arrangements for community based services in Oldville had created a *'very messy picture'* of *'pockets of services'* (Linda, Commissioning Manager, CCG) that were considered not fit for purpose and unsustainable. This was a considered to be a relic of *'previous incarnations of the NHS'* where providers would *'just do what we felt like*' (Sue, Clinical Manager, Community Provider). This was blamed on the responsibility for commissioning falling to many different organisations and numerous changes to organisational boundaries over the years.

'There are some really good pockets of services that were recognised and have always been recognised but they've been set up very differently for different reasons. A lot of it's historical. A lot of it's based around the different ways that places were set up when we had GP fund-holders, when we had PCTs and boundaries kept shifting and management, you know, operationally things changed, and some people would get a pot of money and they'd use it in one particular way and another area might use it differently. So we didn't have a cohesive way that stroke was taken forward'

Julia, Clinical Manager, Community Provider

Oldville quote 1

Stroke survivors had to access a fragmented system in the community that was inequitable and difficult for patients and clinicians to navigate; there was no clear stroke pathway as recommended by regional specifications (Document 4, Community Stroke Specification, AHSN, 2013). The main concern was a lack of *'access to home-based stroke specialist community rehabilitation (beyond ESD)*' (Document 1, Provision of stroke care report, AHSN, June 2015). For stroke survivors that required long term support, additional specialist rehabilitation was only available from neuro-rehabilitation outpatient services which catered for both stroke and neurology patients. Those requiring community rehabilitation were only able to access generic rehabilitation from time limited intermediate care services or domiciliary services.

Previous attempts had been made to develop a specialised stroke pathway. ESD had been previously identified as a commissioning priority because of it's potential to drive quality improvements and reduce length of stay (see Chapter 2). For implementing ESD the CCG had access to a quality premium within their budget. The quality premium was '*a proportion of the CCG's overall funding, allocated on the basis of quality improvements*' (Linda, Commissioning Manager, CCG) that could be used to drive development of high impact services. ESD was selected as a candidate for this funding based on its potential for quality improvement and return on investment through a reduction on costs of acute care. However enabling

investment into ESD meant that other aspects of the stroke pathway could not be considered at the same time.

'There was an imperative to do things. We had to have ESD and it didn't matter what else we did. We had to do ESD, and because we had to do ESD, we couldn't look at anything else for a while. We've given however many hundreds of thousands of grand to develop ESD because it's a 'Government got to do' and the evidence for ESD is huge'.

Wendy, Clinical Manager, Community Provider

Oldville quote 2

After ESD was implemented in 2013, the commissioners were *'very aware that there were gaps as far as the rest of the stroke pathway was concerned'* (Julia, Clinical Manager, Community Provider) and they were '*conscious that there was a significant group of patients that were missing out'* (Linda, Commissioning Manager, CCG). ESD improved the stroke pathway up to that point but commissioners found that they were struggling to make sense of the remaining services in the community because they were sporadic and fragmented. This made considering further specialist community stroke services difficult.

'It's quite clear that it's really-really difficult to sort of identify what the gap is because the current service is so inefficient'.

Linda, Commissioning Manager, CCG

Oldville quote3

Without a clear understanding of what was needed to improve the stroke pathway beyond ESD, community stroke services were not a high priority for the CCG. However stroke patients were raising concerns and formal complaints with the CCG about the standard of care they received in the community which put pressure on commissioners to consider community stroke services more formally.

Patient and public involvement

Patients were able to highlight concerns about care by lodging comments and complaints about services to the CCG. '*Patient stories that show where we're lacking*' (Linda, Commissioning Manager) were important drivers for change as they provoked a response at a high level within the CCG's complaints procedures. Some complaints were serious and helped to raise the profile and priority level for certain conditions including stroke.

'There was patient story that went to the governing body for the CCG. A patient who post-stroke, sort of in the community, number of months and basically services were very disjointed. The patient story was quite embarrassing. It was the person having long waits between services. The person missed out on a lot of rehabilitation opportunities. They had to get private physio. Really not a good picture at all. So that sort of I suppose prioritised some of this work within the CCG ... helps to put it on the agenda at that high level as well, at a kind of an exec and director level to show the need. So that sort of started some of this work'.

Linda, Commissioning Manager, CCG

Oldville quote 4

The complaints stimulated further patient engagement work with stroke groups to get a better understanding of the problems and develop a case for further investigation. The work revealed common themes of long waits for community rehabilitation services (Document 6, CST project scoping document, CCG, January 2016).

The patient view: A patient experience survey was completed by 16 stroke survivors and /or their carers. The survey results reinforce the clinical view that people receiving early supported stroke discharge receive a comprehensive multidisciplinary specialist service within 72hrs but those people with higher needs have to wait a number of weeks for their rehabilitation to commence,

Patient comment: 'I thought it was poor how long I had to wait for community rehabilitation due to me not being able to walk or get out of bed. I thought they would have been quicker.'

Carer comment: 'It was difficult for a confused elderly person to understand waits [for stroke rehabilitation], and impatience is not good for recovery'

Extract from Document 6, CST project scoping document, CCG, Jan 2016

A community stroke working party was then formed to address commissioning arrangements for stroke services in the community and consider how services could be improved. An important consideration for the group was how any developments would fit within transformation plans for wider context of the health and social care network in Oldville.

National and local policy drivers

Commissioners in Oldville were under pressure from *'a national and local drive for transformation and integration of health and social care'* and any planned changes to stroke were under direction to *'fit with the CCG agreed model for integrated care'* (Document 5, CST project initiation document, CCG, Jan 2015) that had been developed for Oldville in their transformation plans. Implementing community stroke services were on the local agenda, but within a wider priority of *'transformation and integration of health and social care services to ensure local people receive better care which includes the shifting of resources away from acute and general hospital settings and into social care and community health service'* (Document 6, CST project scoping document, CCG, Jan 2015). This made the work complex and suggested that any plans had to be strategic in nature by involving different organisations to work together in collaboration to ensure effective integration and a reduced burden on acute services. For the stroke component of the transformation plans, the working party group was *'to consider how local NHS providers and commissioners can use community stroke resources most effectively within the health economy; to map the current specialist stroke rehabilitation provision including psychological therapies and the stroke coordinator role; to*

consider the findings of the Strategic Clinical Network (SCN) specialist community stroke rehabilitation review 2015 (Document 1, Provision of stroke care report, AHSN, June 2015)' (Document 6, CST project scoping document, CCG, Jan 2015).

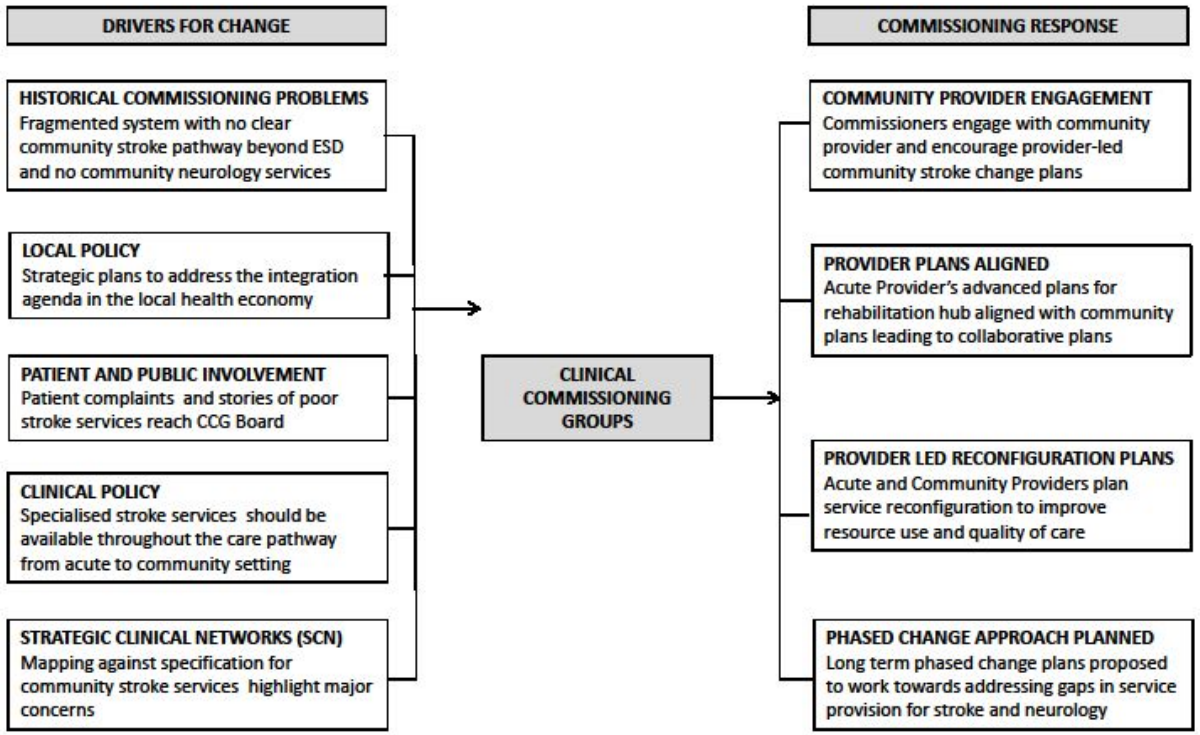


Figure 7:2: Oldville change drivers and commissioning response

Change drivers initiating the commissioning response

The problems with community based services for stroke survivors and commissioning in Oldville were longstanding and had been highlighted by the SCN and AHSN (Document 1, Provision of stroke care report, AHSN, June 2015). As patient complaints about poor care started to reach the CCG Board, community stroke services were prioritised for attention. At the same time national policy and local transformation plans were pressurising the CCGs improve integration between health and social care providers, and any changes to community services for stroke survivors were required to compliment the transformation agenda. Together these change drivers combined to stimulate a commissioning response.

'So I think it's how all these different commissioning levers if you like and different tools and different initiatives, how they all fall into place at different times, have an impact on the kind of process and the timescale for when things are put into place'.

Linda, Commissioning Manager, CCG

Oldville quote 5

A working party group was established to examine the problems associated with current service provision and begin a commissioning process. The commissioning process that followed involved the working party looking at current provision and considering how this could be reorganised to fit a new model of integration being considered across the wider healthcare system. This commissioning process will now be explored in detail.

Commissioning process

The commissioning process (figure 7:3) had four different phases each with their own themes (figure 7:4) which will be discussed in detail. At the start of the process the main problem was considered to be the lack of specialised community stroke services within the wider generic community services. Developing a plan of how to reorganise services to allow a CST to be implemented was the goal of the commissioning process.

The process began with the commissioners tasking the working party group to engage with the Community Provider to assess current service provision for stroke in the community. The commissioners considered that if they had a better understanding of the gaps in the service, they would be better equipped to work towards a plan to address the problems in the system. The commissioners took a supportive role with the aim of facilitating the working party group and Community Provider's explorations. During this process the Acute Provider learnt that the Community Provider was working to understand the problems in the system and considered the work to be aligned with their own internal plans to develop an outpatient rehabilitation hub.

The outpatient rehabilitation hub was focused around neurological outpatients where many stroke survivors were currently accessing long term rehabilitation due to the lack of community stroke service provision. The Community and Acute Providers decided they should be looking at the system in conjunction with each other because they were investigating services for the same clinical populations. They agreed align their work and a representative from the Acute Provider joined the working party group to ensure that changes created an integrated care system where the community and outpatient services could work in collaboration for both stroke and neurology patients.

The working party group considered that existing community services could be reconfigured into specialist teams that could work to support the Acute Provider's new rehabilitation hub. As the plans for the hub were well established, the Acute Provider representatives took the lead on reconfiguration plans for services in the community setting, suggesting a phased change approach. Stage one was intended to make better use of existing resources through reconfiguration to allow gaps in existing services to become more apparent and develop a stronger case for commissioning investment. Stage two was intended to involve the commissioners more closely to develop commissioning plans to address the gaps that had been identified. This would involve considering the costs to invest in and implement new specialised community services. The commissioning process explored here includes the work done up to the proposed implementation of the staged plan.

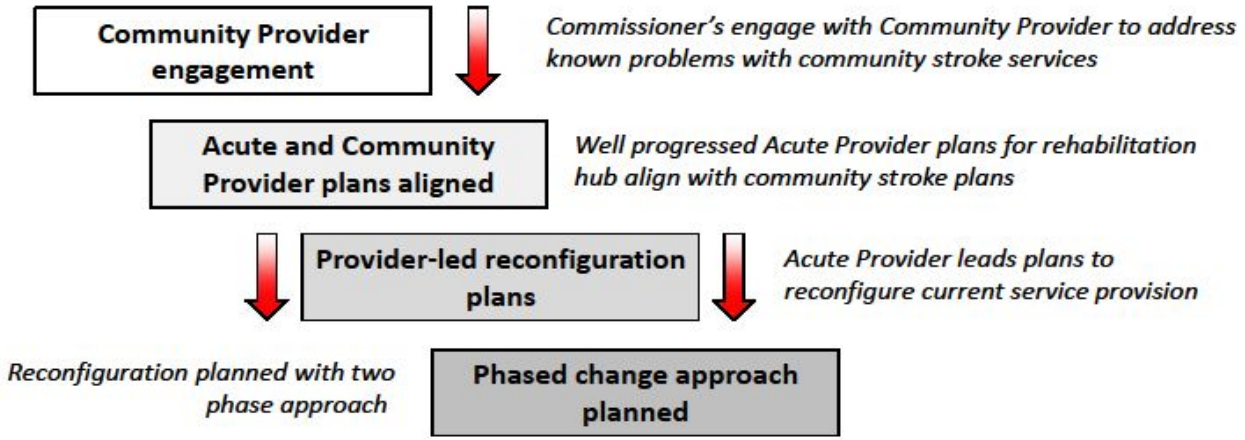


Figure 7:3: Oldville Commissioning process

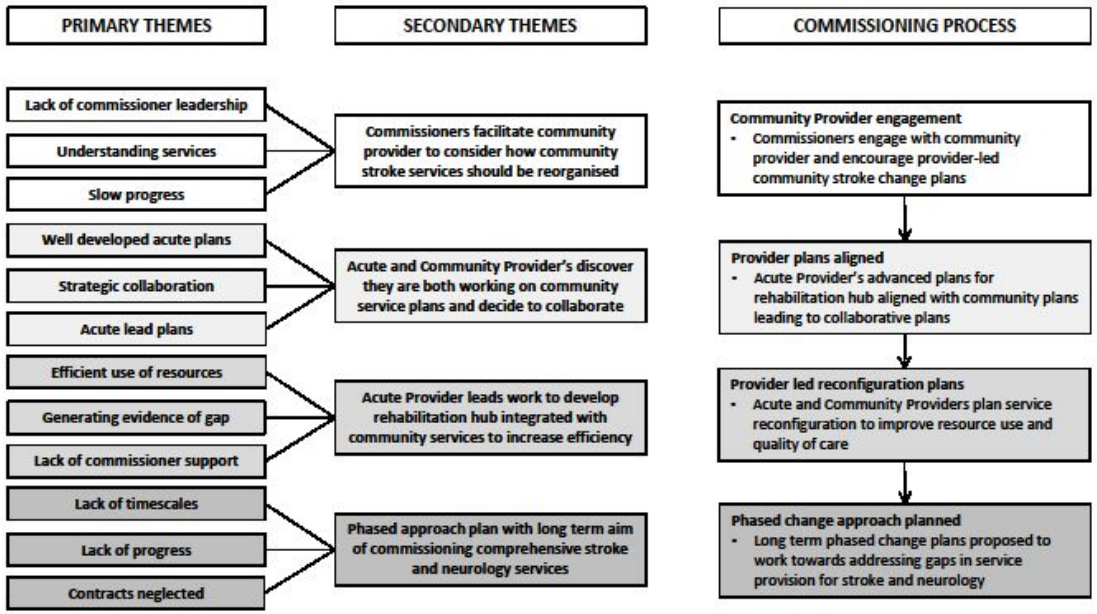


Figure 7:4: Oldville Commissioning process themes

Provider engagement

Commissioners facilitate Community Provider to consider how community services should be reorganised: *Working to understand services but lack of commissioner leadership leads to slow progress*

The commissioners facilitating the community stroke working group began by engaging the Community Provider managers and clinicians to take responsibility for understanding existing service provision. The working party group also included patient representatives from the CCG who were able to feed back on their own experiences but the commissioners themselves appeared to be less engaged in the process. The working group found that the commissioners were '*quite good at things like pulling the meetings together and making them happen, making providers turn up'* (Sue, Clinical Manager, Community Provider). However they found that the commissioners seemed to lack leadership which made it difficult for the working party to understand the goal that they were working towards. They found that they were able to discuss the existing services for stroke and potential improvements but making formal plans to move the work forward was more difficult without commissioning guidance.

'It was generally agreed that the service wasn't what it ought to be. So a working party group was set up which involved about, I think it was, maybe three of us off the main group and a lot of other professionals from within the [Community] Health Service. We went through and discussed how we could improve it and we met at monthly intervals for- I'd say it was end of 2014. It was probably a little bit before that because it seemed we had lots and lots of meetings to discuss ways we could improve it'.

Bob, Patient representative, CCG

Oldville quote 6

The main focus of the work was *'about mapping what the [existing] service is, and where the gaps are and trying to come up with a model of how it can be taken forwards across the community services'* (Ben, Community Manager, Community

Provider). However as the meetings progressed, it was acknowledged that the group were finding it '*really difficult to sort of identify what the gap is because the current service is so inefficient*' (Linda, Commissioning Manger, CCG). Although the working party group were struggling with the task, the commissioners did not appear to be aware that the providers were struggling without commissioning leadership. Instead they considered the approach to have a greater chance of success than a commissioner led process.

'Everyone's in it together and everyone is committed to that vision and it's not like everyone's wearing their provider hat or commissioner hats. It's like everyone comes with what they can offer … you're more likely to reach a successful outcome by involving your stakeholders and providers from the outset. Not only involving them, but having that two-way conversation. If it's a top-down approach, you're likely to get that kick-back'.

Linda, Commissioning Manager, CCG

Oldville quote 7

There were concerns among the working party group that the work that was being done would not lead to substantive change as they felt they were making slow progress. There appeared to be apprehension on the part of the commissioners to commit to any proposed changes as they were finding that they had '*got limited resource within commissioning and we have to work out how to prioritise our time*' (Julia, Commissioning Manager, CCG). The commissioners passed responsibility for the majority of the workload to the working party group to reduce their own resource commitment to a time consuming review and design phase. Although the working party group welcomed being involved, they remained concerned that there was limited commissioning leadership.

'The commissioners didn't have an absolute mandate to say, 'Right. We now can see where the problem is. This is how we're going to resolve it […] I felt that because, you know, she wanted it to be a very collaborative process. I mean that's one of the things that's been very good about this, is that the CCG [wanted it to be collaborative], although they do need to drive direction'

Julia, Clinical Manager, Community Provider

Oldville quote 8

Provider collaboration

Acute Provider and Community Provider both working on community service plans and decide to collaborate: *Strategic collaboration allows Acute Provider to continue to lead their well-developed plans*

As the working party group continued to consider plans for community stroke services, the Acute Provider was working on their own plans to develop a specialist rehabilitation hub that would include a *'stroke and neuro service and pool all their existing outpatient services'* (Lucy, Clinical Manager, Community Provider). Many stroke and neurology patients received their rehabilitation in an outpatient setting delivered by the Acute Provider as there were no specialised alternatives in the community. Due to the cross over in rehabilitation techniques between stroke and neurology, plans were in place to combine the two specialities into a central rehabilitation hub where the Acute Provider could make better use of resources. The rehabilitation hub did not have plans for a domiciliary community component for their services but both the Community and Acute Provider realised that there may be potential to align the services the two providers delivered to allow an integrated pathway that involved both outpatient and community services.

'Well because we eventually realised that there was this parallel project going on with the community teams, we've actually joined up those two projects, and I think the most significant development from that is that we have agreed to work with the one pathway'.

Claire, Strategic Manager, Acute Provider

Oldville quote 9

By collaborating with the Acute Provider, the Community Provider was able to take advantage of the progress that the Acute Provider had made with their well-developed plans for the rehabilitation hub. This helped to address the problems they were experiencing with a lack of direction from the commissioners and allowed a more substantive goal to be developed. The rehabilitation hub had the potential to provide the Community Provider with a base to relocate their

fragmented services into centralised teams which could then work in conjunction with and compliment the new centre for outpatient stroke and neurology services.

'*We can make use of the resources that we have that are designated specialist services, and rather than having them located in lots of different places, co-locate'*

Julia, Clinical Manager, Community Provider

Oldville quote 10

Commissioners were in agreement with the providers as the resources for developing the new hub had been found internally within the Acute Provider using a *'capital plan*' (Claire, Strategic Manager, Acute Provider) and any changes to community services could be achieved through reorganisation of existing resources. This reduced the need for commissioners to source additional funds to enable the reorganisation.

'So then we sat down looking at what are the resources we've currently got and quite early on there was a kind of a mutual agreement between the two providers that they wanted to make this model work and they wanted to put their resources in the pot if you like and reshape them and to look at it completely differently. I think that's what's helped to kind of move everything forward, is the fact that there was that willingness to do that'.

Linda, Commissioning Manager, CCG

Oldville quote 11

Although the Acute Provider was financing the rehabilitation hub internally, they suspected that they would require additional *'external funding come into that as well because it is a fairly significant amount of money [to develop the new hub]'* (Claire, Strategic Manager, Acute Provider) but had not approached the commissioners about the need for additional funding. The collaboration with the Community Provider was important as it could influence how money flowed into their service in the future if the reorganised community services were associated

with the new rehabilitation hub, particularly if the arrangement would increase activity for the Acute Provider.

The providers viewed plans as a strategic collaboration but were aware that the new rehabilitation hub was an alternative take on current policy to move services into the community setting. The Acute Provider was responding to calls to reconsider the *'traditional boundaries between primary care, community services and hospitals'* and shift '*outpatient consultations and ambulatory care out of hospital settings'* (NHS England *et al.*, 2014). The Acute Provider was also aware that their approach had the potential to increase their share of the market by retaining services that were moving out of the acute setting, rather than transferring delivery to an alternative provider but were conscious that it could lead to increased costs for the commissioners.

'[The rehabilitation hub is] a little bit of an anomaly in the fact that the national directive is for things that are in the community, are in the community, and things that are acute, are in the acute, and it sits in both'

Julia, Clinical Manager, Community Provider

Oldville quote 12

'Obviously because if you're bringing teams together, you can create more capacity. So I would anticipate that we'd be able to increase some activity. We need to be a bit careful with that because obviously that has a cost implication to the commissioners. So it's got to be doable for both. There is no other Neuro Rehab Centre in the region. So we might actually attract more referrals from outside of the area. We get quite a number of referrals coming from that area … I think that because we're very confident in demonstrating the changes that we can make, I'm confident that we'll be okay with it'.

Claire, Strategic Manager, Acute Provider

Oldville quote 13

Acute Provider leads plans

Acute Provider leads plans to develop new rehabilitation hub with integrated community services to increase efficiency: *Acute Provider leads plans without commissioner support to make better use of resources and generate evidence for gap in services*

Once the Acute Provider took control of leading the working party group, the project appeared to gain momentum and focused on creating an integrated system that increased efficiency for both providers. This was driven by a realisation that from the commissioner's perspective that there would be no additional resources to invest. Making efficient use of resources and generating evidence of gaps in services was particularly important for all the stakeholders as it would influence how the CCG may be able to make financial investments in the future.

'There is no money, so we've got to try and work out how we can move money round the system, see how we can build an argument'.

Linda, Commissioning Manager, CCG

Oldville quote 14

'We can't ignore the money factor, and I think that it is obviously a huge driver, but that then should ensure that we get the very best out of what we've got. We just can't be complacent about anything really. So I think you should be constantly trying to look at different ways of doing things'.

Helen, Clinical Director, Acute Provider

Oldville quote 15

As commissioners were not able to offer any investment for a specialised CST, reconfiguring existing resources was the only option for the Community Provider by looking at *'what we've already got, bringing together the teams'* (Julia, Clinical Manager, Community Provider). The providers were becoming frustrated by the lack of support from the commissioners and feeling like they needed to '*push the commissioner*' (Helen, Clinical Director, Acute Provider) to get a plan in place for

change. However, having passed the responsibility for change to the providers, the commissioners did not feel that they were in a position to make demands on how the providers changed their existing services and were relieved when the providers decided to go ahead with reconfiguration.

'Fortunately one of the provider staff said, 'Why don't we just do it?', you know, [laughter] and I think that was the real kind of breakthrough moment and as a commissioner I couldn't have said that … I think if I as a commissioner just said to those staff, 'You've got to do it', I think it then goes back to, 'Well what's in the current spec? What's in', and I think a lot is about relationships and I think if a commissioner goes in kind of heavy-handed or says, 'We want you to work differently', then straightaway the providers then, 'Well you give us the money to do that', and it kind of bounces straight back'.

Linda, Commissioning Manager, CCG

Oldville quote 16

This suggested that the commissioners were not confident in the commissioning process because they '*realised that [they] didn't really know enough about what [they] needed to know*' (Zoe, Commissioning Manager, CCG). By making the providers responsible for their actions with the proposed changes, the commissioners reduced the risk that they would be forced to invest scarce resources into community stroke services by forcing the provider's to make better use of the resources they already had.

Phased provider plan

Phased change approach planned with long term plan of commissioning a new community stroke and neurology service: *Plans formed with no contract discussions or timescales leading to a lack of progress*

The working party group's long term goal was to persuade the CCG to commission a CST but to do this the commissioners required a case of need based on a better understanding of current demand and resource use. To do this the working party group developed a phased plan with long term aim of commissioning

comprehensive community stroke services to complete the pathway in conjunction with both the Acute and Community Providers.

The working stroke group developed a two phase plan. Phase one involved reconfiguration of existing services, and phase two was to use data generated from phase one to develop a case for the commissioning of a new CST. By taking this approach, the working party group were hoping that '*the staffs on the ground know that [phase 1], that's got to be better than what they're doing now so they're willing to go with it'* (Linda, Commissioning Manager, CCG). The providers wanted front line staff to engage with reconfigurations plans despite knowing that there was a risk that no further change or investment may be made. Clinical staff had been told that by '*pooling these resources and getting people seen quicker, waiting lists go down and then people don't have to wait as long'* (Lucy, Clinical Manager, Community Provider). Clinical staffs understood the approach but were sceptical as they were aware that it did not resolve the problem of having no CST.

'That's what it's been sold to us as when I ask the question, 'But what about community stroke team?' They said, 'We had to do something with the resources we've got, and once we've done that, then we can more clearly see the gap and then that gives us a stronger case for commissioners'.

Lucy, Clinical Manager, Community Provider

Oldville quote 17

The working party developed a model of what the reconfigured services would look like organisationally but progress remained slow towards finalising a date to implement the reorganisation. There were no timescales for change which meant several months passed without any definitive change or plan for change. It became apparent that no one was clear as to who should be leading the change, as despite planning it the providers were unwilling to commence the reorganisation without formal agreement from the CCG.

'Well time-scales wise I'm not really clear when this is coming on-stream and that's just enough of a concern for me just to want to make sure I have regular dialogue …

If Linda's (Commissioning Manager, CCG) not getting in touch with me in January, I'll be getting in touch with her just to make sure that what's happening, where are we, because there aren't any time-scales are there?'

Bill, Social Services Manager, Local Authority

Oldville quote 18

Through the planning process, contracting arrangements for the reconfigured services had been not been discussed and the project could not move forward without these discussions. The providers had concerns that their different approaches to contracting would make this process difficult. The Community Provider felt that they could probably proceed without too much concern but the Acute Provider's approach would be to get the business managers involved which '*would have a very different tone to* it' (Linda, Commissioning Manager, CCG). There was a reluctance to enter formal contracting discussions as they were assumed to problematic.

'It's a leap of faith and trust really and those providers have shared with me what they know of their current costs and activity with the caveat that it's not perfect and I'm not going to come back and kind of monitor them against what they've given me, because it might not be completely accurate because it's coming out of block contracts and it's a bit of a guesstimate and equally I've shared with them what we understand from our contract. I think the problem is that, as I say, because historically the services have built up over time, unless it's a new service, it's very difficult to put a specific budget line and activity to a lot of these services'

Linda, Commissioning Manager, CCG

Oldville quote 19

The lack of clarity of how reorganisation and change was to be contracted prevented the providers from moving forward with phase one. By April 2016, no change had been made to existing services and although the plans remained in place there was no timescale on when the change was expected to happen.

Commissioning outcome

At the end of data collection period, the providers were continuing to meet regularly with commissioners to discuss the model for the first phase of reorganisation but no plan for implementation was in place. The Acute and Community Provider's clinical staff had been made aware of the plans through a stakeholder engagement event. The clinical staff that attended had made comments on the plans but had not been informed if their concerns had been addressed. They were frustrated by the lack of plan about when change was likely to happen.

'They had that day where we all went and gave comments. Now I've not heard anything back. That's what would be good because there was a lot of buzz in that room and a lot of comments made and I know my acute colleagues have got some concerns which would have been raised. So it's actually where we're going now. I didn't feel that, when I asked, I got a time-scale of when these changes were going to happen'.

Lucy, Clinical Manager, Community Provider

Oldville quote 20

In conclusion, Oldville commissioners facilitated the providers to make plans to reorganise existing services and develop plans for a CST, but were unable to commit support to the plans and drive forward tangible change. The Acute Provider continued to drive their own internal development of a new rehabilitation hub with increased awareness of how their new service would be located within broader plans for the Oldville healthcare system. The reorganisation of existing community services was focused around the rehabilitation hub plans but no progress had been made to commence reorganisation. Difficulties in moving forward were associated with the commissioner's non-committal approach which was largely due to a lack of available resources for any investment.

'That upsets me because I think I don't know, you know, when they were trying to redo these services, but actually will we ever put our money into a community stroke team?'

Lucy, Clinical Manager, Community Provider

Oldville quote 21

Where's the logic in Oldville?

The commissioning process in Oldville was initiated due to inadequacy in community stroke services that was highlighted by the AHSN and SCN, and through patient complaints. This provoked a response within the CCGs to address stroke services in the community within wider plans to transform Oldville healthcare by working towards an integrated system.

The institutional environment in Oldville was complex with historical commissioning arrangements and local transformation policy playing an important role in how the commissioning process moved forward. In Chapter 2 the organisation of the NHS administration was set out and found to be institutionally complex. As the commissioning and healthcare provider functions of the NHS are split, they follow two different representations of logics in the institutional system. Using the ideal type logic typology set out in Chapter 3, a theoretical representation of commissioning and healthcare found that healthcare commissioning was predominantly influenced by market and bureaucratic, whereas healthcare provision was more influenced by corporate and professional logics.

Ideal types follow a theoretical framework but can be used to characterise other context. Using the typology as a guide and based on the behaviours of the organisations in the case study, the theoretic representation of logics in the organisations in the Oldville case study given in table 7:1.

Table 7:1: Theoretical representation of logics in Oldville

	Ideal Type Commissioning	CCGs	Ideal type Provider	Acute Provider	Community Provider
Root metaphor	**Market - bureaucratic** *State redistribution of resources with elements of a market system*	**Bureaucratic** *Redistribution of resources*	**Corporate - professional** *Relational transactions of professional knowledge in corporate hierarchy*	**Professional – corporate** *Relational transactions of professional knowledge in corporate hierarchy*	**Bureaucratic** *Following rule system for redistribution of resources*
Source of legitimacy	**Market - professional** *Decisions legitimised through money and clinical evidence*	**Market** *Decisions legitimised through economic reasoning*	**Professional – corporate** *Specialist knowledge used to determine market position*	**Professional – corporate** *Specialist knowledge used to determine market position*	**Bureaucratic** *Decisions legitimised through democracy*
Source of authority	**Bureaucratic** *Action controlled through policy and governance structures*	**Bureaucratic** *Action controlled through policy and governance structures*	**Corporate - professional** *Clinical standards enforced through top down management*	**Professional – corporate** *Clinical standards enforced through top down management*	**Bureaucratic – corporate** *Bureaucratic domination enforced through top down management*
Source of identity	**Bureaucratic - market** *Defined by political party in power*	**Bureaucratic – market** *Defined by faceless control of the healthcare market*	**Professional – corporate** *Professional reputation maintained through bureaucratic*	**Professional – corporate** *Professional reputation maintained through bureaucratic mechanisms*	**Bureaucratic** *Defined through bureaucratic mechanisms*

			mechanisms		
Basis of norms	**Market - bureaucratic** *Citizenship for equitable access*	**Bureaucratic - Market** *Equitable access managed through budgets*	**Market - bureaucratic** *Citizenship for equitable access*	**Professional – corporate** *Delivery of professional service*	**Bureaucratic** *Citizenship for equitable access*
Basis of attention	**Bureaucratic** *Community rather and individual attention*	**Market** *Status in market as controller of budgets*	**Professional bureaucratic** *Status in profession and community good*	**Professional – market** *Status in profession and position in market*	**Professional bureaucratic** *Status in profession and community good*
Basis of strategy	**Market - bureaucratic** *Economic efficiency for community good*	**Bureaucratic – market** *Economic efficiency for community good*	**Market - corporate** *Reputation, efficiency and profit*	**Professional – market** *Reputation, efficiency and profit*	**Bureaucratic** *Increased community good*
Control mechanism	**Bureaucratic – market** *Finite resource allocation*	**Bureaucratic – market** *Finite resource allocation*	**Corporate – professional** *Clinical and managerial hierarchy*	**Professional – corporate** *Clinical and managerial hierarchy*	**Professional – corporate** *Clinical and managerial hierarchy*
Economic system	**Market - bureaucratic** *Welfare and market capitalisation*	**Bureaucratic – market** *Welfare and market capitalisation*	**Corporate- market** *Managerial and market capitalism*	**Corporate- market** *Managerial and market capitalism*	**Corporate- market** *Managerial and market capitalism*

The analysis shows that commissioning organisations in Oldville attend to logics in the institutional system in a slightly different way to ideal type commissioning organisations. The behaviour of the CCGs in Oldville suggests that they tend to follow logics associated with the bureaucratic and market logics but with emphasis placed on the bureaucratic logic through the redistribution of resources as their root metaphor. This was reflected in their inability to commit further resources to stroke services because they are not available and requirement to make more efficient use of current spending (see quotes 14 and 15).

However the market logic did play an important role. In this case study the market logic appears to constrain behaviour rather than guide it, with economic reasoning working in conjunction with the bureaucratic logic to prevent investment in new services because no resources were available to implement the market logic. The commissioners used the market logic alongside the bureaucratic to stall the implementation of the market logic by continuing to reassess current provision and contracts rather than moving forward to develop and invest in new services (see quotes 14, 17, 19 and 21).

While ideal type commissioning organisations legitimise their behaviour through the professional logic using evidence to support their decision making, the Oldville commissioners relied on the market logic to constrain their behaviour by using a non-committal approach to avoid the need to commit resources to any potential change. Overall this suggests that the commissioners in Oldville used avoidance tactics to attend to logics in the institutional system.

The providers in general showed traits associated with their ideal type characterisation, but with the Acute Provider showing closer alignment than the Community Provider. The Acute Provider followed a predominantly corporate professional logic with their emphasis placed on developing new services that meet both the professional and corporate demands in the institutional system. The Acute Provider's plans to develop a rehabilitation hub demonstrate how they have interpreted a change in the overall institutional environment. Policy was calling for services to be moved out of the acute hospital setting and the Acute Provider

appeared to be using their corporate logic to increase their position in and share of the market (see quote 13). They were developing a service beyond their normal repertoire (see quote 12) and legitimising the decision through their professional associations and clinical expertise (see quotes 13 and 15).

In comparison the Community Provider appeared to be more aligned to the bureaucratic logic with emphasis placed on creating a more equitable system but without a corporate approach. The Community Provider struggled to make any progress with reorganisation plans without assistance from the corporately aligned Acute Provider (see quotes 9 and 11). The difference in the representation of logics in the organisations behaviour may have contributed to how the different organisations worked together and attempted to negotiate a commissioning goal.

Negotiating the goal of the commissioning process

The case study started out with the CCG and Community Provider considering how to address the problems they were experiencing with a lack of community stroke services. However the CCG had no resources to invest in a community stroke service and the Community Provider were limited by their alignment to the bureaucratic logic to allow them to progress with any reorganisation and development plans. The CCG was under pressure to address the problems with community stroke service provision following patient complaints and were also obliged to ensure that any changes were in line with plans to improve integration across the whole Oldville healthcare system.

The combined responses of the CCG and the Community Provider to the institutional demands resulted in avoidance behaviour on the part of the CCG and the Community Provider to realise change (see quote 8). However rather than avoiding all demands, the two organisations proceeded by attempting to negotiate a goal of the commissioning process. They agreed that they initial goal would be to review existing services to determine the changes that were needed (see quote 6). The CCG encouraged the Community Provider to lead the review to give them ownership of the goal through perceived collaboration (see quote 7) but gave no commitment of guidance to how the goal would be achieved in the future.

Therefore from the outset, neither the CCG nor the Community Provider were clear on the goal of the intended commissioning process but it was assumed that both organisations were working towards having a CST in some form.

This suggests that the CCG and the Community Provider were attending to the bureaucratic logic in their attempts to make the system more equitable for patients but were also inhibited by the logic as there was no official mandate to change or known source of investment to fund any potential plans. Under the bureaucratic logic the organisations relied on central direction but neither organisation had authority to lead change (see quote 8).

Once the Community Provider learned the Acute Provider had plans to develop a rehabilitation hub of their own, they were presented with an opportunity to align with another organisation's goal that could be viewed as connected to their own goal. However, the Acute Provider was following a different logic and under their corporate strategy, they had a clear goal of what they wanted to achieve through the development of their new rehabilitation hub. The basis of the Acute Providers attention was to strengthen their position in the market through provision, legitimised through delivery of a highly specialised service under the professional logic (see quote 13).

The Acute Provider's strategy was attempting to manipulate the institutional demands in the system and was potentially high risk if the CCG was unable to commit additional resources to their service in the future (see quote 13). It was in the Acute Provider's interests to gain the support of the Community Provider and CCG to legitimise their own plans without losing control. Without a clear goal, the Community Provider were prepared to align with the Acute Provider (see quote 9 and 10) and progress was made towards developing the rehabilitation hub with reorganisation of community services to strengthen the case for change. At this point the providers were working towards a shared goal but the goal of the commissioning process from the CCG's perspective was still not clear. The CCG continued to provide limited leadership and in doing so retained an element of control as the budget holder through their alignment to the bureaucratic logic.

Implementing the goal of the commissioning process

Without a clear mutually agreed goal, the providers worked towards their own shared goal but progress was hindered by the commissioners who remained unable to commit to the same goal. The commissioners continued to give support to the provider's goal but not substantive commitment which frustrated the Community Provider as they were limited in their ability to implement their overall goal of developing a CST (see quotes 18, 20 and 21).

In comparison the Acute Provider was not reliant on the commissioners to implement their rehabilitation hub so could continue with plans while maintaining the support of the Community Provider that may help them in the future. The Acute Provider with influences from the professional and corporate logics was forthcoming in taking the lead in the process, and aligning the overall goals with their own goal of developing a rehabilitation hub. Without interference from commissioners and with their own finances secured in the short term, the Acute Provider had an advantage by taking control despite the CCGs control mechanism of finite resource allocation in the long term. The Acute Provider based their strategy in the corporate logic by working to increase the share of the market and legitimise their decision making using the professional logic which was difficult to challenge.

While the Acute Provider remained committed to their own representation of the institutional logics in the system and this was not threatened by the Community Provider or the CCG who continue to attend to the bureaucratic logics in the system. Being institutionalised into the bureaucratic logic, the Community Provider sought leadership from above and appeared to be comfortable with the Acute Provider taking control of the commissioning process, even when the Acute Provider was more likely to attend to their own goals at expense of other organisational goals.

The staged plan that emerged through the process appeared to attend to the need of commissioners to justify any investment before a commitment had been made (see quotes 16 and 19). However it worked to the advantage of the Acute Provider by developing a service that the commissioners may be unable to justify

withdrawing funding from in the future. The Acute Provider by controlling the goal of the commissioning process appeared to use logics manipulatively to allow their own goals to be achieved but the commissioners ultimately controlled the outcome of the process by using the bureaucratic logic to limit the flow of resources through the Oldville healthcare system.

Conclusion: Misaligned goals, unknown means

Although the Acute Provider developed a goal and strategy to achieve the goal based on the corporate and professional logics, they were the only organisations in the commissioning process that had a clear strategy for planning and implementation. Their representation of logics in the system allowed them to have the power and freedom to develop plans to maintain their position of power and ensure that they continued to control the healthcare market. They had adapted and responded to policy changes and institutional demands that may have threatened their position. To strengthen their position further, they offered the Community Provider the leadership they required from the bureaucratic logic but were not able to access from the CCG. This allowed the provider organisations to develop a shared goal and work on plans that may achieve integration.

The Community Providers commitment to the bureaucratic logic meant that they sought direction but the CCG were unable to offer this as they were unable to establish a goal in the commissioning process. The CCG was limited by institutional logics that did not allow them to commit resources to developing a CST. However, their bureaucratic logic forced them to attend to other logics that gave the impression that they may commit at some point. Without a clear goal, the commissioners were not able to commit to the providers plans and no progress was made towards implementing the staged plan that had been developed through the commissioning process. The commissioning process had not failed but without a clear goal, there was no way of knowing how the goal would be achieved until they organisations were able to align their goals and develop a shared means of working towards them collaboratively.

Chapter 8: Discussion: Where's the logic in inter-organisational working?

Introduction

This research set out to explore how institutional logics in an institutionally complex organisational field affect how organisations work together to achieve shared goals (see Chapter 3). Commissioning in the English National Health Service (NHS) was identified as an example of an organisational process that required different types of organisations to work together to deliver integrated services in a complex institutional field (see Chapter 2). Three case study examples of inter-organisational working were investigated within the context of stroke service commissioning in the NHS. In each site a different approach to commissioning was taken despite exposure to similar institutional demands.

In each case study site commissioners and providers (acute and community) set out with the intention of addressing inadequacies in community based services for stroke survivors. Neurology patients were included in Edgeham (Chapter 6) and Oldville (Chapter 7) but not Weshall (Chapter 5). All three sites reflected national problems of scarce resources, inefficiency, inequality, variation and falling quality standards (Iacobucci, 2017a) thought to be associated with poor integration between organisations in the system. Each site was under pressure to address integration and new commissioning models had been suggested in the Five Year Forward View (NHS England *et al.*, 2014).

Stroke services already had a strong evidence base to support an integrated pathway of care between acute, community and social care providers (Royal College of Physicians 2016 and see Chapter 2) and the local Academic Health Science Network (AHSN) and Strategic Clinical Network (SCN) had developed commissioning guidance to support decision making. This allowed stroke services to be viewed as a relatively straight forward target for integration and provided an opportunity to test new models of provision suggested in the Five Year Forward View (NHS England *et al.*, 2014).

Each site initiated a commissioning process to reorganise and develop community stroke (and neurology) services to be integrated with existing acute services. Each site used different approaches which resulted in different outcomes. The findings suggested that the organisations in each site interpreted the institutional demands placed on them differently. This resulted in varied institutional logics influencing behaviour which in turn impacted on the way in which the commissioning process in each site played out. This chapter begins with an overview of each commissioning process before the logics identified as being influential to each stage of the three case studies are compared with reference to the institutional logics literature. A theoretical explanation of how logics may have influenced inter-organisational working in each site is then presented to as an answer to the overarching research question (see Chapter 3) before the institutional logics research propositions (see Chapter 3) are revisited in the concluding sections.

Overview of the three commissioning processes

Westhall

In Westhall commissioners faced local pressure to address inequality in stroke services. Commissioners worked with the acute provider, two community providers and other stakeholders collaboratively to develop what appeared to be a shared goal of recommissioning the whole stroke pathway in Westhall to address issues of variability between the two existing pathways; the south pathway that was considered high quality and comprehensive and the north pathway that was considered fragmented and inferior to the south.

Providers were focused on creating an integrated system that developed the under-resourced north pathway to ensure that all stroke survivors in the area would experience the same high standard of care that already existed in the south. They were also focused on addressing problems with funding stroke services as this had created tension between all the organisations in the past. The providers assumed commissioners were working towards the same goal but the commissioners had a different motivation. The commissioners were primarily concerned with changing contracting arrangements to reduce their overall spending on stroke services. They

were interested in improving community services in the north of Westhall but less concerned that services should be brought up to the standard of the south pathway, or concerned that the quality of the south pathway may be at risk from the plans.

The commissioners in the north announced that they considered that the most appropriate commissioning arrangement was to reconfigure all stroke services into a lead provider model which was recommended in the Five Year Forward View (NHS England *et al.*, 2014) but commissioners and providers in the south did not wish to participate as they felt it risked the quality of their existing services. The north commissioners ceased communication with remaining providers and without informing providers of their plans, attempted competitive procurement of the north community stroke team (CST) service component of a new lead provider model as a mechanism to implement integration in the north of Westhall.

Following a period of collaboration, providers then felt obliged to cease communication under the rules of procurement. The providers' behaviour became unpredictable with the Acute Provider making a bid for the north CST with the South Community Provider in an attempt to standardise care across the area. This was a strategy to force the commissioners to increase their budget for CST services to allow standards to be brought in line with the south pathway as their bid exceeded the financial envelope offered. This resulted in the bid being rejected by commissioners and plans for change being abandoned.

During the case study the commissioners followed a market logic which conflicted with the provider's professional and corporate logics and prevented effective inter-organisational working between the providers and the commissioners.

Edgeham

In Edgeham commissioners were under pressure from the local transformation board to address widespread problems with integration across the local health system. Stroke had been identified as an area that could be used as an exemplar for change. The commissioners worked collaboratively with local stakeholders and providers to develop a shared goal of commissioning a new CST and neurology

service to be integrated with, support and reduce the pressure on existing acute services.

The commissioners engaged the SCN to generate a community neurology services specification that could be used in conjunction with an existing community stroke specification to develop a tailored local specification using co-design principles with local providers. The providers were frustrated by past experiences of commissioning community stroke and neurology community services as plans had failed to be realised but the perceived co-design process promoted provider engagement and providers felt empowered in the change process. However the process was tightly controlled by the commissioners to ensure that plans were steered towards their vision of the new commissioning arrangements which included a new lead provider model (NHS England *et al.*, 2014).

The commissioners manipulated the commissioning process to ensure that progress was made. They actively avoided entering a procurement exercise by framing their plans as a redesign with limited investment and steered the new lead provider model towards being led by the Community Provider. Their strategy created the opportunity for the commissioners to gain more control over the Community Provider that had been difficult to manage in the past. However during the process the commissioners made mistakes in calculating how the plans could be funded which threatened implementation of the goal. Despite this progress was made towards commissioning change.

During the case study the commissioners co-opted a professional logic to enhance engagement from the providers and conceal their own bureaucratic logic while rejecting the market logic which threatened implementation.

Oldville

In Oldville commissioners were under pressure from the AHSN and SCN to address longstanding problems with a lack of CST services and were receiving serious complaints from service users who were dissatisfied with sporadic and inadequate generic community services. To address the problems commissioners engaged with the Community Provider in an attempt to understand more about the problems

that stroke survivors were experiencing with CST services. The Community Provider's goal was to develop a CST but the commissioners were unable to commit to this due to a lack of any additional funds for investment.

In an attempt to address the situation, commissioners encouraged the Community Provider to develop plans to make better use of existing resources through reconfiguration into an integrated system. However they did not provide guidance which prevented the Community Provider from making progress as they were unsure of the implications for their existing services.

At the same time the Acute Provider was progressing with their own plans to develop a new rehabilitation hub to support their services. It was intended that the new rehabilitation hub would incorporate the Acute Provider's existing neurological outpatient services that provided some stroke rehabilitation in the absence of a CST service. The Acute Provider and Community Provider considered that their plans may be complimentary and agreed to work together to align plans. The Acute Provider took the lead to plan reorganisation of community services to complement their plans for the rehabilitation hub. However the commissioners remained passive in the commissioning process and their lack of commitment hindered progress towards any implementation of change in community services despite the Acute Provider continuing to progress with the rehabilitation hub.

During the case study the commissioner's bureaucratic logic prevented commitment to through a lack of resource to support the providers who followed a predominantly professional logic.

Influence of logics on commissioning

The findings in the three case studies were analysed further using the institutional logics framework to gain a greater understanding on the institutional complexity they faced when attempting to commission CST services and how this affected the commissioning process. The findings of this analysis will now be discussed.

Interpretation of field institutional complexity

All three case study sites were situated in a highly complex institutional field consistent with other healthcare contexts (Scott, Ruef, P. Mendel, *et al.*, 2000b) with influences from bureaucratic, professional, corporate and market logics in national policy drivers directing organisational behaviour. The drivers were often contradictory. Commissioners were guided by bureaucratic and markets logics from the Health and Social Care Act (Secretary of State for Health, 2012) emphasising the need for competition, and from the NHS itself with the Five Year Forward View (NHS England *et al.*, 2014) focusing on collaboration, quality and evidence through the bureaucratic and professional logics (see Chapter 3). In comparison, institutional logics informing provider behaviour in the Health and Social Care Act (Secretary of State for Health, 2012) were more closely associated with professional and corporate logics. Each site was exposed to similar change drivers associated with focusing on delivering high quality evidence based care within a business structure. This reflected provider drivers found in other healthcare field where business-like healthcare was a priority (Goodrick and Reay, 2011).

Within the policy that informed the whole of the healthcare system's organisation and administration, the boundaries between the different demands were often blurred which increased the complexity of institutional environment at the field level. Commissioners faced different institutional demands to providers while at the same time both types of organisations were facing demands to work together collaboratively. This may reflect how policy reforms are influential for some organisations but not others (McDonald *et al.*, 2013). As a result organisations in each site responded slightly differently to field level logics. This was associated with the interpretation of local institutional complexity.

Interpretation of local institutional complexity

Locally the institutional environment was constructed with a different combination of institutional logics. These were dependent on the organisations and individuals interpretation of field level institutional logics and other local influences. Together these were involved in driving the initiation of the commissioning process in each

case study and combined to create change drivers which were a reflection of the different interpretations of local institutional complexity.

Common change drivers included problems associated with historical commissioning arrangements, national and local policy drivers, and pressure to change from patient and public representatives (table 8.1). All three sites had historical commissioning arrangements that made change more difficult than designing new service from scratch as specific rules limited how and when change could be achieved. The market- bureaucratic control mechanism of commissioning was based in policy (Thornton, Ocasio and Lounsbury, 2012) where complex rules and regulation govern and restrict commissioning behaviour limiting creativity in commissioning practice beyond the definition of the market.

All three sites had successfully commissioned acute stroke services and Early Supported Discharge (ESD) in the past which was attributed to the successful implementation of the Stroke Strategy (2007) where a combination of the bureaucratic and professional logics had been a powerful change driver. With the exception of Westhall which was considered an exemplar by the SCN and AHSN, the sites had been unsuccessful in developing CST in line with clinical guidelines and policy for stroke (NICE, 2013; Royal College of Physicians, 2016b). The Stroke Strategy (2007) was no longer perceived as a national priority suggesting the professional logic associated with stroke had weakened as a driver for change and perhaps suggested a change in the constellation of logics (Goodrick and Reay, 2011) or a reflection of how commissioners were more inclined to respond to other logics in the system which commanded their attention (McDonald *et al.*, 2013).

Although the Westhall stroke pathways were considered high quality and comprehensive, the way in which they had had been commissioned in the past had created problems. Central to the problem was the way community based ESD and CST services were funded. Problems with a lack of financial resources was common in all three sites and provided strong motivation for the commissioners to address commissioning arrangements to improve the quality and equity of services across the area, and regain control of spending that had become unsustainable across the

health system as a whole. The basis of the bureaucratic logic is to redistribute resources for the good of the whole community (Thornton and Ocasio, 2008) but was considered to be failing under current organisational arrangements (Iacobucci, 2017a). There was little clarification on how new models of provision suggested in the Five Year Forward View (NHS England *et al.*, 2014) could be funded (Ham and Murray, 2015) which allowed the bureaucratic logic to only be followed in part.

Table 8.1: Cross site comparison of commissioning change drivers

	Westhall	Edgeham	Oldville
Historical Commissioning			
Funding	Long standing conflict over tariff payments to Acute Provider	Inefficient local health economy; inadequate community provision	Current spend on community services unknown
Investment opportunity	No investment available	Limited investment available	No investment available
National and Local Policy			
National policy	Development of community services and integration	Development of community services and integration	Development of community services and integration
Five Year Forward View	Lead provider model identified as a potential commissioning solution	Lead provider model identified as a potential commissioning solution	Not influential in local strategic planning
Local transformation agenda	Stroke identified as a candidate for improved integration	Stroke targeted as a priority in formal transformation strategy	Any changes must comply with local integration agenda
SCN and AHSN	No specific concerns identified	Poor community service provision	Poor community service provision
Patient and Public Involvement			
Patient feedback	Survey revealed fragmented services	Patient stories of poor community services heard at SCN commissioning event	Patient complaint of inadequate service reached CCG Board
Logic of change drivers			
	Bureaucratic logic dominates as commissioning policy is imposed	Bureaucratic logic strong with corporate and consumer influences as transformation is planned	Bureaucratic logic under pressure from consumer logic
Logic of commissioners			
	Bureaucratic with market influences	Bureaucratic with co-opted professional logic	Bureaucratic

Logic of providers			
	Corporate - professional	Corporate - professional	Corporate - professional

Despite funding concerns the need for change was reinforced by national policy driving change towards integration (NHS England *et al.*, 2014) which was being interpreted and translated in local transformation policy. Under the bureaucratic logic control is achieved through bureaucratic dominance (Thornton, Ocasio and Lounsbury, 2012) and regulative pillars (Scott, Ruef, P. Mendel, *et al.*, 2000a) could be used to enhance bureaucratic domination through local transformation plans. Stroke services presented an opportunity because they had a clear clinical pathway (Royal College of Physicians, 2016b) that crossed between different types of providers in the health and social care system and could be optimised through integration. It was possible that commissioners were drawn to stroke as it was viewed of having a chance of success in a challenging context. Addressing a speciality like stroke would allow bureaucratic and professional institutional demands to be satisfied at a local and national level. Given possible challenges in satisfying the bureaucratic logic to implement policy demands, professional logics appeared to play an important role.

In each site different change drivers stimulated and informed a commissioning response and commissioners took a different approaches suggesting that organisations were interpreting the local institutional environment in different ways or viewing the constellations of logics from different perspectives (Goodrick and Reay, 2011). In each case study different national and local logics influenced the development of the goal of the commissioning process suggesting that the organisations in each site interpreted the arrangement of the logics differently.

Logics informing the goal of the commissioning process

As each site interpreted the field and local logics in different ways, this led to different logics informing the goals of the commissioning processes. The bureaucratic logic was influential to commissioners in all three sites because they were obliged to follow direction from the centre under the regulative pillar (Scott,

Ruef, P. Mendel, *et al.*, 2000b) but other logics were also at play depending where the demand came from. For example the influence of market logic played an important role as policy directed the NHS to operate as a market system. Westhall's commissioners interpreted this as a non-negotiable demand by following a procurement exercise whereas Edgeham's commissioners actively avoided following the market logic but finding an alternative strategy for their commissioning process. This suggested interpretation of logics is a complex process and the different interpretations influenced the commissioner's goals.

In Westhall commissioners' responded to local demands to improve the quality and equity of services and national demands to justify use of scarce resources by attempting to implement a new commissioning model. This suggested the bureaucratic logic was powerful. In comparison the providers were influenced by the professional logic with strong commitment to the implementation of clinical guidelines and elements of the bureaucratic logic that demanded collaboration within the system. However they were also influenced by the corporate logic where retaining or strengthening their position in the market was an important consideration. Both interpretations caused organisations to assume they were working towards the same goal but commissioners and providers had neglected to take into account each other's stance on finance, meaning that their goals were not compatible. The different responses resulted in the organisations entering a commissioning process without an agreed shared goal which may be related to their interpretation of the institutional logics in the system. The contradictory nature of the Five Year Forward View's (NHS England *et al.*, 2014) collaborative approach with the strong market and bureaucratic logics of the NHS internal market and scarce resources (see Chapter 3) may have contributed to confusion about the goal of the commissioning process from a financial perspective (see Westhall quote 13).

In Edgeham commissioners responded to local institutional demands from the bureaucratic logic to address problems with the wider healthcare system using stroke and neurology services as a test for new commissioning approaches demanded in field level logics. Providers were driven by the professional logic to

bring services in line with clinical policy. The corporate logic also important as it informed the community provider's desire to maintain income streams and dampened the acute provider's motivation as they did not consider the financial gain to be worth the work required. The commissioners appeared to be more aware of the provider's interpretation of professional logics and goal in the commissioning process. To stimulate collaborative working, the commissioner co-opted the profession logic to build confidence with providers and develop a shared goal of a new integrated CST and neurology service without losing their own commitment to the bureaucratic logic which limited their ability to invest heavily in a new service. This suggested that the commissioners in Edgeham were able to predict how the provider's interpreted the logics in the system and were able to adapt their behaviour accordingly. The bureaucratic and professional logic were therefore both contradictory and complimentary at the same time (Goodrick and Reay, 2011) and used to strengthen the commissioning approach (Waldorff, Reay and Goodrick, 2013) by allowing a shared goal to be more easily negotiated. Once the shared goal was established the commissioners had a greater opportunity to influence the means of achieving the goal by giving the impression that inter-organisational working was a transparent process (see Edgeham quote 4).

In Oldville commissioners were responsive to local institutional demands from the bureaucratic logic to address the wider problems in the healthcare system by considering how the system could become better integrated. They were also responsive to the professional logic as they felt obliged to act on highlighted problems with services from AHSN, SCN and patient complaints. However they were also limited by the bureaucratic logic as they had no resources to address problems. Again providers were responsive to the professional logic in their desire to improve and develop community services for services and assumed that commissioners were also following this logic. From the acute provider's perspective, this was also associated with the corporate logic which drove their desire to develop a rehabilitation hub that increased their share of that sector of the market. The providers assumed the commissioners were responsive to the professional logic this because the commissioners had approached the providers to request they consider

how problems could be addressed. In this situation the commissioners appeared committed to a shared goal of developing a CST service in the future but were restricted by local logics in their ability to act on the goal. The commissioners were restricted by the bureaucratic logic in their ability to implement the professional logic meaning that the logics were contradictory rather than complimentary (see Oldville quote 8).

Despite exposure to similar change drivers (table 8.1), each commissioning and provider organisation established a commissioning goal but different interpretations of the institutional demands led to slightly different organisational goals. It was only Edgeham that managed to achieve a shared goal between the organisations but this was related to the commissioner's ability to predict the provider's response to institutional demands and adapt their approach to incorporate the provider's values and beliefs. To do this they co-opted the professional logic that the providers followed which resulted in greater provider engagement because they assumed shared beliefs and values with the commissioners. This strategy allowed the organisations to enter the Edgeham commissioning process with a clear understanding of the intention of the process whereas in Westhall and Oldville each organisation assumed a shared goal but were actually working towards different interpretations of the institutional demands and different versions of a broad goal.

Logics informing the means of achieving commissioning goals

In each case study, the means of achieving the organisational goals, shared or otherwise, varied leading to three different commissioning processes (table 8.2).

Conflicting inter-organisational institutional logics

In Westhall collaborative provider engagement was initially used to develop plans for a new stroke pathway that would require reorganisation and investment. However the commissioners were not prepared to make further investment into stroke services which conflicted with the provider's goal for the commissioning process. The commissioners and providers therefore entered a commissioning

process with different versions of the perceived shared goal and therefore established different and incompatible means of achieving those goals.

In situations of logic conflict, organisations are forced to make decisions about which logics they attend to and which they ignore, with groups being more likely to attend to logics in which they have been previously socialised into (Pache and Santos, 2010). Without consulting the providers, commissioners attempted to commission the new pathway using a lead provider model through a procurement exercise by following a standardised procedure informed by the market logic; a procedure they were comfortable and experienced with. By attending to the market logic the commissioners could approach the commissioning process in a faceless manner which would control the flow of resources into the system (Thornton and Ocasio, 2008). By following this strategy the commissioner's logic was clear but it contradicted the professional logic that had been used to develop the collaborative relationships the provider organisations had established and based their organisation goal on.

The commissioners had assumed that they would be able to predict and control the behaviour of the organisations as they entered procurement. However the competitive process had the effect of strengthening some inter-organisational relationships and dissolving others which had been formed through earlier collaborative behaviour. The Acute Provider drew on their corporate logic to establish a new organisational goal with the South Community Provider who shared similar beliefs and values. Together they bid for the lead provider model and forced the existing North Community Provider out of the market.

Table 8.2: Cross site comparison of commissioning process

	Westhall	Edgeham	Oldville
Intention			
Strategy	Reconfiguration of existing services into standardised cross site stroke pathway using lead provider model	Reconfiguration and development of existing services into specialised community stroke and neurology service using lead provider model	Reconfiguration of existing services into integrated community model
Intended outcome	Efficient, integrated, equitable and standardised high quality pathway with no additional investment	Efficient, integrated, equitable and standardised high quality pathway with small additional investment	Efficient and integrated pathway with no additional investment; new pathway to highlight gaps in service
Approach			
Strategy	Commissioner-led procurement following co-production of integrated stroke pathway model	Commissioner-led collaboration following clinically-led design of new community stroke and neurology service	Provider-led collaboration to reorganise existing services into integrated model
Process	Commissioner-driven procurement of lead provider model stroke pathway	Commissioner-driven collaborative agreement of lead provider model stroke and neurology community pathway	Provider-driven collaborative service reconfiguration plans
Institutional logic of commissioners			
Logic	Market/bureaucratic	Bureaucratic with co-opted professional	Bureaucratic
Expressed logic	Clear	Co-opted logic conceals underlying intentions	Clear

Institutional logic of Acute Provider			
Logic	Corporate/professional	Corporate	Corporate/professional
	Professional masks corporate	Clear	Clear
Institutional logic of Community Provider			
Logic	Corporate/professional	Bureaucratic	Bureaucratic
Expressed logic	Professional masks corporate	Clear	Clear

However the commissioners did not support the bid as it did not align with their own goal of reducing over spending on stroke services (see Westhall quote 22). Without the commissioners support of the new organisational goal, the process was destined to fail as they were able to avoid the need to conform to the providers' institutional demands (Oliver, 1991). Without a shared organisational goal, organisations are unable to negotiate and establish an inter-organisational working relationship in a conflicted institutional environment.

Co-opting organisational institutional logics

The Edgeham commissioners also wanted to commission their plans for a new community stroke and neurology service using a lead provider model but incorporated this into their shared goal with the providers. The commissioners recognised that providers approached commissioning from a different perspective and were orientated by a professional logic rather than a bureaucratic logic as they believed they were responsible for providing high quality care with cost an important but lesser priority. By co-opting the provider's professional logic the commissioners were able to use a collaborative strategy to engage the providers in the design of the new model which encouraged the providers to share the overall goal of the commissioning process (see Edgeham quote 16).

However the commissioners retained their commitment to the bureaucratic logic which was responsive to demands to regain financial control of the healthcare system and specifically address problems with the Community Provider's financial affairs (see Edgeham quote 24). By co-opting the professional logic, the commissioners gained the confidence of the providers which made it easier for the commissioners to predict provider behaviour and manipulate the process to ensure they commissioned the new service according to their own logic.

It has been suggested that co-existing logics within the institutional system may create the opportunity for partial autonomy (Martin *et al.*, 2016). In Edgeham the commissioners may have loosely coupled their own logic from that of their actions, allowing them to be manipulative in the institutionally conflicted environment (Thornton, Ocasio and Lounsbury, 2012). This meant that they used the professional

logic to manipulate the commissioning process to ensure that the bureaucratic logic was attended to. By using logics in the system to their advantage, inter-organisational relationships were established more effectively by the commissioners.

Inhibiting inter-organisational institutional logics

In Oldville the commissioners were committed to the bureaucratic logic but did not have a clear strategy of how they could address the problems they were experiencing with their community services. Commissioners were inhibited by their commitment to the bureaucratic logic and relied on the providers to develop a goal as they were not able to satisfy the institutional demands placed on them themselves. The commissioners were perceived by the providers to be acting on the demands placed on them but were actually inhibited to act by the same institutional logics. In an attempt to overcome the inhibition, the commissioners placed responsibility for finding the means of achieving a commissioning goal with the providers.

The providers responded to the commissioner's demands and tailored their plan using influences from the professional logic which they were most responsive to. Without direction from the commissioners, the providers were also limited in their ability to act on the institutional demands from the bureaucratic logic in the system. The Community Provider was not equipped to lead and plan change as the bureaucratic logic prevented them from doing this without clear instruction from commissioners. However by collaborating with the Acute Provider they were able to follow the Acute Provider's lead and respond to logics in the system in a different way.

The Acute Provider followed a corporate logic which ensured any plans aligned with their own agenda to increase power and status in the healthcare market. However progress was slow without commitment from the commissioners and work towards implementing the goal stalled (see Oldville quote 18). This suggested that both the commissioners and the Community Provider were inhibited by the institutional demands placed them, choosing to respond through acquiescence (Oliver, 1991).

They were therefore were passive in their approach as they sought to respond to the demands of the bureaucratic logic they aligned with. In comparison, the Acute Provider used the situation as an opportunity to be partially autonomous in their approach to develop their own services (Thornton, Ocasio and Lounsbury, 2012).

Commissioning response strategies to conflicting institutional demands

The findings of this research suggest that the way in which organisations interpret a conflicting institutional environment is different depending on the context in which they are situated and how they interpret complex institutional environments. In a complex institutional environment organisations must choose which demand to respond to and which to neglect. Oliver (1991) suggested that organisations may use different response strategies to overcome conflicting institutional demands. Pache and Santos (2010) considered that organisations that appear to be structurally similar may interpret demands differently. In this research structurally similar commissioning organisations responded differently according to Oliver's (1991) typology.

Using logics to control commissioning

Field level institutional logics relating to commissioning were strongly influenced by bureaucracy and markets (Chapter 3) but it was only Westhall commissioner's that appeared to interpret the institutional environment with a strong commitment to the internal market using procurement as their response strategy (Chapter 4). In this case study, following the market logic appeared to be a strategy to retain financial control of the commissioning process that was threatened by the collaborative plans that the providers were making. From an institutional logics perspective this indicated that they directly responded to the demands of commissioning policy by operating under the bureaucratic and market logic using defined processes of procurement which could be considered an acquiescence response strategy. By using an acquiescence strategy, they adopted the institutional logic of the market and were compliant with its demands (Oliver, 1991) in an attempt to retain their position as the controllers of the healthcare market.

However in using this strategy the commissioners ultimately lost control as they were unable to implement their goal.

In comparison Edgeham's commissioners were also influenced by the field level bureaucratic logic but actively avoided the market logic that filtered through commissioning policy (Chapter 6). Here the commissioner's interpretation of institutional logics viewed the collaborative approach of a lead provider model to be incompatible with a procurement process. Through co-option of the professional logic they had achieved provider engagement to the extent that providers were willing to enter an agreement without the need for a formal tendering process. In this case study the commissioners used an manipulation strategy to make alterations to the institutional demands and co-opt other demands (Oliver, 1991). This meant that they were able to outwardly project the impression of meeting the demands of the professional logic to gain the allegiance of the providers without having to compromise the demands of the bureaucratic logic that they followed. Although a different response strategy, it also aimed to control the healthcare market.

Oldville also demonstrated strong alignment with the bureaucratic logic but adopted different approaches to the demands placed on them (Chapter 7). In this case study the bureaucratic logic both enabled and hindered the commissioning process. Commissioners were obliged to consider changes to commissioning arrangements because of pressure from patient complaints and unsatisfactory regional reports as the bureaucratic logic demanded that these be addressed through the governance procedures. However the commissioners were limited in their ability to act because there were no funds available to address the problems. To overcome the demands placed on them they followed an avoidance strategy through a façade of acquiescence (Oliver, 1991) by encouraging the providers to complete work on their behalf. This gave the impression of a commissioning process in action but limited the need to respond immediately. Although giving the impression of passive commissioning, the response strategy may also have been an attempt to retain control of the healthcare market.

The three case studies demonstrated how different commissioning responses strategies to similar institutional demands were used in an attempt to gain or retain control of the healthcare system. It has been suggested that the way in which organisations deal with logics they are exposed to in the organisational field is related to how they respond to conflicting demands (Martin *et al.*, 2016). Figure 8:1 represents the different ways in which the commissioning organisations in the three case study sites dealt with the conflicting institutional demands according to Martin et al's (2016) theory.

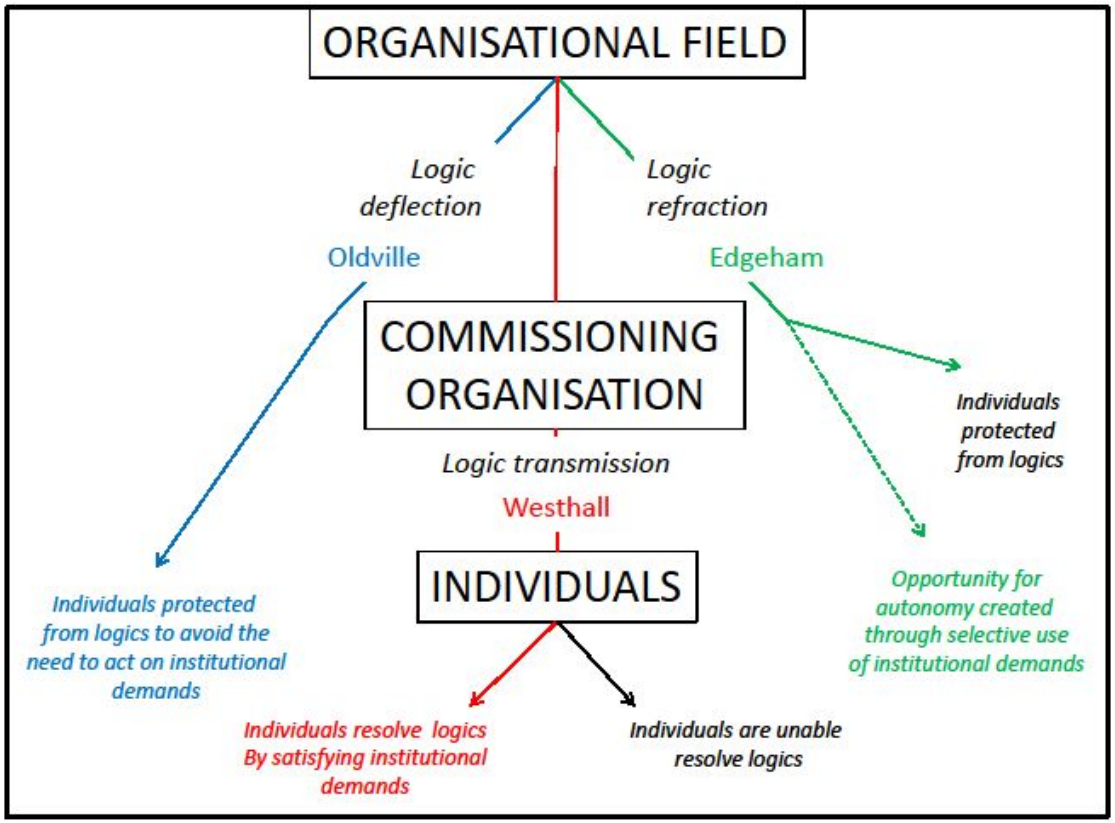


Figure 8:1: Case study responses to institutional demands using Martin et al. (2016) conceptualisation

By using an avoidance strategy, commissioners in Oldville appeared to deflect the institutional demands placed on them from the bureaucratic logic. By avoiding and deflecting the bureaucratic logic the organisation protects commissioners from demands by providing them with the opportunity to avoid action. Commissioners achieved this by acknowledging the need to address commissioning arrangements for stroke to bring services in line with guidelines and other service in the region, and by demanding that any changes be aligned with local plans for transformation towards an integrated system. However rather than acting on these demands directly, the commissioners engaged provider organisations to consider how the problems may be addressed but without giving them formal mandate for change, thereby retaining control.

Deflecting the demands of institutional logics in the system appeared to allow the commissioners to act as facilitators of collaborative inter-organisational working but without making full commitment to any changes. The commissioners in Oldville were therefore able to allow plans to develop without pressure to implement any changes until the organisation was in a position to be able to implement any plans. Deflection may be a strategy that protects individuals in organisations from institutional demands by reducing the need to act (Martin *et al.*, 2016). For commissioning this may be an important strategy as it allows plans and inter-organisational relationships to be nurtured but without full commitment to change. It would be a strategy that in the long term could create sustainable change but risked disengagement from the provider organisations that may become frustrated by slow progress (see Oldville quote 18).

In comparison commissioners in Westhall transmitted institutional demands (Martin *et al.*, 2016) of the bureaucratic and market logics and attempted to resolve those demands by following a procurement exercise to commission an integrated stroke service. By transmitting the logics commissioners were able to attempt to control and modify the behaviour of the providers they were working with. In this case study as the inter-organisational relationships developed between the provider organisations, the commissioners were less able to control their plans and as the plans developed the goals of the commissioners and the provider organisations

diverged. The providers considered that services required development and investment but the commissioners wanted to control spending. By transmitting the logics directly, they placed themselves higher in the bureaucratic hierarchy as the controller of the NHS budget and sought to maintain the position of power by commissioning using market forces by acting on the institutional demands placed on them without deviation.

The commissioners followed the standardised practice of procurement and attempted to align the new models of commissioning without considering if the two processes were compatible. The process failed which highlighted the contradictions in the institutional environment that made implementation of new commissioning models very difficult to achieve and suggests that current commissioning policy is incompatible with the intra-organisational collaborations required for integrated services. Transmission of logics may be highly effective in a field with a high degree of isomorphism but in a diverse field it is a high risk strategy.

In Edgeham commissioners were able to refract the institutional demands placed on them. This suggested that they recognised that conflict between policy drivers for commissioning and integrated services risked failure of the commissioning process. By refracting the logics the commissioners were able to draw on elements of the demands placed on them and reject others to create an opportunity for autonomy (Martin *et al.*, 2016) and generate change without being restrained by contradictory logics.

Refraction of the logics allowed the commissioners to satisfy aspects of the institutional demands that they considered non-negotiable but reject other aspects that they considered high risk. For example they did not consider procurement to be compatible with the lead provider model they were attempting to develop and therefore found an alternative path through policy that allowed them to avoid the market logic. Being selective in their behaviour choices allowed an adaptive strategy that could be altered and adjusted according to how other organisations responded. It also allowed the commissioners to lead the organisations towards their preferred version of the shared goal they had created and maintain control

over the provider organisations behaviour. This demonstrated how through refraction the opportunity for partial autonomy was created (Martin *et al.*, 2016).

The strategy appeared to be most effective because the commissioners co-opted to the professional logic to build relationships with the providers before they entered the commissioning process. Through manipulation of the logics in the system, the commissioners in Edgeham were most successful in responding to the contradictory demands in the institutional system. This suggested that in highly complex and contradictory institutional fields, organisations are most successful at achieving inter-organisational working when they are able to manipulate the demands placed on them. This creates the perception of stability that allows organisations to satisfy the demands placed on them both from higher in the system and other organisations they are working with while maintaining a position of control.

Influence of logics on inter-organisational relationships

In all three sites the bureaucratic logic influenced the commissioner's behaviour as they are bound by commissioning rules and regulations from national policy. However the bureaucratic logic tends to have influences from other co-existing logics depending on the political landscape at the time (see Chapter 2). The requirement to follow rules and regulations is consistent with the regulative pillar of institutions which legitimise behaviour with accepted boundaries (Scott, 2001). However the different change drivers which the commissioners were exposed to originated from different organisations and sources which all may have slightly different versions of institutional pillars depending on how they interpreted the institutional field. The organisations experienced the institutional demands differently (Pache and Santos, 2010) to allow them to establish and attend to their own goals (Greenwood and Hinings, 1996).

The commissioners in all three sites were exposed to the same national and regional change drivers but the way in which the institutional logics in the system were interpreted differently. Despite this collaborative inter-organisational working was a policy key theme meaning provider organisations were also establishing their own goals and means of achieving those goals alongside the commissioners in the

commissioning processes. Organisations were making strategic choices about the institutional logics they chose to attend to and in turn influenced the commissioning processes that followed.

Previous enquiry into how institutional logics influence the formation of organisational goals and means of achieving them have focused on the top down influence of institutional logics from the macro level field (Pache and Santos, 2010) but has not explored the influence of other organisations as they attempt to work together. This research explored multiple organisations working together while exposed to the same field level institutional logics and considered the influence of local institutional logics in how organisations interpret institutional demands.

Influence of an organisation's institutional logic on inter-organisational relationships

The different interpretations of the logics in the wider system and formation of goals seen in the case studies may reflect how different organisations have their own unique internal representation of institutional logics. This representation may be outwardly expressed to other organisations and interpreted by organisations in different ways. How these logics are expressed and interpreted may influence how successful inter-organisational working may be as organisations attempt to collaborate and work together on shared goals. The dynamics of logic interpretation and interaction between organisations may influence how they respond to different demands at the field level and locally. Table 8.2 gives a cross case interpretation of the commissioning processes in each site with analysis of the logics to explore how clear the expressed logic was to other organisations as they attempted to work together.

The case studies suggest that if an organisation expressed its own interpretation of logics in the institutional system clearly, other organisations may be better equipped to respond appropriately or manipulate the situation to their own advantage. For example in Oldville the provider organisations were able to read the commissioners position which informed them that they had limited mandate to proceed with any plans as they were constrained by their bureaucratic logic. In

comparison Westhall's commissioners clearly expressed the market logic through their use of a procurement strategy and the providers responded by following the rules of procurement. Providers understood the logic and could follow with expected behaviours but they followed their own version of the goal when making a bid rather than that of the commissioners. Conversely an organisation may conceal its logic, which in turn may influence how other organisations respond either positively or negatively. In Edgeham commissioners co-opted the professional logic which allowed them to conceal their bureaucratic logic and create improved engagement with the providers as they worked towards their shared goal. The success or failure of the way in which organisations expressed their interpretation of logics may have impacted on the commissioning process that followed and the commissioning outcomes.

Theoretical prediction of establishing inter-organisational working based on expression of logics

Each commissioning process resulted in a different outcome. In Westhall the plans failed (Chapter 5); in Edgeham progress was made towards commissioning a new community stroke and neurology service (Chapter 6); and in Oldville little progress was made (Chapter 7). In each case study inter-organisational working was attempted with success in some circumstances and failure in others. The way in which the commissioners and providers interpreted logics, expressed them and used them to guide their behaviour may have had important consequences for the outcome of each commissioning process. This is explored in figure 8.2 which compares how organisations may control a commissioning process depending on how logics are expressed by commissioners and providers.

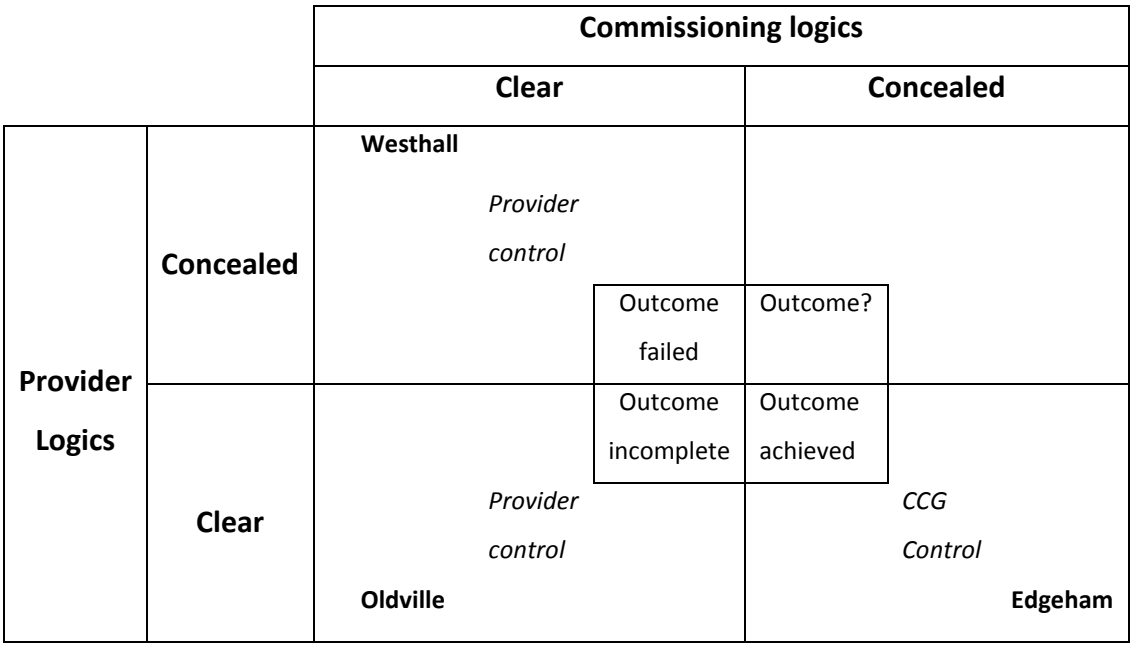


Figure 8.2: Relationship between clear and masked logics and outcome of implementing the goal of the commissioning process.

Each case study provides an empirical example of different combinations of clear and concealed logics which may suggest how power balances favour organisations and how this related to inter-organisational working to achieve an outcome to the goal of the commissioning process.

In Westhall the commissioner's bureaucratic and market logic was clear through their use of a procurement strategy. This allowed the providers to understand the process they were expected to follow and the commissioners expected the provider to behave in a pre-determined way. However the provider's professional logic which advocated increased quality and equity for patients was used to mask their corporate logic which demanded the provider's behaviour sought to increase their share of the market. This approach gave the provider's some control over the outcome of commissioning process but without agreement from the commissioners change was impossible (see Westhall quote 23).

In comparison the logics of the commissioners and the providers in Oldville were clear. The Acute Provider had well established plans to develop a rehabilitation hub and agreed to include the reconfiguration of community services to complement

those plans. Their corporate logic was clear and the Community Provider was receptive to being guided by the bureaucratic logic. The commissioners were open about how their bureaucratic logic limited any investment that could be made into developing services which prevented them from making any definitive plans. The open clarity of the logics allowed free discussion and plans but without a clear goal and inter-organisational working remained speculative and change in commissioning arrangements were slow to be realised. Here the Acute Provider remained in control and could continue with their own plans without commitment from the commissioners to work towards the goal (see Oldville quote 21).

However in Edgeham the commissioners decoupled the bureaucratic logic to allow them to co-opt the professional logic and conceal their underlying bureaucratic logic making it difficult for the providers to interpret their additional goal of regaining control of the Community Provider contract and budget. While working towards a shared goal of developing an integrated CST and neurology service, the commissioners had the opportunity to control and manipulate the situation because the providers were clear and open about their own position. By doing this they coerced the providers into believing they had collaboratively decided how the lead provider model would be established while the commissioners achieved the change that they intended.

The theoretical prediction model assumes that the commissioning organisations are the lead organisation when organisations are attempting to work together collaboratively. The theoretical prediction suggests that for inter-organisational working, goals are most likely to achieve their expected outcome if the lead organisation conceals their logic but are able to clearly identify the logic of the organisation they are attempting to work with. This allows the lead organisation to co-opt the logic of the organisation they are attempting to work with which allows a working relationship to be established (see Edgeham case study). For commissioning this is important as it allows commissioners to maintain a position of control when working collaboratively with other organisations.

If the lead organisation expresses their logics clearly, they are open to manipulation from other organisations and there is a greater risk that the goals will either only achieve a partial outcome (Oldville) or fail completely (Westhall). By being fully open about their intentions and logic, commissioners' risk losing control when working collaboratively with other organisations. For current NHS healthcare policy, maintaining commissioning control appears to be key if the healthcare system is to be successful in its current administrative structure.

This study suggests that the way in which lead organisations represent complex institutional environments has a direct impact on how successfully organisations are able to work together towards goals. Commissioning is an organisational concept positioned as the lead organisations in current NHS healthcare policy and is attempting to maintain a position of control in the complex institutional environment in which they operate. Therefore the way in which commissioning organisations interpret the institutional environment and express their interpretations to organisations they are attempting to work with is important to how successfully inter-organisational relationships can be forms and achieve shared goals.

Revisiting the research propositions

In Chapters3 research propositions were suggested for both institutional logics. These can now be revisited to consider if the research has provided empirical evidence to support the propositions before the overarching research questions is reconsidered. In Chapter 2, specific problems with commissioning were identified and these will also be considered to determine how the findings of this research may influence commissioning practice.

Institutional logics research propositions

After reviewing the current understanding of the institutional logics literature (Chapter 3), three theoretical propositions were made which informed the direction of the research:

Proposition 1: Conflicting institutional logics in the field will lead to different organisations having different interpretations of the institutional demands placed on them leading to different values, practices, rules and beliefs

Proposition 2: Conflicting institutional logics in the field will make it difficult for different organisations to develop and negotiate shared goals

Proposition 3: Differences in interpretations of logics by organisations will lead to different values, practices, rules and beliefs which will make it difficult for organisations in the field to establish effective inter-organisational relationships

The first proposition suggested that in a conflicted institutional environment, different organisations would interpret the institutional demands placed on them differently. The findings of this research support this proposition as in each case study the commissioning and providers responded to different change drivers to

initiate the commissioning process. For example in Oldville commissioners followed a bureaucratic logic whereas providers were more responsive to the professional logic driving change in quality standards.

The existing understanding of internal representation of institutional logics focused the top down influence of field level institutional logics (Pache and Santos, 2010; Goodrick and Reay, 2011; Martin *et al.*, 2016) but this research suggested that the interpretation of institutional logics is more complex and incorporates vertical and horizontal influences from other organisations in the field. In each case study local influences were as important in informing the commissioning process as national policy. The proposition can therefore be revised:

Revised proposition 1: Conflicting institutional logics at multiple levels in the field will lead to different organisations having different interpretations of the institutional demands placed on them leading to values, practices, rules and beliefs as a result of vertical and horizontal influences

The second proposition suggested that conflicting institutional logics in the field would make it difficult for different organisations to develop and negotiate shared goals. At the outset of the research, the case studies appeared to have very similar goals but as the commissioning processes unfolded it became clear that in many cases organisations developed slightly different versions of the commissioning goal. This was related to the different internal representations of logics in the system which informed how organisations framed their goals. For example in Westhall the commissioners goal was informed by the market and bureaucratic logic and focused on reducing the overall spend in stroke whereas the provider's goal was to increase investment and quality of services driven by professional and corporate logics.

Again enquiry has focused on the influence of field level logics informing organisational goals (Pache and Santos, 2010) but this research suggests that local logics may be influential and the proposition can be revised.

Revised proposition 2: Conflicting institutional logics at multiple levels in the field leads to different interpretations of logics and will make it difficult for different organisations to develop and negotiate shared goals

The third proposition suggested that the different interpretations of institutional logics would influence values, practices, rules and beliefs that would in turn make effective inter-organisational relationships difficult to establish. The research suggested that the way in which organisations work together was very dependent on how organisations were influenced by institutional logics in the conflicted system. In all three sites the differences had the potential to make inter-organisational relationship difficult to establish. In Westhall the differences were so great that the relationship between the commissioners and the providers broke down. In Oldville the relationship was maintained but it was ineffective in achieving organisational goals.

However in Edgeham although the differences were apparent, the commissioners were partially autonomous in their behaviour which allowed them to use different logics to stimulate working relationships between the organisations. Martin et al (2016) describe this as logic refraction where individuals are able to selectively use logics to allow autonomous behaviour. The commissioners in Edgeham appeared to do this but were creative in how they expressed logics to other organisations. They appeared to co-opt a professional logic to engage collaborative behaviour with the providers while concealing their own logics. Proposition 3 can therefore remain unchanged but a new proposition can be made which incorporates a new understanding of how logics are used to establish inter-organisational behaviour.

New proposition: Organisations that are able to co-opt the logic of organisations they attempt to work with are able to establish effective inter-organisational working relationships while concealing and maintaining their own logic to guide their values, practices, rules and beliefs

The research has therefore contributed to the existing institutional logics literature by exploring how institutional logics are not only influential from a top down perspective but also horizontally between organisations operating at the same level in the field. This suggested that institutional logics are a more complex dynamic than previously thought and the way in which logics are used are subject to vertical and horizontal influences at all levels especially when organisations are attempting to establish inter-organisational relationships. The findings also build on Martin et al (2016) theory of logic refraction to allow partial autonomy by suggesting that individuals and organisations can express and conceal logics depending on what they are trying to achieve.

Commissioning practice findings

As well as extending the institutional logics theory, the research also set out to explore commissioning (Chapter 2) and the problems associated with it that may be due to the contradictory nature of institutional demands in the field.

In Chapter 2 it was suggested that contradictions between competition and collaboration would make it difficult for CCGs to implement new models of provision set out in the Five Year Forward View (NHS England *et al.*, 2014). The findings suggested that this was correct as evidence from the Westhall and Edgeham case studies demonstrated how competition was used or avoided when commissioning new lead provider models for stroke services.

In Westhall commissioners opted to use a procurement strategy in an attempt to identify a Community Provider to establish a lead provider model with the existing Acute Provider. However the providers considered this problematic as they wanted to negotiate a potential new relationship between themselves but were restricted by the rules of procurement and felt unable to discuss any new relationships with other providers. This demonstrated how policy demanding commissioning to be conducted in a market system was incompatible with the collaborative relationships expected for the new models of provision.

The commissioners in Edgeham faced the same problem but recognised that a procurement exercise was not suitable for what they were trying to achieve as they

already had willing providers to enter a collaborative relationship. To avoid the market, the commissioners identified a way around the system to ensure that they did not break procurement rules and managed to begin contract negotiations to implement their plans. This demonstrated how collaborative relationships were more effective through nurture rather than competition. Concerns regarding the mismatch between the Health and Social Care Act (Secretary of State for Health, 2012) and Five Year Forward View (NHS England *et al.*, 2014) had already been raised (Ham and Murray, 2015). The findings of the research suggest that concerns were justified.

It was suggested that contradictions in policy and the historical legacy of NHS reforms would lead to differences in the beliefs and behaviours of organisations in the NHS. Problems associated with contradictions in policy have been identified above and the findings of the research also suggested that the historical legacy of NHS would be problematic. In all three case studies change was considered difficult because of existing commissioning arrangements that were seen as complex to address. In Edgeham and Oldville the main problems were difficulty in understanding the existing service configuration for stroke. This was less of a problem in Westhall because were commissioned in accordance stroke service clinical guidelines (Department of Health, 2007b; Royal College of Physicians, 2016b) as a distinct entity. However historical commissioning arrangements in Westhall created tension between provider and commissioning organisations and made change difficult. This is consistent with existing understanding of the problems associated with commissioning (Checkland, Coleman, *et al.*, 2012; Checkland, Harrrison, *et al.*, 2012).

Differences in the beliefs and behaviours of organisations were identified as making it difficult for organisations in the NHS to establish effective collaborative relationships. The research suggested that acute and community provider organisations have different beliefs and behaviours that are more easily understood when viewed through the institutional logics lens. This showed that organisations have different logics informing their beliefs and behaviours which made inter-organisational working more challenging.

The findings of the research have shown that current NHS commissioning policy is contradictory which makes implementation of new models of provision and change towards an integrated system complex and challenging. Early enquiry into implementation of the Five Year Forward View has suggested that change has been slow and difficult to achieve (Ham and Murray, 2015; Ham, 2017) which is consistent with the findings in this study. However the findings of this study have used a theoretical perspective to give a deeper understanding of why implementation of policy has been difficult to achieve which will be summarised in the concluding chapter (Chapter 9).

Summary

This research set out to answer the following question:

How do institutional logics in an institutionally complex organisational field affect how organisations are able to work together to achieve their shared goals?

The findings of the research have found that inter-organisational relationships are difficult to establish in a complex and conflicted institutional field which makes collaborative work towards shared goals challenging but not impossible to achieve. Institutional logics were used to explore NHS commissioning and found that commissioners face complex institutional demands from the field level through policy, and locally from organisations, individuals and local policy demands. The demands experienced by organisations were therefore both vertical and horizontal in their influence, and the way in which demands were experienced by organisations and individual impacted on how inter-organisational goals and collaborative working was established.

Chapter 9: Conclusion: Where's the logic in commissioning?

Introduction

The three case studies in this research explored inter-organisational relationships in a complex institutional environment using the institutional logics framework. National Health Service (NHS) commissioning was used as an example of how different types of organisations work together to design and implement services despite having different policy drivers and motivations. This has given a greater understanding about how commissioning works in practice from a theoretical perspective as well as extending the institutional logics theory into how inter-organisational relationships are established to allow inter-organisational working towards shared goals. This has given new insight into how complex and conflicting logics in wider institutional systems may influence how affectively organisations are able to work together to achieve shared goals.

Summary of research findings

Using logics to conceptualise NHS commissioning

Institutional logics have been used to conceptualise healthcare fields both in the UK (e.g. Martin et al. 2016; Martin et al. 2013) and America (e.g. Goodrick & Reay 2011). Studies have suggested that logics in healthcare fields make change and implementation of new innovation more complex and difficult (van den Broek, Boselie and Paauwe, 2014). The English NHS is a publically funded healthcare system that has often faced criticism about the way it administers and delivers healthcare but has continued to remain true to its founding value of free access to healthcare at the point of access (Klein, 2010a). The NHS is currently facing one of the most challenging times in its history and is struggling to maintain standards of care within the confines of a publicly funded service (Iacobucci, 2017a). In an attempt to address this new models of provision have been suggested to transform

healthcare services into an integrated system to make the system sustainable in the future (NHS England *et al.*, 2014).

The new models of provision recommended in the Five year Forward View (NHS England *et al.*, 2014) were published prior to the data collection period of this research and set the policy scene for commissioning along with the Health and Social Care Act (Secretary of State for Health, 2012) which outlines how the current organisational arrangement of the NHS is administered. The research was conducted at a time when it was unclear how innovative new commissioning models could be implemented in practice but developing effective inter-organisational relationships were considered key to successful integration of healthcare services (NHS England *et al.*, 2014; Ham and Murray, 2015). However concerns had been raised about the possible lack of fit between the institutional characteristics of the different types of organisations in the NHS (Checkland, Harrrison, *et al.*, 2012) suggesting that developing an integrated system may be problematic if organisations were not equipped to establish collaborative relationships.

The complexity of the NHS as an organisational field and commissioning as an organisational concept was explored in Chapter 2. The NHS is a complex organisational field composed of multiple component organisations tasked with different component functions including healthcare commissioning, delivery and governance. Commissioning was introduced into the NHS in the 1990s as the purchasing component of the healthcare service internal quasi-market, designed to improve the efficiency of the system (Le Grand and Bartlett, 1993). Changes to NHS administration were implemented in response to concerns that medical professional dominance was negatively impacting on service delivery (Scott, Ruef, P. Mendel, *et al.*, 2000b; Martin *et al.*, 2015). Commissioning has since undergone numerous reforms (see Chapter 2) but the principle of the market remained a key organising principle enforced by bureaucratic administrative procedures as a mechanism to balance professional medical dominance. However the medical profession have always been and will remain an important aspect to healthcare fields and influential in how healthcare services are delivered. Over the last three

decades policy makers have grappled with how to balance medical professionalism with the need to administer an efficient business-like organisation (Le Grand, Mays and Dixon, 1998). This suggested that the NHS was a particularly complex field with multiple and often contradictory institutional demands that made it difficult for organisations to function effectively within it.

Of particular importance for the implementation of new models of commissioning was the mismatch between the competition required for the internal market and collaboration required for integrated care (see Chapter 2). The Health and Social Care Act (Secretary of State for Health, 2012) appeared to give commissioners freedom to find a balance between provider competition and co-operation but the policy lacked clarity on how this could be achieved (Ham and Murray, 2015). No changes were made to the policy when the Five Year Forward View was published (NHS England *et al.*, 2014) and there was little guidance given on how to nurture the collaborative relationships the new models of provision demanded while remaining within the rules of the market. This suggested that in addition to the different beliefs and behaviours of organisations in the healthcare system, contradictions in policy may make effective commissioning through inter-organisational working even more difficult to achieve. The research therefore set out to explore this using the institutional logics perspective to conceptualise commissioning theoretically using case study examples of commissioning stroke services (Chapter 5, 6 and 7) and found that commissioning was taking place in a highly complex and conflicting institutional environment which resulted in different commissioning responses and outcomes.

Commissioning responses to complex institutional logics

The three case studies in this research provided insight into the institutional complexity of the healthcare field and diversity of commissioning practices in the current English NHS. The findings suggested that the institutional demands placed on organisations by logics in the system were often conflicting at a national and local level (see Chapter 2). The organisations studied were structurally similar and subject to the same high level institutional demands but the way in which organisations interpreted and responded to the conflicting institutional

environment was different. This was consistent with Oliver (1991) who suggested that organisations may use different response strategies to overcome conflicting institutional demands and Pache and Santos (2010) who considered that organisations interpret demands differently even when structurally similar.

In all three sites, commissioners set out to address commissioning arrangements for community stroke (and neurology services) with the intention of creating an integrated system across acute and community providers. Findings suggested that although the responses to institutional demands as they attempted to do this were different, each strategy was associated with the commissioners attempting to maintain control of the healthcare system. However only Edgeham was successful in doing this (see Chapter 6 and 8).

Martin et al's (2016) conceptualisation of how organisations deal with the institutional environment provided some explanation for the differences between the commissioning responses in each site. In Oldville commissioners avoided the institutional demands placed on them by deflecting the bureaucratic logic and placing the responsibility of planning change with the Providers. By not acting on demands directly, the commissioners acted as facilitators of collaborative inter-organisational working but without the need to make full commitment to change. This gave the impression of commissioning action and thereby the commissioners maintained an element of control. Deflection may be a strategy that protects individuals in organisations from institutional demands by reducing the need to act (Martin *et al.*, 2016). For commissioning this may be an important strategy as it allows inter-organisational relationships to be nurtured but without full commitment to change. It could be a strategy that in the long term creates sustainable change but risks disengagement from the provider organisations that may become frustrated by commissioner's control preventing change.

Westhall's commissioners transmitted (Martin *et al.*, 2016) the institutional demands of the bureaucratic and market logics and followed the accepted practice of procurement explicitly in an attempt to commission a lead provider model for the stroke pathway. The commissioners used this strategy to control the behaviour

of the providers they were working by following standardised commissioning practice. By transmitting the logics directly, commissioners placed themselves higher in the bureaucratic hierarchy as the controller of the NHS budget. They sought to maintain a position of power by commissioning using the market logic without deviation. The commissioners followed the standardised practice of procurement and attempted to align the new models of commissioning without considering if the two processes were compatible. However the providers considered collaboration to be essential to establishing a lead provider model. The Acute Provider sought to establish a collaborative relationship with the provider of a high quality community stroke service provider in an attempt to raise the standards on services across the area and force the commissioners to commit further resources in to stroke services. The commissioners were successful in maintaining control but the commissioning process failed, highlighting the contradictions in the institutional environment that make implementation of new commissioning models very difficult to achieve. This suggested that current commissioning policy is incompatible with the intra-organisational collaborations required for integrated services. Transmission of logics may be highly effective in a field with a high degree of isomorphism where responses are more predictable but in a diverse and conflicted field it is a high risk strategy.

In Edgeham commissioners refracted (Martin *et al.*, 2016) the institutional demands placed on them suggesting that they recognised conflict between policy drivers for commissioning and integrated services which risked failure of the commissioning process. By refracting the logics the commissioners were able to draw on elements of the demands placed on them and reject others to create an opportunity for autonomy and generate change without being restrained through contradictory logics. Refraction of the logics allowed commissioners to satisfy aspects of the institutional demands that they consider non-negotiable but reject other aspects considered high risk. Here procurement was considered incompatible with a lead provider model and the market logic was rejected. Being selective in their behaviour choices allowed commissioners to develop an adaptive strategy that could be altered and adjusted according to how other organisations responded. This allowed

commissioners to develop inter-organisational relationships while maintaining control over provider behaviour. Refraction created the opportunity for partial autonomy (Martin *et al.*, 2016) and was the most effective strategy of the three commissioning case studies.

Institutional logics and inter-organisational working

While the way in which organisations responded to institutional demands was important to how commissioners maintained control of commissioning processes, the case studies suggested that the dynamics of how logics influenced commissioning appeared to be more complex. The findings of this research suggested that the way in which organisations respond to institutional demands appeared to also be affected by other organisations in the field, particularly if the organisations are required to form collaborative relationships. Therefore other organisations and the way in which they responded to institutional demands were important in understanding and predicting how successful an inter-organisational relationship would be.

The response strategies of the commissioning organisations created different opportunities for provider organisations in the way they responded to demands in the system. The refractive commissioning strategy used in Edgeham was more successful because the commissioners co-opted a logic more closely associated with healthcare provision to build collaborative relationships with the providers. By refracting the institutional demands and co-opting the professional logic, the commissioners were able to tailor the commissioning process to meet their own organisational needs and the needs of the providers they were working with. This made the inter-organisational relationships more successful. As the providers considered the commissioners to be working with the same logics they comfortably followed the commissioner's plans. This allowed the commissioners to work to their own agenda without neglecting their own representation of the logics or risking conflict between the organisations. During the process the commissioners kept their own logics disguised with an illusion of a professional logic. This suggested that logics could be used covertly to maintain control but without impacting on organisational relationships.

In comparison, in Westhall the commissioner's transmission of the market and bureaucratic logic made it clear to other organisation which logic they were following. Providers were able to follow the rules of procurement but as the commissioner's strategy was incompatible with their own plans, they attempted to manipulate the procurement process. However because this did not align with the commissioners intentions, the commissioners were able to maintain their alignment with the logics they followed to maintain control. In an isomorphic field this strategy may have been successful for developing inter-organisational relationships but in a conflicted field it risks a breakdown in collaborative relationships if organisations are not responsive to the same institutional logics.

Commissioners in Oldville deflected the intuitional demands placed on them but were open in expressing their position of not being able to meet the demands placed on them through lack of finance. Deflection of the logics allowed commissioners to support the provider's reorganisation plans while protecting them from the need to commit resources. This placed the commissioners in control and although no change occurred and deflection could therefore be seen as a mean of avoidance or a delay tactic if contextual circumstances were not ideal if organisations are open about their intentions.

The findings of the research therefore suggested that for inter-organisation working, the way in which organisations respond to institutional logics is important but the way in which they express those logics to the organisations they attempt to work with is also important for how inter-organisational relationships are established. In a conflicted institutional environment, this was most successful when commissioners were able to refract and co-opt logics to allow the needs of multiple organisations to be met. In situations like healthcare commissioning where the commissioners are considered the lead organisation this may be an important organisational characteristic.

Implications for commissioning practice

The findings in this research suggested that the way in which organisations respond to conflicting institutional logics and demands, and how their responses are

portrayed and experienced by other organisations in the same field are important for how organisations work together and form relationships. In all cases the commissioners were attempting to maintain control of the healthcare system suggesting that despite a conflicted institutional field, commissioning as an organisational concept is attempting to maintain a position of control as policy commands. CCGs are therefore attempting to be the lead organisations when commissioning inter-organisational relationships are established.

This research suggests that the way in which lead organisations respond to complex institutional environments has a direct impact on how successfully organisations are able to work together. Commissioning organisations that either directly transmit or deflect logics appear to be less likely to resolve institutional demands with other organisations that those that are able to refract logics and create an opportunity for collaboration and change.

All strategies appear to be linked to how commissioning organisations are seeking to retain control in the healthcare market and how commissioners interpret the institutional environment in which they work to allow them to exert control over the healthcare field and market The main findings can be summarised with the following implications for commissioning practice:

Current policy in the English NHS is institutionally complex and contradictory as it demands both competition and collaboration

Problem: The Health and Social Car Act (Secretary of State for Health, 2012) demands that the internal market is the preferred method of commissioning using competitive procurement practices while the Five Year Forward View (NHS England *et al.*, 2014) calls for new models of provision to promote collaboration and integration. However there is flexibility within the framework and the opportunity for creative commissioning.

Implication: New models of provision are incompatible with commissioning using procurement but other commissioning strategies are possible.

Recommendation: Commissioners should be encouraged to commission creatively within the guidelines of the Health and Social Care Act (Secretary of State for Health, 2012). Commissioners should consider how the barriers to commissioning are overcome and adapt their approaches pragmatically to allow new models of provision to be tested.

The beliefs and behaviours or institutional logics of different types of organisations in the NHS are inherently different making inter-organisational relationships and integration challenging

Problem: Separation of the providing and commissioning organisations in the NHS had led to component organisations having different beliefs and behaviours or institutional logics which influence how they consider a healthcare service to be best delivered. However organisations may not be aware of how different types of organisations are different and how institutional logics may affect the way organisations integrate and work together.

Implication: Different types of organisations are at risk of having a poor understanding of the motivations behind how other organisations are administered leading to organisational barriers.

Recommendation: Consider how organisational barriers can be broken down to establish more effective inter-organisational relationships using specific learning from the research to demonstrate how seemingly similar organisations and different organisations behave through their interpretation of institutional logics.

This could be achieved through specialist teaching on institutional logics in the healthcare system and further exploration of logics within organisations to help them understand how they function as organisations alone and as they work with other organisations.

Commissioning organisations attempt to control the healthcare system but are not always equipped to lead change in implementing new models of provision

Problem: Commissioning organisations use strategies to control the healthcare system rather than leading change towards integrating new commissioning models recommending in the Five Year Forward View (NHS England *et al.*, 2014).

Implication: New models of provision are challenging to implement without effective leadership and organisations may find new models of provision challenging if commissioners are unable to guide organisations through a process of change.

Recommendation: Commissioners should consider their roles as facilitators of integration by identifying the strengths of the different organisations involved in new models of provision and creatively developing new ways of working together.

Theoretical contribution

To explore commissioning, this research used the institutional logics perspective as a theoretical framework to allow a complex organisational to be considered abstractly and open the possibility of generalisable findings. Institutional theory and logics had been used to explain commissioning in past enquiry (e.g. Scott *et al.*, 2000a; Goodrick and Reay, 2011; Checkland *et al.*, 2012; Martin *et al.*, 2015) and was an appropriate orientating theory for this research. The overarching theoretical question *'How do institutional logics in an institutionally complex organisational field affect how organisations are able to work together to achieve their shared goals?'* was used to guide enquiry. As well as finding similarities with existing

understanding of the institutional logics perspective on how organisations respond to complex institutional environment (e.g.Pache and Santos, 2010; Martin *et al.*, 2016), the research led to propositions that can now be summarised as theoretical contributions.

An organisation's interpretation of the institutional demands placed on it will be influenced by top-down institutional logics in the macro level of the field as well as the logics from other organisations in the meso and micro levels of the field.

Contribution: Institutional logics can have both a vertical and horizontal influence on organisations making the perspective a dynamic and versatile theory for exploring inter-organisational relationships

Conflicting institutional logics at all levels in a field will be interpreted differently by different organisations and different interpretations may make shared goals difficult to establish between organisations

Contribution: Conflicting institutional logics within a field and between different organisations may make it difficult to establish shared goals for inter-organisational working

Organisations that are able to co-opt the logic of organisations they attempt to work with are able to establish effective inter-organisational working relationships while concealing and maintaining their own logic to guide their values, practices, rules and beliefs

Contribution: Partially autonomous organisations that are able to co-opt the logics of organisations they are attempting to work with have a greater chance of successful working relationships

This research has shown that the institutional logics perspective has the potential to explain a deeper understanding of the beliefs and behaviours of organisations as they attempt to work together. It has shown that institutional logics are more dynamic and multi-dimensional than previously thought, particularly in complex institutional environments.

Limitations to the research and considerations for future research

While research has potential to extend practical and theoretical knowledge about social phenomenon, it is import to consider the findings and claims it makes within the context of its limitations. Limitations to this research include the case studies themselves and the use of an adapted version of a theoretical framework as a methodological tool.

Case study limitations

Multiple case studies were used to improve the generalisability of the findings (Yin, 2009b) and carefully selected to ensure that the contextual setting for each case study was comparable (see Chapter 4). The use of multiple case studies is based on the assumption that case studies will be replicated to confirm the findings in different locations. However in this research, three different examples of commissioning were identified and therefore replication was not achieved in a practical sense. It was beyond the scope of this thesis to complete further case studies but it should be recognised that the research does therefore not represent exhaustive examples of commissioning practice.

In comparison, a strength of the research is that a level of theoretical generalisability was found. The findings of the study reflect the theoretical contributions of Pache and Santos (2010) and Martin et al (2016) which allow the understanding of institutional logics literature to be developed and extended to give greater depth to understanding how logics influence the way in which organisations work together.

However it was beyond the scope of the research to address the relationship between the individuals and their own organisation or other organisations. The research focused on individual constructions of the commissioning process to build an understanding of institutional logics at an organisational level. This assumed that the resulting findings reflected the institutional logics within the organisation but as only one clinical speciality was addressed, the findings may have been different had

another speciality been studied. Further research in this area would allow this to be explored further along with influence of individuals themselves.

To reduce variations between the institutional demands facing commissioning, the three case study sites where chosen in the same SCN with the expectation that that commissioners in each site would be exposed to the similar regional institutional demands. While this was true, one of the main findings of the research was that organisations interpretation and responses to similar demands can be different and therefore increases the scope for many different interpretations of institutional demands. This may limit the generalisability of the results to the contextual setting rather than to other areas of the English healthcare system.

Access to the case study sites was at times limited which reflected the way in which services were commissioned. Commissioners were responsible for many different specialities and therefore split their time between different tasks. This made access to every aspect of commissioning difficult but the use of three case studies compensated by increasing the scope for data collection. Further research focusing on one commissioning site may yield interesting findings, particularly if an ethnographic case study approach was used to give greater attention to the individuals and the organisation through greater use of observation of commissioning practice.

Adapted theoretical framework

The institutional logics perspective is an orientating theory rather than a methodological tool. However the concept of ideal types (Thornton, Ocasio and Lounsbury, 2012) was used in the research as a method of analysis to identify characteristics in organisational behaviour as a method of typological analysis (Yin, 2009b) which has been used in other studies of institutional logics in the healthcare field (e.g. Goodrick and Reay, 2011). The use of ideal types in qualitative analysis has been criticised as it assumes that ideal types exist empirically (Cruz, 2016) but for this research it was accepted from the outset that multiple logics were likely to co-exist and that the concept of a dominant logic had been developed to allow for

incorporation of multiple logics (Goodrick and Reay, 2011; Waldorff, Reay and Goodrick, 2013).

For this research four recognised institutional logics in the healthcare field were identified for use as an analytical tool. The logics of bureaucracy, markets, professions and corporations were chosen as being most closely associated with healthcare but that does not mean that other ideal type logics were not present in the data. Through the literature reviews in Chapters 2 and 3, the author considered that the characteristics of multiple logics could already be applied to the policy landscape in which the research was situated. This led to the adaption of ideal type logics to give an ideal type commissioning and healthcare provider ideal type based on the characteristics of the four ideal type logics thought to be present in healthcare. This was not an established method but served to orientate and focus the research back to the policy landscape and provide an understanding on how policy was directing the healthcare field from a macro level. This could be considered a limitation to the analysis as it limits generalisability with other studies using the institutional logics perspective and was based on the author's interpretation alone. However the adapted typology was constructed from the components of Thornton et al's (2012) typology so the essence of ideal types should not have been lost. As a methodological tool, adapted ideal types merits further investigation as it allows for the dynamics nature of logics in action and acknowledgement that pure ideal types are unlikely to exist empirically.

Where's the logic in commissioning?

Commissioning is a concept in the NHS that has existed since the 1990's, undergone numerous reforms, been heavily criticised as failing to make the positive changes to the NHS that it was intended to do but remains as an organisational concept with no sign of being abandoned in the near future. So where is the logic in commissioning?

This research has attempted to answer that question and shed new light on commissioning as an organisational concept. It has shown how it is a complex process, carried out by commissioners in organisations attempting to make sense of a highly politically charged and conflicted institutional environment. In all of the case studies, commissioners were attempting to improve the healthcare system within their own interpretations of what they thought was expected of them. Some were successful and some were not. What was clear was that commissioners face an unprecedented challenge to reverse the fortunes of the NHS and are likely to be subject to further criticism in the coming years unless a more logical organising strategy for the NHS can be found.

Appendix 1: Research protocol



Commissioning strategies for community stroke teams

(Adapted to protect identity of case study sites)

Final Version 1.1

4th December 2014

Short title:	Commissioning CST
IRAS Project ID:	165321
Study Sponsor:	University of Nottingham
Sponsor reference:	14105
Funding Source:	The Health Foundation

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SYNOPSIS

Title	Commissioning strategies for community stroke teams
Short title	Commissioning CST
Chief Investigator	Dr. Rebecca Fisher
Objectives	To understand the strategies used when commissioning specialist community services such as community stroke teams. To understand how commissioning strategies may be influencing service development of community services. To understand how strategies may be used to drive change towards specialist or generalist care in community services.
Study Configuration	Comparative case studies in two sites
Setting	Clinical Commissioning Groups associated with a large central provider of acute stroke care.
Number of participants	Participants per site estimated at a minimum of 15 and not expected to exceed 25.
Eligibility criteria	Adults aged over 18 years Involved/stakeholder in the commissioning process

	English as first language
Description of interventions	Case study methodology using interviews of stakeholders involved in the commissioning process; observation of commissioning meetings; document analysis of historical and current documents.
Duration of study	Overall the study will take approximately one year Up to 75 interviews will be completed, lasting up to 90 minutes. Interviewee's will be interviewed between 1 and 3 times during the course of the study Observations of meetings will occur when relevant during the study period
Methods of analysis	Qualitative thematic analysis

STUDY BACKGROUND INFORMATION AND RATIONALE

Commissioning has evolved into an important organisational concept in today's National Health Service (NHS). The Department of Health (2010) describe commissioning as 'the process of ensuring that the health and care services provided effectively meet the needs of the population (Department of Health, 2010). It is a complex process with responsibilities including assessment of population needs, prioritising health outcomes, procuring products and services, and managing service providers'. It was introduced based on the principles of a healthcare market where competition between providers is thought to improve quality and values for money. However, commissioning has been criticised for failing to have made a significant impact on healthcare quality and costs. It has been suggested that a lack of fit between commissioning and the institutional characteristics of the NHS may contribute for this perceived failure (Checkland et al., 2012). This means that there may be distinct characteristics in the way commissioning is organised and played out in practice that are affecting how services are designed and procured.

Acute hospital care has become highly organised into distinct specialities with most of the population having access to the services that would be expected in this setting. Community healthcare is much more variable. Current policy suggests that community healthcare should be developed to provide a more equitable service, but also to reduce the burden on expensive hospital care by providing multidisciplinary treatment in patients own home's (NHS England et al., 2014). Community healthcare needs are diverse and it is not entirely clear how community services can be commissioned to meet this goal. The specialist treatment patient's receive in hospital may or may not be readily transferable to the community where care had been traditionally managed using the generalist skills of the General Practitioners. The *NHS Forward View* (2014) is recommending that community services should be equipped to meet the wide-ranging needs of the community through local teams that are able to treat all conditions. However for some conditions like stroke, the evidence suggests that community teams should be specialist and treat stroke exclusively. As a result, commissioners are being faced with difficult clinical and economic decisions about the healthcare services they procure for their local populations. With current policy drivers and an increasing emphasis being placed on value for money, it is possible that generic services may be commissioned to meet the needs of the wider population in favour of more specialist services, which are more evidence based.

Stroke services provide a contextual example of this problem. Stroke treatment has developed into a condition with highly specialist treatments supported by a strong evidence base. This has led to organisational change within the NHS to allow almost all stroke victims access to specialist treatment in dedicated stroke units; this has dramatically improved survival and long-term outcome (Stroke Unit Trialists' Collaboration, 2000). With many more people surviving stroke, stroke now accounts for the greatest cause of disability for people living in the community making community based services for stroke survivors very important. Evidence suggests that stroke survivors with mild and moderate stroke who return home with stroke specialist Early Support Discharge (ESD) services experience better outcomes (Langhorne and Widen-Holmqvist, 2007) but many stroke survivors have longer

term needs that extend beyond time limited ESD services or do not meet the criteria for ESD services. Longer term and more inclusive services are required to meet these needs and address the variation in the healthcare a stroke survivor can expect to receive in the community setting (Fisher et al., 2013, Walker et al., 2013).

Stroke guidelines recommend that stroke survivors should receive specialist care in both the acute and community setting, with all eligible patients having access to ESD and other specialist services to meet their long term needs (Royal College of Physicians, 2012). However, it is not clear if the long term needs of all stroke survivors require a specialist community stroke team or a generic community team with or without stroke specific skills. This uncertainty may make it difficult for commissioners to make decisions. Commissioners must work with local stakeholders to decide how the stroke population's needs are best met. They must consider the evidence and guidelines available, and negotiate with local providers and stroke service leaders to develop a service that is right for the local area. Commissioning policy suggests that commissioners should lead on this process using the principles of the healthcare market, but it is possible that other stakeholders have greater influence in how decisions are made. Stakeholders may have unique institutional characteristics that influence the way they view service design and delivery, and use strategies to steer commissioners towards alternative decisions that may not ultimately increase quality and value for money.

This multisite case study will examine the commissioning process for community stroke services provision in two different sites to explore the policy and clinical drivers contributing to strategic decision making for community services. It will aim to understand the strategies used by commissioners to make decisions about community services, specifically services in which the evidence base suggests needs are best met by specialist care using stroke as a contextual example. It will consider if the institutional characteristics of the stakeholders involved in these decisions are contributing to the lack of clarity on what and how services should be commissioned in the community setting. The findings of this study will be used to inform commissioning and clinical policy to guide decision-making for service design

and delivery and ensure patients receive the most appropriate care at an acceptable cost to the taxpayer.

Justification of site selection

Case study sites will be selected based on their current stroke service organisation. Sites will be located within the same strategic network to ensure consistency for local policy. Sites are located with the [redacted] Strategic Clinical Network for Cardiovascular Diseases (including stroke): the network offers a service specification for stroke services from which stroke services may be commissioned in accordance with local need. This specification is available to the commissioning stakeholders in each site but it is not a requirement to conform to the specification. Study site demographics have been compared to ensure similar characteristics to allow comparison of commissioning strategies between the different locations. Both sites have a large central stroke unit serving the surrounding area consisting of inner city, suburban and rural populations. Each site has multiple Clinical Commissioning Groups (CCGs) that commission stroke services from the central stroke unit and community providers; the study will be primarily based within these CCG's but also include other NHS organisations such as providers and clinical networks who are working alongside the CCG's to commission community stroke services.

The first site has been selected to represent a pre-existing comprehensive stroke pathway. This means that in addition to the central stroke unit, the site will have an established Early Support Discharge (ESD) service(s) and established Community Stroke Team(s) (CST).

The second site will represent a partial stroke pathway. This means that in addition to the central stroke unit the site has an established ESD but will not have any other stroke specialist community services.

Selected sites

[Westhall] and [Edgeham], which have relatively similar demographics to provide a valid comparison for the organisational structure of stroke services. [Westhall] and

[Edgeham] are both located in the [redacted] Strategic Clinical Network for Cardiovascular Diseases and hold similar geographic and demographic characteristics. Population sizes in the cities are around 350,000 and in the surrounding area approximately 700,000. Both hospitals serve city, semi-rural and rural populations. Both [Westhall] city and [Edgeham] city have greater deprivation and lower life expectancy than the national average, whereas the surrounding areas have less deprivation, better health profiles and greater life expectancy except for females in [Westhall] who have a lower life expectancy. Both localities have similar early detection of cardiovascular disease and stroke rates. Both [Westhall] and [Edgeham] are ethnically diverse but [Edgeham] has a greater Asian population. This was not considered to be problematic as the project is focussing on how services are commissioned, although it is acknowledged that ethnic diversity will play a role in what and how stroke services are designed.

Both sites include a central acute stroke unit and surrounding community healthcare settings to which stroke survivors are discharged. The central stroke units are located within the city and accept all people who have suffered a stroke in the area. Community healthcare services cover city centre, suburban and rural locations associated with the central stroke unit. Some of the community services are stroke specific and some are generic, and differ between each site. This will be explained in more detail for each site.

[Westhall] has been selected as a best practice example as their stroke pathway demonstrates comprehensive coverage for stroke rehabilitation in the hospital setting and the community in line with current guidelines. It also demonstrates slightly different ways of achieving this through different providers in the city and suburban/rural community settings. In total there are three providers of stroke specific services; [Westhall Acute Hospital] NHS Trust provides hospital based care and an [skeleton ESD] (similar to ESD) for stroke patients living in county locations; [Westhall] [South Community] provides ESD and a Community Stroke Team for stroke patients living within the [South]; and [Westhall][North Community Provider] provides a Community Stroke Team for stroke patients living in the [North].

Stroke patients enter the stroke pathway at the [Westhall Acute Hospital] NHS Trust Stroke Unit. Stroke survivors requiring on-going rehabilitation after treatment in the acute stroke unit may receive inpatient rehabilitation at [Westhall Acute Hospital] or if eligible (mild and moderate stroke), discharged home with ESD or the [skeleton ESD], depending on where they live. Early Supported Discharge is available for patients who live within the [South] boundaries and the [skeleton ESD] is available for patients living within the [North] boundaries. Other stroke patients from areas beyond the [South] and [North] boundaries may be referred to services in their own area but this are not included in this study. Both [South] and [North] eligible patients (mild and moderate stroke) can access respective Community Stroke Teams and there is an outpatient neuro-rehabilitation for severely affected patients who are not eligible to access the community-based services. Healthcare services in the [Westhall] [South] and [North] areas are commissioned by four CCGs; one CCG representing the city population ([Westhall] [South] CCG); and three representing surrounding area's ([North] CCGs).

[Edgeham] stroke services represent a pathway with current best practice for acute stroke and ESD provision for eligible patients. For those requiring on-going rehabilitation, services are more fragmented and variable in term of their stroke specialist provision. Patients not eligible for ESD are transferred to stroke rehabilitation beds in community hospitals and there is provision for community based rehabilitation although these services are generic. This model has elements of a stroke specialist model and elements of a generic model in the community and offers the opportunity to determine if model meets the local needs or is ready to change towards a model more focused on specialist or generic services. [Edgeham] has a total of three CCGs.

STUDY OBJECTIVES AND PURPOSE

Purpose

The purpose of the study is to understand the decision making strategies used by stakeholders when commissioning services for community dwelling stroke survivors. The study will aim to gain each stakeholders perspective on why and how

commissioning decisions are made to understand the decision making process used in commissioning within the context of community stroke services. The study will explore institutional characteristics that may be involved in decision making and consider if the stakeholder's institutional characteristics are aligned or competing, and how in turn this may influence the commissioning outcome.

Primary Objective

To identify the decision making strategy used by each stakeholder in the commissioning process and how this impacts on the commissioning outcome.

Secondary Objective

To determine if the strategies employed by commissioning stakeholders are competing or aligned and how these strategies are used to influence the decision making process.

STUDY DESIGN

Study Configuration

Multiple case study design using two purposively selected sites. Data collection techniques will include interviews, direct observation and document analysis.

Study Management

The Chief Investigator has overall responsibility for the study and shall oversee all study management. The day-to-day management of the project will be overseen by Rebecca O'Connor (PhD student), who is supervised by the Chief Investigator. Rebecca O'Connor is based at the Nottingham University Business School. Rebecca O'Connor will conducted all data collection and lead the data analysis under the supervision of and Rebecca Fisher and Justin Waring. The data custodian will be the Chief Investigator. Source data will be securely stored at Nottingham University Business School. Anonymous transcripts may be stored on a password-protected computer for analysis.

Duration of the study and participant duration of involvement

Study Duration: Enrolment to the study will begin in January 2015 and continue for 12 months until December 2015.

Participant duration: Participants will be enrolled in the study until the study closes.

Participant involvement: Each participant will be interviewed on up to three separate occasions with each interview lasting approximately 1 hour. Some participants will be observed in meetings, depending on their role in the commissioning process.

End of the study

The end of the study will be when all interviews have been completed.

Recruitment

Participant identification

The study will aim to invite all stakeholders in community stroke commissioning to participate in the study. It is anticipated that there will be a minimum of 15 stakeholders interviewed per site. Participants will be identified using chain referential sampling. Initially a key informant with specific knowledge of the organisations structure for stroke within the sites will be approached and invited to participate in the study using an email or letter introduction which will include the participant information sheet (see copy of letter and participant information sheet). This participant is most likely to be the lead commissioner for stroke services in each site. If the key informant agrees to participate, they will be asked to identify stakeholders that they work with in the community stroke commissioning process. Stakeholders that are identified by the key informant will then be approached by Rebecca O'Connor and invited to take part in the study using the email or letter introduction and information sheet. If these stakeholders agree to participate, they too will be asked to identify all of the people they work with when commissioning community stroke services. Any new stakeholders that are identified will be approached in the same way and this process will continue until all community stroke commissioning stakeholders have been identified for each site.

It is possible, that some stakeholders may not have been identified prior to the researcher attending a commissioning meeting that will be observed as part of the study. In this case, the information sheet will be sent out with the meeting agenda to stakeholders attending the meeting who have not already been recruited to the study. These stakeholders will be contacted prior to the meeting to complete the informed consent process if they are willing to participate.

Potential participants will be associated with a number of NHS organisations if they are employees or may be patient representatives. The stakeholders who are NHS employees are expected to be part of the following types of NHS organisations:

Clinical Commissioning Groups
Acute hospital Trusts and providers of acute stroke services
Community Healthcare Trusts and providers of community services
Strategic Clinical Networks
Public Health

Commissioning policy recommends that patients should be involved in the process and therefore it is important that the patients view is captured. It is anticipated that patient representatives will be involved in the commissioning process and may act as a lay person on commissioning boards. However, in the event of no patient representatives being currently involved in community stroke commissioning, additional patient representatives may be recruited. These participants will be identified through stakeholders, most likely clinicians and staff from provider organisations, and will be patients who have been a patient representative in other aspects of stroke services. The stakeholder will approach these participants initially and if they are interested in taking part, they will be contacted by the researcher to allow the study to be explained, issue the information sheet and complete the informed consent process. A slightly different introduction letter and information sheet will be used as knowledge of commissioning may be less well developed in these participants (see patient representative introduction letter and information sheet).

It is unlikely that translators will be required for interviewee's. This is because the study is investigating an administrative process within the NHS where English is expected to be used in all circumstances. All information sheets and consent forms will be in English.

Inclusion criteria

Ability to give informed consent

Adults (over age 18 years)

Stakeholder in the commissioning of stroke services or related speciality (cardiovascular disease or neurological conditions) or generic community services. For example, these may include commissioners, acute and community providers, clinicians and patient representatives. Patient representative refers to a stroke patient who has worked in the commissioning process in an advisory capacity or is known to a commissioning stakeholder and may have previously acted as a patient representative for other stroke services in a formal or informal capacity.

Exclusion criteria

Communication problems (e.g. aphasia) that prevents participation in interview.

Unable to give informed consent

Expected duration of participant participation

Study participants will be participating in the study for up to 12 months, although involvement in research activity will be dependent on the role the participant takes in the commissioning process and involvement will not be continuous throughout the year Inclusion may involve up to 3 interviews lasting up to 60 minutes. Participants who play a large role in commissioning are likely to be interviewed 3 times, however those that play a smaller role may only be interviewed once or twice. Participants may also be observed during commissioning meetings and this

will depend on the frequency of planned interviews and the number the researcher is granted access to.

Participant Withdrawal

Participants may withdraw from the study if they withdraw consent to be interviewed or observed. Participants may be withdrawn from the study either at their own request or at the discretion of the Investigator. The participants will be made aware that this will not affect their future care (in the case of stroke survivors). Participants will be made aware (via the information sheet and consent form) that should they withdraw the data collected to date cannot be erased and may still be used in the final analysis.

Informed consent

All participants will provide written informed consent prior to participating in interviews and being observed in meetings. The Consent Form will be signed and dated by the participant before they enter the study. The Investigator will explain the details of the study and provide a Participant Information Sheet, ensuring that where possible the participant has sufficient time to consider participating or not. The Investigator will answer any questions that the participant has concerning study participation. Informed consent will be collected from each participant before they participate in any interviews or observations related to the study. The participant will keep one copy of this and the Investigator will keep one. Should there be any subsequent amendment to the final protocol, which might affect a participant's participation in the study, continuing consent will be obtained using an amended Consent Form, which will be signed by the participant.

Participants identified through the chain referential sampling strategy will give consent at a convenient time prior to the first interview or meeting. This may occur immediately before the interview or meeting in no other convenient time can be arranged with the participant.

Some potential participants may not have been identified before they are identified as a meeting attendee. Participants identified as a meeting attendee will be

contacted prior to the meeting to determine if they are willing to participate. The introduction letter and information sheet will be sent out with the meeting agenda. The presence of the researcher will also be included in the meeting agenda to inform all meeting attendees, who may or may not have been previously consented, that the researcher will be attending the meeting. Contact details for the researcher will be included to allow participants to contact the researcher to allow them to ask questions, discuss any concerns and request that they do not attend if they do not consider attendance appropriate. Any meeting attendees not consented to participate will be consented prior to the meeting by arranging a meeting to take consent at a convenient time.

It is possible that a meeting attendee may have been invited to attend the meeting at short notice and did not receive the agenda and information about the study. Any unexpected meeting attendee's will be given a verbal explanation of the study and an information sheet and asked to give informed consent before the meeting proceeds.

Study regime

The setting for the data collection will predominantly be the administrative centres for the CCGs involved commissioning community stroke services to serve the stroke unit. Stakeholders may be located in the administrative centres for the acute provider and community provider, public health, strategic clinical networks and other administrative locations. All participants will be invited to interview by the research team. Participants may also be involved in observation. Document analysis may involve an author who is a participant.

Interviews

Commissioning stakeholders who consent to participate in the study will be interviewed at a time and venue of their choice. This may be outside of their normal office hours to reduce the impact on their working day if this is convenient. It is most likely that the interviews will take place at the participant's place of work. For patient representatives, interviews are most likely to take place at the patient

representative's home. In this case the University of Nottingham lone working policy will be adhered to. Where possible, a quiet room will be requested where disturbances can be kept to a minimum and to ensure confidentiality. Participants will be asked to arrange a suitable room prior to the interview. Rebecca O'Connor will conduct interviews. Interviews will be semi-structured in nature and follow a topic guide to prompt discussion. As the study progresses, the topic guide may be adjusted according to the findings in the preceding interviews and preliminary analysis. All interviewed will be audio recorded and transcribed verbatim. Field notes will also be recorded and transcribed. Transcription will be completed by Rebecca O'Connor or a University of Nottingham approved transcription service.

All personal identifiers will be removed from transcriptions and each participant will be allocated identifying code and a pseudonym to be used in the report. Audio files will be stored securely on a password-protected computer and backed up to the University of Nottingham protected network. Electronic copies of transcripts and field notes will be stored in the same way. Paper copies of all transcripts and field notes will be stored in a locked filing cabinet at Nottingham University Business School.

Example topic guide for interviews

- I'm interested in understanding how community services like community stroke are commissioned; can you first tell me about your role in this?
- Who else do you work with on this? And what are their roles?
- Are there any key documents or policy you are working with? Is it possible to have a copy?
- Are community services a priority for the CCG this year?
- How do you decide what is going to be in your priorities?
- Who is involved in priority making decisions?
- Stroke is considered a speciality in the acute setting. Do you think the speciality is sustainable in the future in the acute setting and the community?

- Do you think services in the community should be specialist for some conditions like stroke?
- Is moving specialist stroke care into the community achievable?
- Which stroke patients do you think should be offered community stroke?
- What are the current commissioning intentions for community stroke services?
- How do you set about addressing those intentions?
- Where do you get the information you need for those decisions? What else would help in the process?
- What are your targets for stroke at the moment? In the future?
- What are the cost implications for having stroke services in the community? Where does the additional funding (if its needed) come from?
- How do you see the stroke pathway evolving over the next 5 years?

Observation

During the interviews, the investigator will determine if there are any commissioning meetings relevant to the study that may provide additional data for the study. Permission will be sought to attend these meetings. If appropriate, meetings will be audio recorded and transcribed verbatim. Field notes will be recorded and transcribed. Transcripts will be stored securely on a password-protected computer and backed up to the University of Nottingham protected network. Paper copies of all transcripts and field notes will be stored in a locked filing cabinet at Nottingham University Business School.

Documents

Documents will be identified through formal and informal discussion with participants. Access will be requested once a document has been identified. Where possible, the author of the document will also be invited to interview. Documents will be stored in a locked filing cabinet at Nottingham University Business School.

Compliance

Compliance is defined as participant's adhering to the study protocol. Compliance will have been breached if participants do not attend interviews having consented to participate. Compliance will be monitored for the study and reported in the final results. Not applicable to this study.

Criteria for terminating the study

The study will be terminated should the case study site wish to withdraw from the study.

Analysis

Methods

Data will be analysed using qualitative techniques consistent with case study research methodology (Yin, 2009).

Analysis strategy

To assist with data management and the organisation of the analysis output, NVivo software package will be used for all data. Pre-determined theoretical propositions will be used to guide the data analysis along with the aim of providing a rich case description for each site. This will be used to build a case and explain the strategies used in each site. Comparisons will be made between stakeholders within each site and then cross case analysis will be used to look for trends and rival explanations in the data.

Data analysis

Data analysis will commence with data collection and will continue throughout the data collection process and beyond. Findings may influence data collection. Analysis will be inductive and thematic, allowing a story to emerge from the data following rigorous and logical examination grounded in the traditions of institutional theory (Scott et al., 2000). Data will be managed using CAQDAS (Computer Assisted Qualitative Data Analysis) package, NVivo 10 (service pack 5). This allows large

quantities of data to be stored and accessed quickly as the analysis progresses but does not contribute to the analysis itself. The researcher will engage and immerse themselves within the data through thorough reading of transcripts, documents and field notes and listening to audio recordings. Ideas, impressions and reflections will be recorded using comments in NVivo 10. Data will then be coded by highlighting sections of text and allocating a code. Codes will reflect concepts that emerge within the data and much of the data may be allocated multiple codes if the data relates to multiple concepts and ideas. Coding is an iterative process and as new codes emerge, previous data will be reviewed to determine if this code should be allocated elsewhere. Following the preliminary analysis, codes will be grouped into themes and extracts or data will be used to explain the meaning of the theme. Data extracts will be labeled with the Unique Identifying Code of the informant and with the place in data from which the extract originates using a line number identification system. Themes will then be organised to give an account of the understanding that has been gained from the data using extracts to give deeper meaning.

Sample size and justification

Sample size is determined by the number of stakeholders involved in community stroke commissioning in each site. This has been estimated to be at least 15 in each site and all identified participants will be invited to participate to ensure perspectives of all the stakeholders are investigated.

Adverse Events

The occurrence of an adverse event as a result of participation within this study is not expected and no adverse event data will be collected.

Ethical and Regulatory Aspects

Ethics Committee and Regulatory Approval

The study will not be initiated before the protocol, consent forms and participant information sheets have received approval / favourable opinion from the Research

Ethics Committee (REC), and the respective National Health Service (NHS) Research & Development (R&D) department. Should a protocol amendment be made that requires REC approval, the changes in the protocol will not be instituted until the amendment and revised informed consent forms and participant information sheets (if appropriate) have been reviewed and received approval / favourable opinion from the REC and R&D departments. A protocol amendment intended to eliminate an apparent immediate hazard to participants may be implemented immediately providing that the REC are notified as soon as possible and an approval is requested. Minor protocol amendments only for logistical or administrative changes may be implemented immediately; and the REC will be informed. The study will be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki, 1996; the principles of Good Clinical Practice, and the Department of Health Research Governance Framework for Health and Social care, 2005.

Informed Consent and Participant Information

The process for obtaining participant informed consent will be in accordance with the REC guidance, and Good Clinical Practice (GCP) and any other regulatory requirements that might be introduced. The investigator and the participant shall both sign and date the Consent Form before the person can participate in the study. The participant will receive a copy of the signed and dated forms and the original will be retained in the Study records. A second copy will be filed in the participant's medical notes and a signed and dated note made in the notes that informed consent was obtained for the study. The decision regarding participation in the study is entirely voluntary. The investigator or their nominee shall emphasize to them that consent regarding study participation may be withdrawn at any time without penalty or affecting the quality or quantity of their future medical care, or loss of benefits to which the participant is otherwise entitled. No study-specific interventions will be done before informed consent has been obtained. The investigator will inform the participant of any relevant information that becomes available during the course of the study, and will discuss with them, whether they wish to continue with the study. If applicable they will be asked to sign revised

consent forms. If the Consent Form is amended during the study, the investigator shall follow all applicable regulatory requirements pertaining to approval of the amended Consent Form by the REC and use of the amended form (including for ongoing participants).

Records

Individual Case Study Forms

Each participant will be assigned a study identity code (consisting of a site reference name, stakeholder description (e.g. commissioner, service user, clinician), participant's initials and a number to identify multiple stakeholders of same description) for use on CSFs, other study documents and the electronic database. The documents will also use sites codes (site reference name) and abbreviated document description. CSFs will be treated as confidential documents and held securely in accordance with regulations. The investigator will make a separate confidential record of the participant's name and contact details, and study identity code, to permit identification of all participants enrolled in the study, in case additional follow-up is required. CRFs shall be restricted to those personnel approved by the Chief or local Investigator and recorded as such in the study records. CSF's will contain transcripts and other data associated with the participant. All paper forms shall be filled in using black ballpoint pen. Errors shall be lined out but not obliterated by using correction fluid and the correction inserted, initialled and dated. The Chief or local Investigator shall sign a declaration ensuring accuracy of data recorded in the CRF.

Source documents

Source documents shall be filed at the investigator's site and may include but are not limited to, consent forms, study records, field notes, interview transcriptions and audio records. A CRF may also completely serve as its own source data. Only study staff shall have access to study documentation other than the regulatory requirements listed below.

Direct access to source data / documents

The CRF and all source documents shall made be available at all times for review by the Chief Investigator, Sponsor's designee and inspection by relevant regulatory authorities.

Data Protection

All study staff and investigators will endeavour to protect the rights of the study's participants to privacy and informed consent, and will adhere to the Data Protection Act, 1998. The CRF will only collect the minimum required information for the purposes of the study. CRFs will be held securely, in a locked room, or locked cupboard or cabinet. Access to the information will be limited to the study staff and investigators and any relevant regulatory authorities (see above). Computer held data including the study database will be held securely and password protected. All data will be stored on a secure dedicated web server. Access will be restricted by user identifiers and passwords (encrypted using a one way encryption method). Electronic data will be backed up every 24 hours to both local and remote media in encrypted format.

Quality Assurance and Audit

Insurance and Indemnity

Insurance and indemnity for clinical study participants and study staff is covered within the NHS Indemnity Arrangements for clinical negligence claims in the NHS, issued under cover of HSG (96)48. There are no special compensation arrangements, but study participants may have recourse through the NHS complaints procedures. The University of Nottingham as research Sponsor indemnifies its staff, research participants and research protocols with both public liability insurance and clinical trials insurance. These policies include provision for indemnity in the event of a successful litigious claim for proven non-negligent harm.

Study Conduct

Study conduct may be subject to systems audit for inclusion of essential documents; permissions to conduct the study; CVs of study staff and training received; local document control procedures; consent procedures and recruitment logs; adherence to procedures defined in the protocol (e.g. inclusion / exclusion criteria, timeliness of visits); accountability of study materials and equipment calibration logs.

Study Data

Monitoring of study data shall include confirmation of informed consent; source data verification; data storage and data transfer procedures; local quality control checks and procedures, back-up and disaster recovery of any local databases and validation of data manipulation. The Study Coordinator/Academic Supervisor, or where required, a nominated designee of the Sponsor, shall carry out monitoring of study data as an ongoing activity. Entries on CRFs will be verified by inspection against the source data. A sample of CRFs (10% or as per the study risk assessment) will be checked on a regular basis for verification of all entries made. In addition the subsequent capture of the data on the study database will be checked. Where corrections are required these will carry a full audit trail and justification. Study data and evidence of monitoring and systems audits will be made available for inspection by the REC as required.

Record Retention and Archiving

In compliance with the ICH/GCP guidelines, regulations and in accordance with the University of Nottingham Code of Research Conduct and Research Ethics, the Chief or local Principal Investigator will maintain all records and documents regarding the conduct of the study. These will be retained for at least 7 years or for longer if required. If the responsible investigator is no longer able to maintain the study records, a second person will be nominated to take over this responsibility. The study documents held by the Chief Investigator on behalf of the Sponsor shall be finally archived at secure archive facilities at the University of Nottingham. This

archive shall include all anonymised audio recordings, study databases and associated meta-data encryption codes.

Discontinuation of the Study by the Sponsor

The Sponsor reserves the right to discontinue this study at any time for failure to meet expected enrolment goals, for safety or any other administrative reasons. The Sponsor shall take advice as appropriate in making this decision.

Statement of Confidentiality

Individual participant professional or personal information obtained as a result of this study are considered confidential and disclosure to third parties is prohibited with the exceptions noted above. Participant confidentiality will be further ensured by utilising identification code numbers to correspond to transcript data in the computer files. If information is disclosed during the study that could pose a risk of harm to the participant or others, the researcher will discuss this with the CI and where appropriate report accordingly. Data generated as a result of this study will be available for inspection on request by the participating physicians, the University of Nottingham representatives, the REC, local R&D Departments and the regulatory authorities.

Publication and Dissemination Policy

The findings of this study will contribute to a PhD due to be complete in September 2016. It is anticipated that a number of publications will be produced. The sites will be identified in the publications but the individual participants will not be identified.

Study Finances

Funding source

This study is funded by The Health Foundation.

Participant stipends and payments

Participants will not be paid to participate in the study. However any travel expenses incurred as a result of participation will be reimbursed.

Signatories to Protocol

Chief Investigator: _____

Signature: _____

Date: _____

Appendix II: Participant information sheet

Nottingham University Business School
UNITED KINGDOM · CHINA · MALAYSIA

Participant Information Sheet

Commissioning Stakeholders

Final version 1.1: 8th January 2015

Title of Study: **Commissioning Community Stroke Teams**

Researcher(s): Rebecca O'Connor (PhD Student)

Dr Rebecca Fisher

Prof Justin Waring

We would like to invite you to take part in our research study, which is being organised by Nottingham University and funded by The Health Foundation. The work is being done as part of a PhD project and findings may help improve the way community services are commissioned in the future. Before you decide if you would like to take part, we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

Commissioning is an important organisational concept in today's National Health Service (NHS). It is the process used to ensure that healthcare services meet the needs of the population. Commissioners must assess what those needs are, prioritise which healthcare outcomes should be addressed, buy services from healthcare providers and monitor how effectively services are meeting needs. It is a complex process where difficult decisions must be made about the best ways to spend public money. Despite its efforts, commissioning has been criticised for failing to improve healthcare and reduce spending. We are interested in finding out more about the difficult decisions commissioners must make when they buy healthcare for the population. We are particularly interested in understanding how decisions are made about community-based services that involve healthcare professionals delivering care in the patients home. It is thought that services like these can help prevent people having to go into hospital, which is expensive, and improve their quality of life when they are living at home with medical conditions. We would like to find out how the people involved in commissioning decide what sort of services these should be and how they will be delivered. To do this, we would like to look at how decisions are made for services that deliver healthcare to people who have had a stroke.

People who have suffered a stroke are an example of people who might need healthcare at home when they are discharged from hospital. Stroke care in hospital is very specialised and this has helped many more people survive stroke. Specialist stroke therapy can make a big difference to recovery but unfortunately there is still no cure for stroke and often people don't make a full recovery from their symptoms and may have to learn to live with stroke impairments for the rest of their life. This means that community services that can meet the needs of stroke survivors are very important both in the short and long term. Although specialised hospital stroke healthcare has made a huge difference to people who have had a stroke, it's not clear if stroke survivors need to have specialised stroke healthcare in the community or if more general community services can provide the care they need. This makes it difficult for the people involved in commissioning to decide what type

of healthcare stroke survivors need and what offers the best value for money. We would like to look closer at how these decisions are made so that we can understand what the challenges are and help to make commissioning easier in the future.

Why have I been invited?

You are being invited to take part because you are involved in the commissioning process for stroke services in some way. This might mean that you are working in commissioning, working with the organisations that provide healthcare services or someone who acts a patient representative. We are inviting around 50 participants from several different locations to take part so we can find out what your role is in the process and what your thoughts and opinions are on how commissioning works.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

If you decide to take part, there are a few ways that you may be involved in the research. We would like to interview everyone that takes part to find out their opinions about commissioning community stroke teams. We expect that the interviews will last around 60 minutes and will take place in a location that is convenient to you. Ideally, this would be a quiet room that may be at your place of work or somewhere else. If you would like to be interviewed at work, it would be helpful if you were able to arrange a meeting room where we could talk privately without being disturbed. If you prefer to be interviewed somewhere else we can discuss where the best place would be and make arrangements for that. We would like to record the interview using an audio recorder so that we can go back and listen to what you have to say again. We will ask your permission to record the interview. The questions will be about the role you play in commissioning

community stroke teams and what you think about the commissioning process. We may ask if you would participate in more than one interview, possibly up to three and these will take place over the course of a year.

As part of the research, we are also interested in seeing how commissioning meetings are carried out. To do this, we will sit in on meetings and observe what happens. During this, we won't be participating in the meetings but might make notes about things that are interesting. We will ask everybody that attends whether they are happy for the researcher to be in the meeting before the meeting takes place and you can request that the researcher doesn't attend the meeting if you don't feel comfortable with them being there. You may find that during the meeting, you change your mind about the researcher being in the room. If you feel like this, you can ask the researcher to leave the meeting at any time.

The final part of our study is about looking at the documents that are associated with commissioning community stroke teams. These might be reports or minutes of meetings. If you have been the author of these documents we will ask if you would allow the documents to be part of our study.

Confidential information that comes up in meetings and documents such as the minutes of meetings will not be included in the study. Confidential information will not be recorded in the filed notes for the meeting observations and we will ask that anything confidential is removed from the documents before the researcher is given them.

Expenses and payments

Participants will not be paid to participate in the study. However we are able to reimburse any travel expenses that you may incur as a result of being in the study.

What are the possible disadvantages and risks of taking part?

There are no anticipated risks to health from being part of this study. However, you may find the presence of a researcher in meetings to be inconvenient or possibly intrusive. The researcher will not be involved in the meeting and it only there to observe what happens, but this may make you feel that you are unable to speak as

freely as you usually would. It is possible that the interview questions may also make you consider aspects of commissioning in a different way and may challenge the way you feel about commissioning.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help to improve the way services are commissioned in the future.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting:

NHS Staff should contact Nottingham University Business School – please contact Adam Goldberg (Research Manager), B34b North Building, Nottingham University Business School , Jubilee Campus, Nottingham , NG8 1BB, Tel: 0115 8466604 Email: adam.goldberg@nottingham.ac.uk

Patient representatives should contact the Patient advice and liaison service (PALS) at Nottingham University Hospital NHS Trust. Tel: 0800 183 0204

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (address, telephone number) will be kept for 2 years after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw, we would like to be able to keep the information you have given us to be used in the project. However, if you prefer we can retract and erase the information you provided and it will not be used in the project analysis.

What will happen to the results of the research study?

The results of this study will be written up as part of a PhD thesis (Rebecca O'Connor). It is also intended that the results will be published in an academic journal. This is likely to happen in 2016 and we will be able to give you the details of when and where this will happen towards the end if the study. Research participants will not be identified in the thesis or any publications. We would also like to give detailed feedback to each organisation that takes part in the study and will arrange to give presentations and a written report of our findings. It is hoped that this will help organisations to improve the way services are commissioned.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and funded by The Health Foundation.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Wales REC6 Research Ethics Committee.

Further information and contact details

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Email: justin.waring@nottingham.ac.uk
Tel: 0115 9515117

Appendix III: Data summary

Participants

Case study site	Identifying name	Organisation	Role
Westhall			
1	Sharon	North CCGs	Commissioning Manager
2	Carol	North CCGs	Commissioning Director
3	Maggie	North CCGs	Chief Executive
4	Nat	North CCGs	Commissioning Manager
5	Simon	North CCGs	Commissioning Manager
6	Beth	North CCGs	Commissioning Manager
7	James	South CCG	Commissioning Manager
8	Pat	South CCG	Commissioning Manager
9	John	South CCG	GP Clinical Lead
10	Sarah	Transformation Board	Commissioning Director
11	Liz	South Community Provider	Business Manager
12	Nancy	South Community Provider	Clinical Manager
13	Wendy	North Community Provider	General Manager
14	Bob	North Community Provider	Clinical Manager
15	Caroline	Acute Provider	General Manager
16	Nadia	Acute Provider	General Manager
17	Bill	Acute Provider	Contracts Manager
18	Sophie	Acute Provider	Clinical Specialist
19	Margo	Public Health	Consultant
Edgeham			
20	Jane	CCG	Commissioning Manager
21	Hannah	CCG	Commissioning Manager
22	Geoff	CCG	Commissioning Manager
23	Amy	CCG	Commissioning Manager
24	Angela	CCG	Contracts Manager
25	Rob	CCG	Carer Representative
26	May	CCG	Patient Representative
27	Lynn	Community Provider	Clinical Manager
28	Tim	Community Provider	Contracts Manager
29	Jackie	Community Provider	Strategic Manager
30	Holly	Community Provider	Strategic Manager
31	Jess	Acute Provider	Strategic Manager
32	Toby	Acute Provider	General Manager
33	Jill	Acute Provider	Consultant
34	Sam	Acute Provider	Consultant
35	Anne	Acute Provider	Clinical Manager
36	Kirsty	Acute Provider	Clinical Manager
37	Adele	Acute Provider	Clinical Manager
Oldville			
38	Linda	CCG	Commissioning Manager

39	Zoe	CCG	Commissioning Manager
40	Becky	CCG	Commissioning Officer
41	Bob	CCG	Patient Representative
42	Dot	CCG	Carer Representative
43	Bill	Social Services	Commissioning Manager
44	Helen	Acute Provider	Clinical Director
45	Julia	Acute Provider	Clinical Manager
46	Sue	Acute Provider	Clinical Manager
47	Claire	Acute Provider	Strategic Manager
48	Ben	Community Provider	Clinical Manager
49	Sandra	Community Provider	Clinical Manager
50	Martha	Community Provider	Clinical Specialist
51	Lucy	Community Provider	Clinical Specialist
Other			
52	Cathy	SCN	Quality Improvement Manager
53	Joanna	AHSN	Academic
54	Ivy	Stroke Association	General Manager

Documents

Document number	Author	Title	Date	Description
1	AHSN/SCN	Provision of stroke care report	June 2015	Review of stroke services across SCN and recommendations for improvement
2	SCN	Provision of neurology care report	January 2015	Review of neurology services across SCN and recommendations for improvement
3	Ernst and Young	Edgeham health economy report	July 2014	Financial and quality report with recommendations for healthcare system
4	AHSN/SCN	Community stroke specification	2013	Regional commissioning specification document
5	Oldville CCGs	CST project initiation document	January 2015	Outline of plans to review community stroke services
6	Oldville CCGs	CST project	January	Outline of initial

		scoping document	2015	findings of community stroke services review
7	Westhall Transformation Board	Public engagement report: stroke services	November 2014	Findings of public and patient review of stroke services
8	Westhall CCG	Stroke services review	September 2014	Findings of stroke services review
9	SCN	Community neurology specification	2015	Regional commissioning specification document
10	Edgeham CCG	Community stroke and neurology service business case	September 2015	Business case presented to CCG Board for new community stroke and neurology service

Observations

	Meeting	Date	Description
Westhall			
1	Stroke Network Meeting	April 2015	Local stakeholder meeting to discuss stroke services in Westhall and update on commissioning plans
2	Commissioning Meeting	April 2016	Debrief following failed commissioning process and plans for future
Edgeham			
3	Design Workshop 1	July 2015	Local service specification design with providers and commissioners
4	Design Workshop 2	July 2015	Local service specification design with providers and commissioners
5	Design Workshop 3	July 2015	Local service specification design with providers and commissioners
6	Contracts Meeting 1	December 2015	Provider and commissioner meeting to discuss contracting new service
7	Contracts Meeting 2	January 2016	Provider and commissioner meeting to discuss contracting

			new service
Oldville			
8	Provider Meeting	November 2015	Provider and commissioner meeting to update on progression of plans
AHSN/SCN			
9	Commissioning Workshop	July 2015	Regional update on commissioning arrangements for stroke services
10	Stroke Service Provision Workshop	June 2016	Roundup of AHSN work in stroke services and stroke networking event

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