

**HOW GENERAL MEDICAL PRACTITIONERS MAKE SENSE OF THEIR
COMMISSIONING ROLE IN THE ENGLISH NATIONAL HEALTH SERVICE
AND WHY IT MATTERS**

**THEORISING FIELD CHANGE THROUGH THE INTERRELATIONSHIP OF
RULES, NETWORKS, AND COGNITIVE FRAMES**

ADELE CRESSWELL, BA (HONS)

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Abstract

This thesis includes theoretical contributions to organisational studies and medical sociology, drawn from a three levelled ethnographic case study of commissioning by General Medical Practitioners in the setting of the English National Health service. In order to locate these levels as interrelated structures, the concept of "field" (Bourdieu, 2005, Fligstein, 2001, Fligstein and McAdam, 2012, Lewin, 1997 [1951]) is used. Jens Beckert (2010) has developed a framework in which cognitive frames, networks, and rules are in a relationship of irreducible interdependency. The definitions of analytic categories in the extant framework are under-developed. In this thesis, the framework is empirically applied to add definition to the analytic category "cognitive frame". Beckert's Framework and Weick's (Weick, 1995, Weick, 2000, Weick et al., 2005) Sensemaking Perspective are intersected to develop a reciprocal relationship between the two theories. By conceptualising cognitive frame as a sensemaking process, insight is gained in three different but overlapping facets: wider contexts, temporality, and distributed sensemaking. At the level of an industry a cognitive frame can be described as a sensemaking type, which will have constituent sensemaking styles associated with that industries internal networks. When rules require organisations from separate industries or sectors to form partnerships then actors with different sensemaking types will be required to interact within one network. Organisational development techniques can be used to support and align sensemaking in both of these circumstances. Sensegivers may have an important role in pacing, including suspending, sensemaking. The thesis also contains insights for medical sociology in respect of how and why GPs commission as they do. These relate to the impact of belonging to the NHS family; differing permutations of changes to the profession (hybridisation, restratification, and the delimitation of autonomy) in GP networks; GP compliance with rules; and the characteristics of an inner-city GP workforce.

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Abbreviations

APMS	Alternative Personal Medical Services
AQ	Advancing Quality
AQP	Any Qualified Provider
BF	Beckert's Framework
CPG	Care Provision Group
CSR	Case Study Research
CLAHRC-NDL	Collaboration for Leadership in Applied Health Research and Care for Nottinghamshire, Derbyshire, and Lincolnshire
CCG	Clinical Commissioning Group
doc	Document
FLE	Focused Learning Event
GP	General Medical Practitioner
GB	Governing Board
HSCA 2012	Health and Social Care Act 2012
HSCCB	Health and Social Care Commissioning Board
HWB	Health and Wellbeing Board
HWP	Health and Wellbeing Partnership
ICF	Informed Consent Form
ISPL	Inter-agency Strategic Partnership Level
LA	Local Authority
LES	Local Enhanced Services
LGA	Local Government Association
LMC	Local Medical Committee
LSP	Local Strategic Partnership
NHS	National Health Service
NUBS	Nottingham University Business School
NW	New World GP-group
OPL	Operational Partnership Level
OD	Organisational Development
PIS	Participant Information Sheet
PbR	Payment by Results
PBC	Practice Based Commissioning
PCT	Primary Care Trust
PC	Principled Collaboration GP-group
PrC	Professional Cabinet
QOF	Quality and Outcomes Framework
SIT	Structural Interests Theory
SCL	Strategic Collaboration Level
SP	Sensemaking Perspective
SoP	Sociology of the Professions
TM	Total Members

Chapter One: Introduction

1.1 Aims of the research

This is a thesis about the dynamic relationship between sensemaking, networks and rules in the empirical context of a Clinical Commissioning Group (CCG) in the English National Health Service (NHS). The research questions were open and broad, designed to orientate investigation and open up lines of enquiry, rather than to delimit the study. These were:

- Why and how did GPs enact their commissioning duties in the ways that they did?
- How does sensemaking influence field change within the context of networks and rules?

The first question relates to my aim to add depth and nuance to our understanding of *why* and *how* General Medical Practitioners (GPs) commission services in the way that they do. The second question relates to my aim to extend a conceptual framework first proposed by Jens Beckert in an article in *Organization Studies* in 2010, *How Do Fields Change? The Interrelations of Institutions, Networks, and Cognition in the Dynamics of Markets* (2010). I have replaced the term “institution” with “rule” the reasons for which I explain in 2.3: *Selecting the theoretical framework*. My aim is to extend this framework by providing definitional clarity for the term cognitive frame, and to do this by developing theory at the intersection of Beckert’s Framework (BF) and Karl Weick’s (Weick, 1995, Weick, 2000, Weick et al., 2005) Sensemaking Perspective (SP).

1.2 A reflexive comment

Six months before embarking on this research I ended a career as a manager in the NHS. In the 1990s and early 2000s, I had worked with GPs in the CCG that I studied. My last NHS role was in a large mental health services provider organisation and, whilst there, I had

been struck by how limited others' understanding was regarding the jobs that GPs were required to do. In my view no other group of doctors was expected to have a similar breadth of knowledge, or to perform as many different roles. They ran their own businesses, provided a clinical service to patients, commissioned secondary care services, and worked in interagency environments all at the same time. When GPs talked to me, as many had done over the years, they told me that this complexity could cause anxiety. They worried that their commissioning responsibility would compromise their ability to advocate for their patients. One once told me that GPs were people who wanted to be liked, explaining that in his opinion it was this affiliative personality that motivated them to become community-based family doctors. In my opinion, GPs navigated an extremely complex environment, and did this as sensitively, kindly, and intelligently as they were able. Reflexively I recognised the potential for my personal opinion to affect the reliability and robustness of my evidence and conclusions. In order to guard against bias I ensured I approached the study reflexively (see 3.2.2) and that my data analysis process was systematic and thorough (see 3.5).

I left the NHS in April 2011, encouraged by academic colleagues to pursue a long held ambition to "do research". "You don't know less as you get older, you know more" one of them said to me. This was like a light shining into the darkness of ageing. I applied for, and was successful in gaining, a Nottingham University Business School (NUBS) bursary to support my doctoral studies. This was offered in partnership with the Collaboration for Leadership in Applied Health Research and Care for Nottinghamshire, Derbyshire, and Lincolnshire (CLAHRC-NDL). CLAHRCs were a national initiative with the objective to transfer knowledge into practice (Kislov et al., 2011, Rowley et al., 2012, Smith and Ward, 2015). During my PhD project I experienced a dual identity. On the one hand I was an apprentice researcher new to the world of academia. On the other I was an experienced health service manager with, I like to think, a

long-won insight into the way people who work within the NHS think, feel, and interact. With one foot in academia and the other in healthcare management, the personal challenge I have set myself for the remainder of my working life is to play my small part in bringing these two worlds closer together.

1.3 A background note: essential terms

In order that this thesis is intelligible to non-NHS readers, I have, throughout, included definitions for NHS terms and a glossary at Appendix 1. In addition, sections 1.3.1 – 1.3.3 are detailed definitions of: *General Medical Practitioner and Primary Care*; *Commissioning*; and *Clinical Commissioning Group*.

1.3.1 General Medical Practitioner and Primary Care

The vast majority of the population are registered with a *General Medical Practitioner* known as a GP. GPs are usually, but not always, independent business men and women. They have retained their pre-NHS status as independent practitioners, unlike hospitals that transferred into national ownership at the inception of the NHS in 1948. In the vast majority of cases a partnership of GPs owns a business which is called a *general practice*. A GP is a doctor, based in the community, who employs a practice based team including nurses, practice managers, and receptionists. By definition GPs are generalists not specialists and illnesses are usually presented to them in an undifferentiated way. They treat patients with minor or chronic conditions, issuing prescriptions for medication and/or referring to other community services as appropriate. Each surgery has close working relationships with other community-based healthcare professionals such as midwives, health visitors, district nurses, and social workers. GPs also provide various other health services, for example health education advice and clinics, vaccinations, and medical support to nursing homes. This part of the healthcare system is known as *primary care* because it is the primary or first point of contact for most people in most situations.

The GP or other primary care professional, through the referrals mechanism, is the access point for hospitals and other specialist *secondary care* services, and because of this is in a position to affect demand for those services.

1.3.2 Commissioning

In the NHS *commissioning* is a process by which health care services are acquired. A commissioning body holds a budget, whether real or indicative, and uses that budget to acquire healthcare for its local population. This is usually through contracts with providers from the NHS and other sectors (for example hospitals, community services, private sector providers, and charities). The term commissioning tends to be used to describe linked activities (Ovretveit, 1994, Smith et al., 2006, Smith et al., 2010, Woodin and Smith, 2006). The NHS commissioning process has existed since the introduction of the internal market in 1990 (Currie and Brown, 2003, Parliament, 1990) when a separate third party payer role was implemented. The third party payer acts on behalf of the principal funder (citizen) to secure care from the provider (hospital or other organisation) (Checkland et al., 2009a, Ham, 2009, Ovretveit, 1994, Woodin and Smith, 2006). The process of commissioning is sometimes presented as a rational cycle. Woodin and Smith's (2006:p279) cycle is often used, and is made up of five elements.

Figure 1: Woodin and Smith's commissioning cycle



More recent representations show an increased number of stages. The National Association of Primary Care (2010) has a cycle of twelve activities under three main headings of planning, procurement and monitoring. Whether this rational model of a cyclical activity will still be relevant in the new competitive environment is an area currently under investigation. There is limited research regarding the dual imperatives to commission in a system that promotes competition and integration at the same time. In a study that examined activity in four CCGs the authors concluded that running competitive and collaborative systems in parallel has introduced complexity into the commissioning process, the implications of which are not yet fully understood (Allen et al., 2014). What is for certain, is that healthcare commissioning is already complex, and is set to become more so. It is not a linear, static activity, and its definition will continue to evolve as new commissioning policies are implemented and interpreted.

1.3.3 Clinical Commissioning Group

A CCG is an inter-disciplinary group of health clinicians and managers, led by GPs, which holds the health budget for patients in a local area. Membership of a CCG is not optional for GPs; these arrangements came legally into force on 1st April 2013.

Commissioning by GPs is not a new phenomenon; it has existed since the introduction of fundholding in 1990 (Parliament, 1990). The fundholding scheme was abolished in 1997 by the incoming Labour government, but the concept of the GP, or latterly the General Practice, as best placed to allocate and manage resources, has remained in place under different names including the immediate antecedent to CCGs, Practice Based Commissioning (PBC). GP commissioning is based on two main assumptions. The first is that the GP is frontline and therefore best placed to plan and design health services. The second is that GPs can to some degree control the use and costs of secondary care. This allocation of budgets to the GP for the cost of secondary care used by his/her patients is intended explicitly to align cost implications with clinical decision making.

1.4 Research design

My study coincided with the implementation of the Health and Social Care Act (HSCA) (Parliament, 2012) herein after HSCA 2012. HSCA 2012 contained changes to the national rules pertaining to health and social care. GPs became contractually required to be members of local CCGs. Public health duties were transferred from the NHS to Local Authorities (LAs). Added emphasis was given to arrangements for commercial competition through changes in the duties of Monitor, the healthcare regulator. In parallel there was a drive to provide closer alignment between services, referred to by the term integration. This was an imprecise term which could mean closer alignment of health services, or of health and social care services.

The empirical setting for my study was an urban CCG made up of over sixty general practices serving a population of approximately 300,000 people. I conducted a single site case study using ethnographic methods including direct and participant observation and semi-structured interviews. I designed a three level embedded case study comprised of an Operational Practice Level (OPL), a

Strategic Collaboration Level (SCL), and an Inter-agency Strategic Partnership Level (ISPL). This three-level design allowed me to observe GP commissioning as enacted through operational referral and prescribing decisions, their arrangements to collaborate with other practices to procure secondary care services, and their arrangements to commission in partnerships with other agencies. This was an ambitious study, but everything in my own experience and conversations with GPs had led me to conclude that understanding the impact of acting in this multi-levelled environment was key to comprehending how and why GPs commissioned in the way that they did.

1.5 Thesis outline

The thesis is organised into nine chapters, including this one.

Chapter Two is a review of the relevant literature. First, I critically review the literature in the fields of Sociology of the Professions (SoP) and Medical Sociology. Next I present my arguments for selecting BF to theorise my findings. Following on from this, I critically review BF and its early applications in order to establish my rationale for contributing additional definitional depth to the analytic category cognitive frame. Finally, I present my rationale for developing this definition via a reciprocal relationship with SP using the analytic co-ordinates wider contexts, temporality, and distributed sensemaking.

Chapter Three, is a description of the methodology and methods for the study. It includes an outline of the use of Case Study Research methodology with ethnographic methods. It also includes details of how the site was selected, how the research was conducted, the processes of data analysis, and the display of data throughout the thesis.

Chapter four is a preamble to the three data chapters. In it I explain the use of the concept of “field” within BF, and also give background

to the three levels (OPL, SCL, and ISPL) which constitute the empirical field for this study.

Chapters five to seven are presentations of the three empirical case studies, each including a discussion and summary of the theoretical implications of the findings.

Chapter eight is a discussion of the findings presented in the three preceding chapters, and an extrapolation of the implications for the theoretical development of SP and BF.

Chapter nine is the conclusion, including: the theoretical contributions; and a description of the limitations of the study, the implications for health policy and practice, and potential areas for further research.

1.6 Theoretical contributions of the study

The theoretical contribution of the thesis is at the intersection of BF (Beckert, 2010) and SP (Weick, 1995, Weick, 2000, Weick et al., 2005). Beckert's argument is that networks, institutions (or rules), and cognitive frames are in a dynamic and irreducibly interdependent relationship in a field. Beckert integrates these forces to analyse field change at a macro level. Weick's sensemaking has been mainly developed at micro levels when individuals respond to a problem or a crisis. By developing a reciprocal relationship between the two theories, SP has extended to the macro level, and the concept of cognitive frame has been given a descriptive definition. The theoretical contributions derived from this study are presented in terms of their implications for SP and BF individually. These contributions address underdeveloped areas of wider contexts, temporality, and distributed sensemaking in SP, and an under theorised concept of cognitive frame in BF.

1.6.1 Contributions to Sensemaking Perspective

I propose the following contributions to SP.

The concept of a *sensemaking type* is potentially useful in understanding how networks interpret rules, respond to tensions, and succeed or fail in achieving collective action. A type is a shared perspective on the nature of cues that workers in a particular organisational context will seek to identify when making sense of new rules or contexts. At such times, new rules are interpreted through the lens of the established sensemaking type. In some circumstances a new rule may imply a change in type. In others new rules are interpreted in a field of multiple sensemaking types in the same network. The consequent ambiguity in either circumstance can trigger sensemaking. Tensions in sensemaking may be a stage in resolving ambiguity, or may be ongoing especially in networks with multiple sensemaking types.

Even when an industry has a shared sensemaking type, there will be co-existent variances in how that industry's sub-networks interpret rules. I have conceptualised these differences within an overall type as sensemaking styles. Styles both reflect the networks' history, and effect its future-orientation, and distribution of actors.

Sensemaking, in wider contexts, is an active distributing process. Networks are adaptive; distribution patterns alter according to the implications of the sensemaking project. Various active processes were associated with distribution, including sensegivers spanning network boundaries; networks splitting to take differentiated positions; networks taking time out to reflect; and a uni-professional network retreating to reflect.

Sensemaking is paced over time. Not all actors share a time horizon. It is not necessary for sense to be made by all actors before action can commence. Leaders, at times when they themselves are interpreting new rules, can suspend sensemaking amongst networks of followers. This is achieved by socially skilled leader-facilitators diminishing resistance by diverting the attention of the wider network onto, in this case, the call to professionalism.

1.6.2 Contributions to Beckert's Framework

Where SP is extended by using BF to face the macro level, in a reciprocal relationship BF is extended by using SP to face the micro level. This extension is in the form of a description of the analytic category cognitive frame, and is summarised in the following points.

Cognitive frame is not a fixed entity. Rather it is an ongoing process of sensemaking situated in the actors' context of rules and networks.

Cognitive frame in an industry context is conceptualised as that industry's established sensemaking type. This type is shared amongst actors and can be a unifying force both within and between field levels. When a rule is introduced that implies a change in sensemaking type then a reframing process will be initiated, and this will be enacted using the lens of the pre-existing frame.

The concept of a cognitive frame as a sensemaking type at industry level does not explain how the networks that comprise that industry interpret rules. Within the overall cognitive frame of an industry with multiple networks there will be differences in sensemaking, which is conceptualised as differences in sensemaking style. Style is a combination derived from legacy, future-orientation, and the distribution of the actors.

In fields with more than one industry or sector, multiple cognitive frames may mean that alignment of actors towards the goal of collective action is difficult to operationalise. In these circumstances, the emphasis may be on understanding and accommodating differences, or on legitimising a lead cognitive frame.

Tensions between sensemaking styles or types can exist within or between field levels. This may be a stage in a process towards the development of a shared cognitive frame within a field, or it may reflect a redistribution of power in a field change. The distribution and/or redistribution of networks and actors within networks is in itself an active process which is triggered by cognitive reframing.

Patterns of distribution are created by actors as they interpret new rules. In a field with distributed networks this cognitive reframing can be a managed process. In these situations, OD is important. This can take various forms, depending on the nature of the field rule that is being interpreted.

1.7 Contributions to Medical Sociology and healthcare practice and areas for further research

Whilst the primary purpose of a PhD is to make theoretical contributions as outlined in 1.6 above, in addition this thesis offers insights for healthcare practice and Medical Sociology in respect of how GPs commission and why they enact the role as they do.

One important finding was the impact of belonging to the NHS Family. The NHS Family network had an important stabilising effect but also limited the interpretation of new rules. Despite its apparent importance in shaping the field it remains a fluid and undefined concept. I suggest its mechanisms are an important area for further research, the outcomes of which should be used to inform public policy as more traditional NHS organisations move into new business models, and more NHS functions transfer to LAs.

A further important finding was the differing patterns of hybridisation, restratification, and the delimitation of autonomy in GP networks. More research is indicated on the effect of multiple developments within the profession and the variations that this creates as GPs adopt these changes.

A third important area was that GPs did not appear to critically engage with the role. Despite some initial grumbling, doctors responded to new rules compliantly. Leaders synonymised compliance with professionalism (Evetts, 2003, Evetts, 2006). GPs collectively appeared to be compliant, and orientated towards improvement and sustainability of services for patients, without a strategy to safeguard their own interests.

Fourthly, this was a study of an inner-city area. This workforce had characteristics of ethnic heritage and vocation that were inner-city specific and this inevitably affected how doctors made sense of their role. In addition to their own personal attitudes, inner-city GPs reported feeling overwhelmed with the social problems of their patients meaning it is difficult to make the space and time to think proactively and critically.

1.8 Conclusion

In this introduction I have set out the main elements of the thesis, including research design, the thesis outline, and the main contributions to theory, medical sociology, and practice. The following chapter is a review of the relevant literature.

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Chapter Two: Literature Review

2.1 Introduction

This chapter is designed to reflect the developing nature of my PhD project. My approach to theorising was developed in parallel with data analysis, explained further in *Chapter Three: Methodology and Methods*. In first year of a full-time PhD project in NUBs, a literature review is produced to include the identification of theoretical gaps that the study has the potential to address. The subsequent fieldwork, analysis, and presentation of findings should be the basis of a theoretical contribution to those gaps.

For me, this initial year coincided with the NHS preparing to implement the HSCA 2012. New laws implied fundamental structural changes; for example, NHS providers must now secure business in open competition (Collins, 2015), and increasingly the control of healthcare was to be democratised including the transfer of statutory public health duties to LAs (2012). In response to the structural nature of these rule changes my first literature review was a critique of Robert Alford's SIT and its subsequent applications in the English NHS. SIT was a heuristic framework used to analyse the dynamic relationship between separately identified structural groups of doctors, managers, and patients or citizens. In these early stages, and before entering the field, I anticipated that my theoretical contribution would be to SIT.

During the second and third years, as I began to produce and analyse field data and identify early findings, I revised my initial intention to theorise using a purely structural framework. As my reading of SoP and Medical Sociology progressed, discussed in sections 2.2 and 2.3, I realised that a pure structural analysis would be outmoded. The structure of the profession, and associated sociological thought, was changing. Doctor-manager hybrids occupied new leadership roles, meaning the profession had restratified and increased regulation meant a reduction in clinical

control and autonomy. As underlying structures changed, actors were engaged in a process of interpretation. This necessitated the identification of a framework with the capacity to integrate structural and interpretivist perspectives (see 2.3). First I considered institutions theory, specifically Scott's (2014) concept of three pillars, a model which integrated regulative (structural), normative (combination of structural and interpretive), and cultural-cognitive (interpretive) processes. The problem for me was that Scott's model lacked a pillar by which to theorise the impact of *networks*, which appeared to shift and adapt as part of the interpretation processes in my early findings. In the end, I adopted a framework developed by Jens Beckert in *How Do Fields Change? The Interrelations of Institutions, Networks, and Cognition in the Dynamics of Markets* (2010). Beckert integrated institutions (rules), networks, and cognitive frames into one framework. BF had the potential to support the analysis that, inductively, my data indicated. It is a new framework however, untried empirically and underdeveloped theoretically. Turning this to advantage, there is an opportunity for extension, and for me to do this as the theoretical contribution of my doctoral project.

My next decision was how to construct this theoretical contribution. Beckert used the terms cognitive frame and cognition interchangeably. From this point on I use the term *cognitive frame* for reasons of consistency, and also because my interest is in how networks of actors share ways of thinking, not individual cognition. Section 2.4 is a critique of BF and its applications leading to the identification of an opportunity to develop a more nuanced understanding of the term *cognitive frame*.

The last decision was how to theorise this understanding. My starting point was to explore the intellectual roots of Beckert's own thinking, which he attributed to Karl Weick's Sensemaking Perspective (SP) (1995, 2000, Weick et al., 2005). Section 2.5 is a discussion of the main tenets of SP and how these might be applied and developed within BF. Fortunately for me, scholars had seen the

need to take stock of sensemaking literature. Three separate critical appraisals had recently been published (Brown et al., 2014, Maitlis and Christianson, 2014, Sandberg and Tsoukas, 2015). In terms of my own theoretical contribution, here was a timely opportunity not only to extend BF, but to do this in such a way as to respond to the reviewers' suggestions regarding the future direction of the SP.

I conclude the chapter in section 2.7 by identifying two research questions arising from the critical review of the literature and the parallel process of analysis of empirical findings.

2.2 Relevant debates in Sociology of Professions and Medical Sociology

2.2.1 Professions as an evolving concept

The empirical focus of this study was the enactment of the commissioning role by doctors. Relevant literature was located in medical sociology which was in turn located in the field of SoP.

The term "profession" has traditionally included those occupations which are both knowledge and service based, and into which individuals are admitted after higher/further education and the completion of further specific vocational training/experience. However, the concept of "profession" is contested and shifting, and has historical dimensions.

Early sociologists conceptualised professions as occupations that helped to maintain a stable social order by conforming to a shared value system. Tawney (1921) conceived of a community focus that acted as a counterbalance to individualism. Carr-Saunders and Wilson (1933) described professionalism as a force for stability and freedom that mitigated the encroachment of new emerging public and private bureaucracies. In this early period professions were regarded as having shared normative values focused on serving the "common good" (Evetts, 2003). The field continued to develop, and by the 1950s and 1960s academics were treating professions as a

“socially-grounded normative order” (Dingwall and Lewis, 1983:p2). Professionals formed moral communities (Durkheim, 1957) that willingly complied with that community’s terms of engagement. Functional links between the professions and the rest of society were made, most famously by Talcott Parsons (1951) who argued that capitalism, social order, and the professions were all interrelated in order to maintain the stability of a values-based social order. This consensus that the professions were orientated towards the common good, and a force for social stability was not to endure however.

The focus of SoP changed in the 1970s and 1980s, reflecting the move in sociology as a whole to a more critical position. Professions were understood to be powerful, privileged, self-interested monopolies. Critical theorists (Freidson, 1970a, Freidson, 1970b, Johnson, 1972, Larson, 1977) argued that professions achieved dominance within their sphere(s) and could act with autonomy. Johnson described professionalism as a successful ideology which had entered the political vocabulary of a wide range of occupational groups in their claims and competition for status and income (Johnson, 1972:p32). Larson (1977) devised the concept of the ‘professional project’. The outcome of the successful professional project was a ‘monopoly of competence legitimised by officially sanctioned “expertise”, and a monopoly of credibility with the public’ (Larson, 1977:p38). Later Abbott (1988) would develop the idea of professions protecting their own interests by controlling their own jurisdictions. In this period, the idea of “professionalism” as a normative value serving the common good was viewed with scepticism. Instead, professions and the concept of professionalism began to be understood as an ideology used to protect the interests of the powerful elites that constituted the profession’s membership (Evetts, 2003).

In the mid-1980s, there was a shift away from this idea of professions promoting their own interests. Instead sociologists began to describe an attrition of autonomy and dominance. (Allsop

and Mulcahy, 1996, Freidson, 1988, Harrison, 1999, Harrison and Ahmad, 2000, Mechanic, 1991). Professions appeared to be less able to exercise occupational control of work (Freidson, 1994) or to retain control over regulation (Macdonald, 1995). Evetts (2003) summarised the shift as a time when professions became responsive rather than pro-active:

“More generally, it has turned out that radical governments could successfully challenge the professions. Professions do sometimes initiate projects and influence governments but as often professions are *responding* to external demands for change, which can be political, economic, cultural and social”. (Evetts, 2003:p403)

This was a change in the nature of the relationship between the professions and the state.

This, along with an expansion of knowledge-based occupations (Murphy, 1988), contributed to a reassessment of the concepts of professions and professionalism by scholars in the 1990s. Evetts (2003, 2006) argued that it was during this period that there was an epistemological change in that “professionalism” replaced “professions” as a valued concept. The adoption of the concept of “professionalism” across a wide range of occupations was used to encourage normative behaviour amongst workers. Professionalism in the workplace implied compliance with external controls, and it was on this basis that an increasing number of occupations, including that of managers, now aspired to be described as professional:

“[Professionalism] is used increasingly as a marketing device in advertising to appeal to customers (Fournier, 1998) and it is used in mission statements and organizational aims and objectives to motivate employees. It is an attractive prospect for an occupation to be considered a profession and for occupational workers to be identified as professionals”. (Evetts, 2003:p396)

The aspiration of workers to be labelled “professional” created an appeal that facilitated a values-driven compliance with organisational bureaucratic, hierarchical and managerial controls such as performance targets, accountability frameworks and other

such mechanisms. The term “professionalism” had become a values-based normative force with an impact on the behaviour of workers.

This shift in meaning underpinned a new analysis of traditional middle-class professions and their attitude to their own market position and interests. Scholars proposed that professions could be public value orientated whilst also maintaining their own interests. Saks (1995) argued that the pursuit of self-interest and public interest were compatible endeavours. Freidson (1994, 2001) argued that professionalism had its own logic which had distinct advantages over market and bureaucratic forms of control. Professions were less able to secure occupational controls over their practice and knowledge-base (Freidson, 1994) and were subject to increasingly neo-liberal bureaucratic controls such as “strict organizational regimes, with planning and control, performance measurement, quality models, strategic frameworks, and divisional structures” (Noordegraaf, 2007:p776). All professions, including that of medicine, increasingly undertook management roles. Llewellyn (2001) introduced a metaphor of “two-way window” to describe this role duality; individual professional managers were required to face into two worlds simultaneously. The term “hybridisation” has become the more common descriptor used by scholars to describe this emerging and complex development (Kirkpatrick et al., 2009, McGivern et al., 2015, Noordegraaf, 2007, Waring and Currie, 2009).

In summary then, the debates in SoP relate to the contested and evolving concept of “profession” itself, and the organisational contexts in which professions operate. Early sociologists argued that the existence of the traditional professional groups served to maintain a stable social order and formed moral communities. This shifted in the 1970s and 1980s when critical theorists cast professions as dominant elites who protected and promoted their own interests. This has shifted again since the mid-1980s with the advent of managerialism and an associated attrition of professional

influence, and autonomy. There has been a shift in the epistemology of “profession” from a community of members (which may or may not protect its own interests), to “professionalism” as a behaviour that is compliant with organisational and political expectations. Scholars have argued that as a result new roles and hierarchies have developed in response. Key amongst these are hybrid forms of manager-professionals who operate in new hierarchies. Of interest in this thesis is how these new roles are enacted, and what their impact is on the wider network of professionals. The empirical focus of this thesis is medicine. The next section is a discussion of how these debates in SoP have been positioned in the intellectual field of Medical Sociology.

2.2.2 GPs as commissioners in Medical Sociology

GPs through consultations, referrals, and prescriptions have always allocated NHS resources. The explicit alignment of this, with cost-control was first introduced in the fundholding scheme, and has continued in commissioning policies ever since. This explicit link between clinical practice and financial management is an example of hybrid doctor-manager role; the development of which has taken place over a period of decades.

“Numerous evaluations” of primary care commissioning have taken place (Smith et al., 2005 p1397 - 1399). These have, however, focused on process and organisation (Coulter, 1995, Curry et al., 2008, Greener and Mannion, 2006, Greener and Mannion, 2008, Mannion, 2008, Mannion, 2011, Smith et al., 2004, Williams et al., 1997). By contrast, we know very little about the experience of GPs as enactors of this new role as it has developed.

In this section, I trace the development of commissioning, and reflect on how this links to debates in SoP. The importance of the historical context in order to understand current issues and dynamics in healthcare is widely recognised (Harrison and Ahmad, 2000, Harrison and Lim, 2003, Mannion, 2008, Miller et al., 2012). As already described in the introduction to this chapter, I embarked

on this thesis intending to use SIT (Alford, 1975); a widely used heuristic in Medical Sociology (Currie et al., 2012), in order to explore the relationships of doctors and management. Whilst SIT was developed in the US, it has been applied to the English NHS over a twenty-eight year period (Allsop, 1984, Checkland et al., 2009b, Ham, 1981, North, 1995, North and Peckham, 2001, Wistow, 1992). Its repeated use over time means that it provides a chronological thread to explore the developing relationship between management and doctors, specifically GPs in later applications.

SIT was first articulated in Robert Alford's *Healthcare Politics: Ideological and Interest Group Barriers to Reform* (1975). It was empirically situated in the US private health insurance model of healthcare, and of its time sociologically. Written in the critical theory period of SoP, Alford saw doctors as a professional elite operating with structurally embedded dominance. Management or bureaucratic interventions were an attempt to delimit and rationalise this dominance. The data was a retrospective analysis of the reports of a series of commissions of investigation on New York City's hospitals between 1950 and 1970 (p.xiii). Alford argued that doctors and the bureaucrats who sought to control them each pursued their own interests whilst at the same time repressing the interests of patients. He argued that this repression was constructed through a dynamic triangle of relationships in which doctors were dominant ("professional monopolisers"), the managers attempted to assert power over doctors through standardisation and bureaucracy ("corporate rationalisers"), and in the process patients' interests were repressed. Alford formed arguments that were almost certainly influenced by contemporaneous thinking in sociology and political science. Niskanen (1971) had recently produced his seminal text in which he argued that bureaucrats served their own interests by maximising their own utility. Five years earlier Eliot Freidson had published two important works (Freidson, 1970a, Freidson, 1970b) in which he had argued that professions occupied a position of dominance, conferred by the state, and asserted without effort:

"The foundation on which the analysis of a profession must be based is its relationship to the ultimate source of power and authority in modern society – the state. In the case of medicine, much, but by no means all, of the profession's strength is based on legally supported monopoly over practice." (Freidson, 1970b:p83)

Freidson's work in the same period almost certainly contributed to Alford's un-evidenced assumption of medical dominance within the healthcare context, and Niskanen's to his negative opinion of bureaucrats as self-legitimising and self-justifying. In line with the contemporaneous concept of "professions as ideology" (Evetts, 2003) the emphasis was on how doctors achieved and maintained dominance through strategies such as the commodification of sickness (Johnson and Ruane, 1977, Navarro, 1978).

When SIT was used again it was six years later in England in the context of a social insurance healthcare model. Here, scholars took a more positive view about the contribution of managers. Where Alford had cast "bureaucrats" as self-serving and self-legitimising, in England the intervention of managers was seen by policy makers and academics alike as a desirable and necessary development. The NHS had been introduced in 1948. Up until and through the 1970s the NHS had administrators (not managers) who had a "diplomatic" role to provide support to the doctors who were uncontestedly in charge (Harrison, 1982, Harrison and Lim, 2003). Some six years after Alford, Ham (1981) published a study which used SIT to describe the power dynamics in an acute hospital. He argued that doctors dominated resource allocation processes, and that money was spent according to their interests, both in terms of their personal remuneration and also the prioritisation of services to be funded. He argued that the rationalising effect of management was a desirable challenge to the self-interested actions of doctors.

Ham was supportive of contemporaneous public policy. The Griffiths Report (1983) introduced a general management function, including the creation of Chief Executive equivalent positions at district, regional, and hospital level, as well as an objective setting and

performance review cycle, and mechanisms for budget management. Following the introduction of general management SIT was again used as a framework to analyse its impact. Allsop (1984) described general management as a new corporate rationaliser:

“.....politicians, administrators, at central and local level, and some professionals whose main objective is to achieve greater co-ordination and integration of health services, and to achieve improvements in the planning and delivery of health services.”
(Allsop, 1984:p9)

Like Ham before, Allsop was pro-management and supportive of the introduction of rational planning and increased national coordination.

Despite the introduction of these new managerial arrangements, medical power and autonomy remained a live issue in health service policy and research during the 1980s and early 1990s, with consensus that the powerful dominance of the profession needed to be curbed (Coburn, 1993, Gabe et al., 1994, Harrison et al., 1989, Hunter, 1991, Hunter, 1994, Willis, 1983). From the mid-1990s onwards if and how this dominance could be limited became the prominent problem with which scholars engaged. They concluded that despite the Griffiths reforms medical autonomy remained in place (Gorsky, 2013, Harrison, 1988, Macfarlane et al., 2012, Pollitt et al., 1991), summarised below:

“Although general management has been widely accepted in the service, and seems to have resulted in some improvements to management processes, there has been no substantial change in organizational culture. We conclude that the impact of the Griffiths model of management has been limited in comparison with the continued influence of medical autonomy and financial limitations”
(Pollitt et al., 1991:p61)

If the Griffiths reforms had not succeeded in curbing medical dominance then other solutions would be tried. During the 1990s new mechanisms to increase the accountability of doctors were introduced. One of these was the first involvement of GPs in

procuring healthcare for their patients. In 1991, the GP Fundholding scheme commenced as one element of an internal market (1990) which separated out purchasers (GP fundholders and health authorities) from providers (hospitals and other healthcare organisations). Fundholding, and its variants multi-funds and non-fundholding, was intended to incentivise GPs to control demand for services by allowing them to retain savings generated as a result of their proactive management of referral and prescribing levels. The link between GPs' clinical practice and the NHS budget became a matter of policy. SIT was applied once more by Nancy North (1995) in the first of a number of applications of SIT to the changing relationship between doctors and management in primary care. In North's analysis GPs, through the mechanism of fundholding, were now the corporate rationalisers. In other words previously dominant doctors were now occupying a rationalising role, in an early example of a hybrid role that encouraged the 'colonization' of managerial priorities in professional practice (Ackroyd et al., 2007, Currie and Croft, 2015). For North, the Department of Health was now dominant in a new era of centralised control.

In 1997 there was a change of government, and Tony Blair became Prime Minister. The hallmark of the early Blair period was the standardisation of the quality and range of health services, for example through the use of targets, national service frameworks, and national clinical guidelines. This standardisation programme was set out in the white paper *The New NHS; Modern and Dependable* (Department of Health, 1997). The Conservative's market-based fundholding scheme was abolished in 1998, but the enduring project of GP -hybrids had begun. One of the intentions was the delimitation of medical autonomy (Allsop, 2006, Checkland and Harrison, 2010, Dixon-Woods et al., 2011, Harrison and Lim, 2003, Kuhlmann et al., 2013, Salter, 2007) which would be addressed by involving doctors in guiding and regulating their own colleagues in partnership with general managers.

During the subsequent three terms of the Blair government, three different arrangements were put in place. The first of these, Primary Care Groups (PCGs), was ostensibly focused on the quality of primary care itself rather than commissioning secondary care (Department of Health, 1998, Secretary of State for Health, 1997). North and Peckham (2001) once more used SIT to analyse the structural relationship between doctors and management. PCGs included designated roles for executive GPs including responsibility for the control of indicative prescribing budgets for a group of constituent practices. For the first time some GPs were “policing” (p432) others in a move to delimit clinical autonomy. This had the potential to extend to other clinical matters such as clinical governance. The term “fledgling corporate rationalisers” (p429) was used to encapsulate this incorporation of management duties into the role of lead GPs.

Even though PCGs were to be relatively short-lived, the precedent for management of the profession by the profession was established. Health Authorities were abolished on 31st March 2002. The second arrangement during the Blair period for engaging GPs in management was Primary Care Trusts (PCTs). These were new statutory bodies which inherited secondary care commissioning duties from health authorities, and responsibilities for direct service provision from community trusts. Each PCT had a Professional Executive Committee including, and usually led by, GPs. In the early days of PCTs, GPs did not hold budgets as in fundholding - now considered to be inequitable due to its voluntary nature and to incur high transaction costs. At this point GPs were involved in commissioning, rather than accountable for it.

In somewhat of volte-face (Mannion, 2008 p718) the third arrangement for GP engagement in management during the Blair government was introduced. Practice Based Commissioning (PBC) (Department of Health, 2004) was a policy intended to put GPs in control of resource allocation, and GPs, as in fundholding, were transparently accountable for the costs of their referrals. PBC was

enacted using a new payment system called Payment by Results (PbR) (Department of Health, 2002) where hospitals were paid for completed activity rather than paid a pre-negotiated block sum. SIT was applied again (Checkland et al., 2009b) to explore the impact of PBC and PbR. GPs reported that hospital doctors and managers had colluded to maximise income under PbR and were “gaming” (p615). Staff were being encouraged to code clinical activity in ways that would produce higher payments to the hospital. Checkland et al. argued that power structures were no longer differentiated into doctors and managers. Rather, hospitals were dominant and PCTs, doctors and managers together, provided rationalising challenge. The dominant-challenger dynamic had changed:

“In this article we abandon this implicit assumption that professional monopolists and corporate rationalisers are immutable analytical categories, thereby liberating us to ask more general questions about structural interests.” (Checkland et al., 2009b:p610)

This was a disruption of the SIT triangle of doctors, managers, and patients in a relationship of dominance, challenge, and repression. In empirical terms, the implication is that the structural mechanism that separated doctors from managers no longer existed. In response to centrally organised policies significant changes to the role of doctors had become established and embedded. As a result, commissioning doctors appeared to be aligned structurally to their respective organisations in management relationships, rather than collegiately to their profession.

This adoption of management roles by GPs was a similar process of hybridisation to that which was occurring in other branches of medicine and other professions (Kitchener, 2000, Kuhlmann et al., 2013, Noordegraaf, 2007). Scholars began to describe the onset of entrepreneurial forms of clinical engagement (McDonald, 2009, McDonald et al., 2009a, McDonald et al., 2008). Managers and doctors combined to regulate the profession. (Davies and Harrison, 2003, Harrison and Lim, 2003, Kirkpatrick et al., 2008, Kitchener,

2000). New leadership structures had developed within the profession based on internally organised hierarchies. Lead doctors joined with managers to guide and monitor the “rank-and-file” in a process of restratification (McDonald et al., 2009b, Sheaff et al., 2002). Even though new forms were being described in Medical Sociology, there remained a tendency to focus on the “what?” rather than “why?” or “how?” Scholars have called for a move away from this and its attendant focus on dominance and the challenge to dominance in a continuation of the use of a conflict model (Kuhlmann and Von Knorring, 2014, Numerato et al., 2012). Thomas and Hewitt (2011) as a result of a study of a CCG in the North West of England have specifically argued that a more nuanced approach is needed that shifts from the conflict model to a consideration of why GPs did or did not engage in management tasks, and how they interpreted their new roles.

Two papers that do consider the experience of GPs use evidence from the same dataset. The National Primary Care Research and Development Centre (NPCRDC) published a Department of Health funded evaluation of PBC based on data collected in five PBC consortia in 2007. Methods included observations, interviews, and document analysis. In a NPCRDC report *Practice-based Commissioning: theory, implementation, and outcome*, Coleman et al (2009) explored why GPs would or would not engage in commissioning. The importance of personal aspiration was identified:

“A necessary conditionis for GPs to ‘buy in’ to the concept of going beyond their traditional roles.” (Coleman et al., 2009:p18)

The researchers identified that this “buy-in” could be created by a combination of direct and indirect incentives including, importantly, the opportunity to create and develop services. In a separate paper, Coleman et al. (2010) reanalysed the same data using SP to examine how actors interpreted the commissioning role. The authors concluded that local histories or “legacies” were a major determinant in how policy changes were interpreted and enacted.

Previous experiences of commissioning especially fundholding, and the relationship with the local authority were identified as legacies that affected the enactment of PBC.

It is important to better understand the experiences and motivations of GPs as they commission. To this end, ethnographic studies, such as the one presented in this thesis, become increasingly relevant. In the next section I discuss how questions were devised from SoP and Medical Sociology in order to orientate the study.

2.2.3 The identification of research questions

Drawing on the preceding review, in the next paragraphs I extrapolate issues from SoP and Medical Sociology in order to identify research questions. These are in the areas of *changes to the profession*, and *history and legacy*.

2.2.3.1 Changes to the profession

As with the other traditional professions, in medicine the appeal of “professionalism” (Evetts, 2003) had facilitated a move to compliant behaviours responding to the expectations of employing organisations. According to the literature, two major adaptations to accommodate and reinforce this change were the emergence of hybridised doctor-managers, and a re-stratification in the organisation of the profession into a hierarchy of leaders and rank-and-file.

GPs are expected to enact the unique management role of commissioning. Not only are they required to manage their own services, but they also have responsibilities in the planning and procurement of secondary care health services. In order to gain insight into the experience and motivations of doctors as they enact these roles, a number of questions can be extrapolated from the literature including:

- What is the impact of hybridisation, restratification, and the delimitation of autonomy in combination?

- Are all doctors making sense of these changes in a similar and/or compatible way?
- Why have leadership structures evolved as they have, and what do they depend upon for their legitimacy?
- “Buy-in” (Coleman et al., 2009) is important, but how is this secured and nurtured?

2.2.3.2 History and legacy

Academics have recognised the importance of analysing the historical development of commissioning. GPs appear to have formed legacies which inform their approach to enactment. Coleman et al. (2010) have argued that previous experience of commissioning reaching back as far as fundholding in the 1990s is a major influence in how GPs interpret their commissioning duties when new organisational forms are introduced. In order to gain insight into the impact of commissioning legacies, the following questions are relevant:

- Why is history important and how does it influence how GPs decide to act in the future?
- How do legacies interlink with sociological arguments regarding changes to the profession?

Changes to the profession, and *history and legacy*, became the basis of that element of my coding structure derived from Medical Sociology, discussed further in *Chapter 3: Methodology and Methods*. They, along with three empirically derived codes (see 3.5.3.1.2) combined into the first of two over-arching research question used to focus of the study:

- Why and how do GPs commission in the way that they do?

My next step was to determine the theoretical approach to the exploration of these areas. This is the topic of the next section.

2.3 Selecting the theoretical framework

As early findings emerged it became evident that an analysis based on SIT would not facilitate the telling of the story that was beginning to be revealed in the data. It increasingly appeared that groups of doctors interpreted the requirement to commission differently, evidenced in a heterogeneous pattern of adoption of changes to the profession's structure. These differences correlated to differences in historical relationships and experiences. I needed to use a framework that would integrate an interpretivist and a structural analysis. This process of data-analysis which led to this research decision is described fully in *Chapter 3: Methodology and Methods*.

The first step was to explore the use of a major integrating framework in the area of Institutional Theory. This proved to be an important step towards identifying the framework that I would ultimately use. Scott, in his seminal work *Institutions, and Organizations; Ideas, Interests, and Identities* (2014[1995]), proposed an integrated model organised as three pillars of institutions. Each pillar represented a distinct element within an overarching framework. His composite definition for these pillars reads:

"Institutions comprise regulative, normative, and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life." p56

Within this definition he has identified three concepts – regulative, normative, and cultural-cognitive – upon which his framework is based. Scott's model was created by reviewing the work of institutional theorists, and organising their contributions into the three pillars. In the paragraphs below, I briefly define Scott's three pillars, before critiquing his model with regard to its usefulness in the context of my own study.

The regulative pillar (p59-64) refers to those institutional processes designed to set rules, and to monitor and/or sanction

activities. Sanctioning processes may be informal (shaming, shunning) or formal and assigned to specialist roles. Examples of formal processes in the healthcare context would be financial and clinical audit processes, professional regulation, and statutory policy requirements. Formal rule systems operate through obligation, precision, and delegation. The primary mechanism of control in these systems is coercion. In reality, though, incentives are used. Individuals conform to laws and rules in pursuit of attendant rewards, or the avoidance of penalties. The institutional logic underpinning the regulative pillar is an instrumental one.

The Normative Pillar (p64-66) refers to those processes that both define goals or objectives and also how they should be enacted. The normative pillar includes value-based conceptions of “the preferred” or “the desirable”. Rules can be normative, in that they are prescriptive, evaluative, and obligatory. They define legitimate means to pursue goals or interests. Some values and norms apply to the whole collectivity, whilst others may apply only to certain groups. This is the basis of specialist roles, and role construction which can be formal (for example a job description) or informal (for example sharing out chores in a family). Normative systems are usually thought of as constraining behaviour, but they can also empower and enable social action. The institutional logic is one of appropriateness as opposed to the regulative logic of instrumentality.

The Cultural-Cognitive Pillar (p66–70) refers to those shared conceptions that create the frames through which meaning is made. This pillar relates to the internal representation of a person’s environment. Symbols – words, meanings, gestures – shape the meanings we attribute to objects and activities. Meanings arise in interaction and can also be maintained and transformed. For Scott, *cognitive* related to information-processing activities such as evaluations, judgments, predictions, and inferences. Cognitive processes span a wide array of information-handling functions. These include: determining what information will receive attention;

how it will be encoded; how it will be retained, retrieved, and organised into memory; and how it will be interpreted. The *cultural* element of the pillar refers to those symbolic systems that are considered to be external to individual actors. Cultural theorists differ from normative theorists in that rather than stressing obligation, they point to templates and scripts for action.

Scott's model went some way to addressing the deficits that I had identified by using a structural theory. It was an integrating theory which enabled an analysis with a structural and interpretivist distinction. The regulative pillar would enable me to consider the impact on structures that resulted from the new rules in HSCA 2012. The normative pillar would enable me to consider the impact of a changing profession. The cognitive-cultural pillar would allow me to consider the impact of local histories and interpretations by individual actors.

However as I attempted to apply Scott's model, I became increasingly dissatisfied with its usefulness in the context of my study. This was for two reasons. The first was that it felt contrived to separate normative and cognitive-cultural forces in this study. The changes affecting the profession were too closely coupled with the processes of local interpretation. I was trying to make a device work for its own sake rather than for the purposes of telling the story of the lives of the GPs in the study. The second reason was that I was increasingly recognising the importance of networks, and the pattern of those networks within and across the three levelled field. The nested nature of my analysis included a landscape of interrelated networks. I needed a way to map the relationships between groups within levels, and across levels. What's more, networks appeared dynamic, forming and reforming, as new rules were enacted. I needed to add networks into the analytic weave.

During the period in which I considered Institutional Theory, I found an article by Jens Beckert *How Do Fields Change? The Interrelations of Institutions, Networks, and Cognition in the Dynamics of Markets*

(2010). Beckert integrated rules, networks, and cognitive frames into one framework. The following section is a critical review of BF, including considerations of how I might contribute to its development.

2.4 Beckert's Framework

Beckert is a German scholar whose academic interest is in the area of economic sociology. In order to better understand the dynamics of markets, Beckert developed a framework predicated on the "irreducibility" of three "structural forces" (p606) – networks, institutions, and cognition. The essence of his hypothesis, in his own words, is:

I argue that networks, institutions, and cognitive frames are irreducible and that one important source of market dynamics stems from their interrelations. The structures lead to the stratification of fields by positioning actors in more or less powerful positions. At the same time, actors gain resources from their position which they can use to influence institutions, network structures, and cognitive frames. To simultaneously consider all three social forces in market fields and their reciprocal influences allows us to consider their interrelations as sources of field dynamics. While it might be useful to distinguish the three structural forces analytically, any approach that does not take into account all the forces influencing action remains necessarily incomplete in its analysis and is in danger of drawing a distorted picture of the embeddedness of economic action and the dynamics of market fields. (Beckert, 2010:p606)

Beckert's was a conceptual rather than an empirical project. His intention was to describe the dynamics within markets, and thus to address the inadequacies of a segmented approach which, he argued, can at best only ever give an obscure picture. A change in one of the forces will lead to changes in the others, forming constant momentum, through a system of mutual influence (p608). In the article, the argument is established through a critique of perspectives that have either focused on or prioritised one of the forces, and thus not explored the dynamics of their mutual

influence. He made his case in two ways. Firstly, he criticised those approaches that focused on one of the structures and thus neglected the others, for example network analysts paid scant regard to the impact of formal institutions; and historical institutionalists and cultural analysts underestimated network structures; structural determinism did not do justice to agency and so on. Secondly, he criticised attempts at integration where the distinct separateness of the structures was lost in the process, for example the integration of cognitive frames into sociological institutionalism had conflated institutions and cognitive frames.

Beckert argued that it is by understanding social networks, institutions, and cognitive frames as individually distinct whilst in a dynamic relationship with an irreducible mutual impact that the “multidimensionality of social structures” (p608) could be understood. It is these interrelations that, Beckert argued, are disrupted and reshaped during times of change. In particular he was interested in how these forces act to both destabilise and stabilise markets as they “emerge, reproduce and change” (p605). In order to make it possible to conceptualise his argument, Beckert used the mechanism of “field” (Bourdieu, 2005, DiMaggio and Powell, 1991, Fligstein, 2001, Fligstein and McAdam, 2012, Lewin). In broad terms, a field was a way to conceptualise a bounded arena of social and occupational interaction “where actors develop mutual expectations with regard to each other’s behaviour” (Beckert, 2010:p609). *Chapter Four: Introduction to the empirical chapters; Castlefield as a “field”* includes a description of the use of “field” in this thesis. Having first presented his ideas in the abstract, Beckert then tested his own concept by considering it in relation to two field-based scenarios. The first was post war German banking and the emergence of shareholder value, where he drew on Beyer and Höpner’s (2003) analysis of changes to capitalist market arrangements. Beckert argued that institutional reforms (new permissions encouraged sell-off of stocks owned by companies), cognitive orientation (towards shareholder value) and changes in

network structures (decoupling of the financial sector with industry and societal concerns) resulted in a changed financial sector, and a dismantling of the arrangements that bound industrial firms, banks and insurance companies together. The second was the transformation of American industry from the use of an expansion model primarily based on vertical integration to one primarily based on diversification, drawing on Fligstein's account (Fligstein, 1990, Fligstein, 1991). A change in cognitive frame (diversification would lead to new markets), institutional changes (The 1950 Celler Kefauver Act made mergers that increased concentration of business lines illegal), and the resulting changes in inter-firm networks resulted in diversification as the main expansion model.

Searches of Scopus (Elsevier) and Web of Science databases (latest access 23rd September 2015) yielded fifty separate citations of Beckert's paper; a clear indication that the framework is attracting scholarly interest. Whilst BF may be gaining traction, it remains relatively new and its limitations and areas for potential development were as yet unidentified.

BF was predicated on the argument that it was essential to eliminate the conflation of cognitive frames, networks, and institutions. If this analytic distinction was core to the framework, then it would be crucial to have clarity on the separate and distinct nature of the categories. Whilst this may be the case, it was an aspect of the framework that Beckert left open for further development. He considered the categories only briefly, each one discussed in one or two paragraphs (p610). Network structures were the spatial relationship between both organisations and individual actors. Institutions were those regulative institutional rules which allowed and supported some behaviours whilst discouraging others. Cognitive frames were ways to mentally organise the social environment, and operated as a source for cue extraction for sensemaking. A further insight was his substitution of the term cognitive frame with "local cultures".

“This understanding of markets as fields encompasses conceptualizations that view markets as realms of interaction structured by institutions or by networks or by local cultures” (Beckert, 2010:p609)

The outline nature of Beckert’s definitions left open an opportunity for subsequent scholars to sharpen them through empirical testing. Beckert’s own application of his framework was at the macro-level of market dynamics. The retrospective nature of the application resulted in a static quality. BF required testing in organisational settings in order that its dynamic nature might be more fully understood.

My next step was to explore if and how the framework had developed since its original publication. Thus far authors of two papers have applied BF empirically. The first application is in *Evolutions in the Literary Field: The co-constructive forces of institutions, cognitions and networks* (Childress, 2011). This was a retrospective application of the framework to a development in the publishing industry. Childress examined the circumstances where Andrew Wiley, the literary agent, launched Odyssey Editions. This caused upheaval and conflict in the publishing world, especially in terms of whether pre-existing publication rights on back titles would still remain with those publishing houses that had rights to hard copy printing. In his use of BF Childress redefined the three analytic categories (p117). Cognition was defined as “evolving roles”. Institutions became “industry wide norms and patterns of belief”. For networks he drew on Granovetter’s (1985) “institutional embeddedness” concept where actors are both socially networked, and atomised and rationally self-interested at the same time. The second application was *A qualitative and quantitative evaluation of the Advancing Quality pay-for-performance programme in the NHS North West* (McDonald et al., 2015). This was a study of the implementation of programme to align financial incentives with hospital performance at 24 hospitals. In this application, recognising the need for analytic clarity, the authors began by defining the

categories. In the original BF the term “social network” (p605) was used to describe the position that organisations and individual actors occupy in a space; the focus being on networks where actors had personal contact, and where conversations could influence decision making. McDonald et al. extended this definition to include networks based on interdependency of function where the actors may well never meet or speak to each other. Beckert’s use of the term “institution” referred to external regulatory and legal frameworks which served to boundary the actions of individuals and organisations. McDonald et al. extended this definition to also include other formal rules such as directives associated with initiatives and policies. The term “institutions” was replaced by “rules” (p16). Beckert’s definition of cognitive frame (the mental organisation of the social environment) was not altered. The application of this adapted version of BF allowed the authors to show that new rules required new network structures, and that these interacted with existing network structures. In terms of cognitive frames, the focus was on what type of activity was required to achieve a shift in the way that people thought. The authors found that shifts in cognitive frames depended on discussions and the opportunity for actors to re-conceptualise. Part of this process was enacted through new networks, such as a collaborative learning events. The effect of emotion on cognitive frame was also explored; supportive emotionally based relationships with colleagues in a parent organisation in the United States were shown to have had a positive impact on confidence of actors implementing the AQ rule, and also the transparent sharing of comparative scores had an emotional impact producing increased levels of motivation to succeed.

Table 1 below summarises the different definitions that have so far been used in BF.

Table 1 Definitions of Beckert's analytic categories

Analytic Category	Beckert (2010)	Childress (2011)	McDonald (2015)
Institution/Rule	External regulatory and legal frameworks which serve to boundary the actions of individuals and organisations.	Changed the definition to "industry wide norms and patterns of belief" more akin with definitions of "cognitive frame" in Beckert and McDonald.	Replaced the term institution with rule, and includes formal policies and directives as well as external regulatory rules.
Cognition/Cognitive Frame	The mental organisation of the social environment, and the way in which actors interpret structures in terms of the implications for their behaviour.	Uses the phrase "evolving roles".	Concurred with Beckert with the addition of emotion as part of interpretive process, not just cognitive schema.
Network	The spatial relationship between both organisations and individual actors. Beckert uses the term "social network", and refers to networks where actors have personal contact.	The socialisation of individuals should be neither over nor under emphasised, rather actors are both socially networked, and atomised and rationally self-interested at the same time.	Extends the definition to include networks based on interdependency of function, where the actors may never meet or speak to each other.

From these early applications it is evident that whilst ever analytic categories remain under defined the framework will be vulnerable to the re-conflation of the categories, the distinction between which is at the core of Beckert's argument. Childress in particular has undermined the framework by replacing Beckert's definition of institution as monitoring and regulatory arrangements, with a behaviourally based concept including "norms and patterns of belief" similar to the normative pillar in Scott's (1995, 2014) model of institutions. For Beckert this would fall within the definition of cognitive frame. McDonald's substitution of "rule" is a helpful clarification, serving to mitigate potential confusion arising from the various uses of "institution" in academic and simple descriptive writing. For the purposes of this thesis, the term "rule" is adopted.

In the above paragraphs I have argued that the usefulness of BF is dependent on the clarity and depth of the definitions of its analytic categories, and have shown how those definitions have been interpreted by subsequent scholars. I have indicated that I intend to

adopt Macdonald et al.'s (2015) definition of institution and to substitute the term "rule". In addition, the definition of "network" to mean spatial relationships based on interdependency of function is one that I will adopt without further adaptation. It is the category "cognitive frame" that I intend to problematise in this thesis, as Beckert's own definition is based on a number of assumptions that require empirical testing. First of these is the assumption that, at times of change, actors follow "social norms" and adopt "how-to" (p610) behaviours in an obedient, uncomplicated manner. Extant evidence suggests that change is met with resistance especially when actors are faced with the requirement to reappraise organisational meaning (Labianca et al., 2000). A further assumption is that consensus exists regarding the direction of field change. In the case of commercial markets it may be the case that all actors concur on the desirability of growth and profitability. However, field changes in markets may not always mean the advancement of profit; and not all fields are profit-driven. Finally there was an assumption that actors will always pursue their own interests, linked to related assumptions that they would know how to do this. Each of these assumptions fall within the category of cognitive frame. BF could usefully be developed by a descriptive definition of this category. My study had the potential to contribute such a definition since my empirical questions (see section 2.2.3) were about the interpretation processes of GPs as they implemented the HSCA 2012.

Having established my aim to make a theoretical contribution in the form of definitional anchorage and clarity to the analytic term cognitive frame in BF, my next step was to locate my starting point for this definition. This is the subject of the next section.

2.5 Cognitive frame and Sensemaking Perspective

2.5.1 Sensemaking, networks and rules

My starting point was Beckert's own limited description. He argued that cognitive frames were rooted in concrete reality (Edelman et al., 1999, Jackson, 2005), that actors used "taken-for-granted" scripts (Meyer and Rowan, 1977) and that these scripts reflected socially anchored cognitions (Dimaggio, 1997). These are however characteristics of a cognitive frame, not active interpretation processes. My aim was to define cognitive frame as a separate force constantly affected by and affecting networks and rules whilst remaining distinct and independent. Whilst Beckert's case examples do not explore the processes connected with the mutability of cognitive frames, he does refer to Weick's sensemaking (Weick, 1995, Weick, 2000, Weick et al., 2005) as a theory which would account for it.

Whilst my primary project is to extend BF, inherent in this is a corresponding contribution to ideas about sensemaking. I begin this by outlining the development and main tenets of the Weickian SP, including its properties, the type of occasions that trigger the process, and what makes sensemaking likely to fail or succeed.

Weickian sensemaking is rooted in the work of earlier scholars. An early contributor was Garfinkel (1967) who used "sensemaking" to describe everyday practices of actors as they interacted, interpreted, and took account of their experiences. Also in the late sixties Polanyi (1967) used related terms of "sensegiving" and "sense-reading" to conceptualise how people gave meaning to the spoken word. Sensemaking was first proposed as a useful theory in organisational studies in the late 1960s (Maitlis and Christianson, 2014) in Weick's *The Social Psychology of Organizing* (1969). In this work sensemaking is described as process of response to often unexpected variations or discontinuities in events. Actors enter recursive cycles of discussion and/or actions in attempts to

determine the right way to respond to and enact the changes that they were experiencing. During the 1960s and 1970s, at the same time as SoP scholars began to challenge functionalist concepts that professions were driven by moral value, the wider sociological context was increasingly emphasising a social constructionist perspective (Berger and Luckmann, 1967), with a corresponding shift to a focus on cognitive processes. This was reflected in SP research as scholars began to focus on cognitive processes. Louis (1980) considered the concept of "surprise" as a violation of expectations that could trigger sensemaking. Kiesler and Sproull (1982) considered how stimuli from the environment were noticed, interpreted, and incorporated. Daft and Weick (1984) and Starbuck and Milliken (1988) considered the effect of "cues" and why some of these were noticed more than others.

It was against this backdrop that Weick published his seminal work *Sensemaking in Organizations* (1995). In it he presents a summary of research to date, drawing on this to propose a sensemaking paradigm consisting of seven properties. These properties together, Weick suggests, enable action in a given context. First, sensemaking is linked to our *identity*. Who we understand ourselves to be, and how we relate to the world around us, is the source of how we make sense of the world. Secondly, for Weick, sensemaking is always *retrospective*. We understand our present experiences according to memories of past experiences, and we draw upon these for causal reasoning and expectations about future events when we are confronted by change. Thirdly, sensemaking is *enacted* and this is limited according to what we are able to perceive as *sensible*. The environment we inhabit, especially how we were socialised, will affect our ability to make sense. Fourthly, sensemaking is a *social process* dependent on the interaction and thought processes of individuals. Fifthly, sensemaking is *ongoing and continuous*; it happens in the midst of events. Sixthly, sensemaking is a process that builds on *cues*. Cues are filtered in a process that Weick calls "bracketing" where some cues are noticed

and others disregarded. We notice cues through sense and perception, and give them cognitive substance by speaking and writing. Seventhly, sensemaking is based on what is *plausible* rather than what is accurate.

In Chapter 4 of *Sensemaking in Organisations* Weick identifies sensemaking triggers in the organisational context. The first of these is *ambiguity*, and the second is *uncertainty*. Weick argues that whilst both act as triggers, the mechanisms are different. Ambiguity creates confusion, a state where there is a lack of clarity and often high complexity. Ambiguity is associated with unclear goals resulting in difficulty in making sensible suppositions. Uncertainty, by contrast, is a state of ignorance (Milliken, 1990) resulting in an inability to predict due to lack of knowledge of other changes (state uncertainty), of impacts (effect uncertainty), or about how others will react (response uncertainty). To remove confusion from ambiguity, agents need clarified information (via social interaction), whilst more information is needed to counter uncertainty.

In their review of organisational sensemaking Maitlis and Christianson (2014) provide an overview of what contributes to successful sensemaking in organisations. Some of these were especially relevant in the context of this study. Sensemaking is successful when actors are motivated to make or adopt changes. This happens most successfully when those leading change have made adaptations in their own roles and can convince others that the proposed changes are of value, acting as collaborative leaders and sensegivers (Denis et al., 1996, Gioia and Chittipeddi, 1991). It is in this way that new organisational order is created, and new strategies become plausible. Sensemaking and sensegiving can fail, and this can compromise the success of a strategic change initiative. In Yu et al.'s (2005) longitudinal study post-merger integration process in a large health care system showed that the senior team became preoccupied with too narrow a set of cues relating to administrative integration and allowed their attention to be distracted from patient care. Nag et al.'s (2007) study of an R&D

organisation showed a failure to adjust to a market-orientation because actors were so attached to the pre-existing organisational identity showing the difficulty in changing an approach to sensemaking. Another reason for failed sensemaking was described in Mantere al.'s (2012). In this study a proposed merger was abandoned after leaders had successfully convinced workers that the change was of value. In this case employees struggled to return to the status quo when the change program was cancelled.

In the study, these sensemaking concepts, and the reasons for successful and failed sensemaking, would provide some of the basis upon which I would derive a definition of "cognitive frame". I would also draw on three important critical reviews of SP that helped identify where my contribution would be positioned. These are discussed in the next section.

2.5.2 Current debates in Sensemaking Perspective

Since Weick first proposed his framework, sensemaking has developed in various directions. My starting point was to understand the current debates in sensemaking literature, specifically its application in organisational studies. My job in this respect was made easier in that three recent papers drew together the latest thinking about the uses, limits, and areas for further development of sensemaking (Brown et al., 2014, Maitlis and Christianson, 2014, Nag et al., 2007, Sandberg and Tsoukas, 2015). Sensemaking literature is far from homogenous. The wide and varied academic interest means that theorising has become fragmented, and it is in response to this that these reviews were undertaken. There is not even agreement on whether sensemaking is a theory, a framework, or a perspective (Maitlis and Christianson, 2014). Already and throughout this thesis I have adopted the term Sensemaking Perspective (SP).

Brown, Colville and Pye (2014) published *Making Sense of Sensemaking in Organization Studies* in the journal *Organization Studies*. These authors aimed to understand the key debates that

“fracture the field” (p1). They based their review on the eight most cited papers with a key word “sensemaking” from the journal *Organization Studies* (Abolafia, 2010, Alvesson and Kärreman, 2001, Bolander and Sandberg, 2013, Brown, 2004, Malsch et al., 2012, Vlaar et al., 2006, Weber and Glynn, 2006, Zilber, 2007). The tensions they identified were fourfold. Firstly, despite Weick’s starting point that sensemaking was social there was no consensus amongst subsequent scholars regarding whether it was a collective process or rooted in individual cognitive schema. Secondly, there was divergence of opinion amongst scholars about whether sensemaking was a routine activity or was confined to times of crisis or puzzlement. Thirdly there was no absolute position on whether sensemaking was always retrospective or could also be a prospective future-orientated process. Finally there was no agreement on whether teams or groups shared understandings. Having identified tensions and inconsistencies in the existing body of literature, the authors suggested areas for further development. The first suggestion was the development of new areas of non-language-based sensemaking including emotion/mood, moral awareness, metaphor, and embodiment. Secondly, the areas of politics and power were currently underdeveloped. Thirdly, the temporal nature of sensemaking including its future orientation was an area for further theorising. Finally, they argued that the SP should be further developed in relation to mundane and ongoing situations rather than one-off and crisis events.

Maitlis and Christianson (2014) published their chapter *Sensemaking in Organisations: taking stock and moving forward* in the *Academy of Management Annals*, which they described as an “overview of the field”. Their analysis was structured to identify areas of difference and debate and then to discuss the implications of tensions in the literature. They observed that in early uses sensemaking was presented as a purely cognitive process in which actors constructed cognitive schemas (Lambert et al., 2000), new schemas (Bingham and Kahl, 2013) or changed interpretive

schemas (Bartunek, 1984). From 2000 sensemaking had been increasingly conceptualised as a social process rooted in language and the creation of shared narratives (Brown et al., 2008, Currie and Brown, 2003, Humphreys and Brown, 2002). The chapter includes a typology of specialised forms including market sensemaking (Kennedy, 2008) and prosocial sensemaking (Grant et al., 2008) amongst others. They concluded by discussing areas where SP is underdeveloped and identify areas for further evolution. These were: sensemaking and its reciprocal relationship with emotion; the temporal nature of sensemaking especially in relation to the lack of scholarly consensus regarding whether sensemaking is continuous or episodic; distributed sensemaking; and wider institutional contexts. They also identified the need for different methods including participant observation, embedded case studies, mixed methods, mathematical modelling, and social network analysis.

Sandberg and Tsoukas published Making sense of the sensemaking perspective: Its constituents, limitations, and opportunities for further development (2015) in the Journal of Organizational Behavior. This was based on a review of papers in nine leading journals in organization and management science. The authors set out to critically review key concepts, to account for gaps at the conceptual level, and to develop SP in a new direction. The authors suggested five key areas in this latter respect. Three were focused on intrinsic concepts of SP. First of the three was the opportunity to challenge the dismissal of the possibility of prospective sensemaking. Second, the notion of “process” remained relatively vague especially in terms of the conflation of the creation and interpretation processes. Third the concept of sense itself was overlooked. The final two related to the nature and range of empirical studies that had been undertaken using SP. First, only a few studies have taken into account wider institutional contexts such as history, culture, and industry. Second, uses of SP have

tended to focus on language and cognition, at the expense of embodied sensemaking, perception, and emotion.

In table 2 below I summarise the scholars' suggestions for developing SP further:

Table 2 Potential areas for the further development of Sensemaking Perspective

	Suggestions for development		
	Sandberg and Tsoukas (2015)	Maitlis and Christianson (2014)	Brown Colville and Pye (2014)
Emotion, moral awareness, and embodied sensemaking	Move from a "cognition and interpretation" emphasis to one that involves non cognitive and tacit knowledge and experience.	The reciprocal relationship between emotion and sensemaking. Sensemaking as an embodied process.	Theorisation of emotion, moral awareness, and embodiment.
Contexts (politics and power, wider contexts), comparisons, and ongoing situations	Larger contexts both institutional and epistemic. Routine decision making in mundane circumstances. Comparisons within and between different types of sensemaking episodes. Distinguish between First Order (workers) and Second Order (managers) sensemaking.	Intersection of institutions and sensemaking. The macro-social structures, including social, cultural, economic and political forces, which can be "collectively enacted". Embedded case studies to be used to capture comparisons across contexts.	Mundane rather than crisis orientated situations. Politics and power. Novel situations, e.g. Virtual environments. Identity and cultural influences within mundane situations, and their effect on collective action.
Distributed sensemaking		Sensemaking as a distributed process, and the creation of collective responses.	How individuals who own different pieces of information are able to construct new meanings.
The process of sensemaking and prospective sensemaking	The separate stages of the process (creation, interpretation, and enactment) removing unhelpful distinctions between the categories. The intra-action of sensegiving and sensemaking, and the importance of anticipation.	The link between sensemaking and innovation, change, and learning and the emergence of "novel accounts". Temporal work in multi-levelled case studies.	

Three of the areas identified have particular relevance at the intersection of SP and BF, and act as analytic co-ordinates for the development of a definition of cognitive frame in this thesis.

First of these is contexts. All of the reviewers identify wider institutional contexts and more mundane routine situations as an

area for further development. At the same time, the macro-level focus of the extant BF is lacking a dimension to explain interpretation and enactment. From here on in, I use the term “wider contexts” to label this area.

The second is the temporal aspects of sensemaking, including prospective sensemaking, which was identified in two of the three reviews of SP. Maitless and Christianson (2014) specifically identified temporal work in multi-levelled case-studies. From the Medical Sociology literature I had identified history and legacy as important factors in how doctors’ interpreted their roles. From here on in, I use the term “temporality” to label this area.

The third is distributed sensemaking, which is identified in two of the three reviews. I have already discussed the importance in my data of the spatial relationships of actors in the form of networks. Networks are the landscape in which multiple actors engage in distributed sensemaking. Understanding the mechanisms associated with this would form a contribution to BF and the interface with SP. From here on in, I use the term “distributed sensemaking” to label this area.

My three analytic co-ordinates were thus decided, and were to be: *wider contexts*, *temporality*, and *distributed sensemaking*. In sections 2.5.3 -2.5.5 I consider each of these areas in turn. Even though I will consider each separately, in practice they intermesh and overlap. For instance a wider context by definition is likely to involve greater numbers of actors, who will in turn be distributed within that context.

2.5.3 Wider contexts

BF was developed in relation to the mechanism of markets at the macro-level. By contrast, sensemaking literature has for the most part been focused on individuals and their action during time-limited events. This focus was often further narrowed to unexpected crisis events. In the words of Weber and Glynn (2006)

"This theoretical distance may be related to criticisms of sensemaking that claim the theory overlooks the role of larger social, historical or institutional contexts in explaining cognition. As a theory of seemingly local practice, sensemaking appears to neglect, or at least lack an explicit account of, the embeddedness of sensemaking in social space and time." (Weber and Glynn, 2006:1639)

Despite Weber and Glynn making this argument nearly ten years prior to this thesis, this continues to be an area identified for further development in the recent reviews.

There are earlier studies that use a multi-levelled approach. Kaplan and Orlikowski (2013) studied five simultaneous strategy projects in one organisation facing a crisis in its industry, and Maitlis (2005) studied three different British symphony orchestras to identify four forms of sensemaking: guided; fragmented; restricted; and minimal. Balogun and Johnson (2004) considered the impact of large scale one-off planned change initiatives. There remains, however, an absence of studies that examine sensemaking across operational and strategic functions in single or multi-organisational context.

It is because the process of sensemaking is located in the individual in the extant literature that sensemaking in wider contexts has not been problematised. In wider contexts actors are organised in a networked distribution. A major study of networks in healthcare (Ferlie et al., 2010) contributed a typology of networks (p.143-145) which identified that these vary in: complexity of context; whether they are mandated, hybrid, or organic; the level of resources; the degree of formality (including formal roles); the number and diversity of stakeholders; and the extent to which they could access process and management support. Furthermore these networks were overlapping and interlocking, each with a pattern of political and professional affiliations. This was an important dimension where change initiatives take place in the context of an industry with its own legacies and embedded culture (Coleman et al., 2010, Segar et al., 2014).

Using Beckert's argument, rule change and networks go alongside sensemaking. Putting these concepts together would enable me to contribute ideas about sensemaking in wider contexts. Maitlis and Christianson (2014) identified that there are sensemaking "forms" (for their full list see appendix 2). For the purposes of this thesis, I replace "form" with "type" to avoid confusion with Maitlis's (2005) use of the term form to differentiate four distinct social processes of organisational sensemaking ("guided, fragmented, minimal, and restricted"). Actors in the NHS have developed a prosocial type (Grant et al., 2008) with a shared expectation that actors will take care of each other and each other's interests. One of the new rules contained in HSCA 2012 was a requirement to adopt competitive approaches to the procurement of healthcare, which implied a change in inter-organisational relationships to mirror a competitive market with winners and losers (Kennedy, 2008). Jones et al. (2013) argue that this requirement to operate a market triggered coping strategies rather than a full adoption of competitive behaviours. One way that this can potentially be understood is to use the concept of sensemaking type, and to explore what happens when new rules create ambiguity and/or confusion regarding how actors should respond. The concept of sensemaking type can also be used to add to understanding about the dynamics between actors when representatives of multiple organisations, with multiple sensemaking types, are required by rules to work together. Using a concept of sensemaking type(s) manifested in networks at times of rule change was a way to both explore sensemaking in wider contexts and to add description to Beckert's category cognitive frame.

2.5.4 Temporality

In Weick's model sensemaking was always retrospective, and related to the process of cue extraction. Actors extracted cues from the environment as a precursor to creating a version of sense. Sense was only made when the cues had been reflected on, and the

version of sense implied was considered to be plausible. This plausibility, in Weickian sensemaking, had to be in place before enactment could take place. It was this act of reflection prior to enactment that caused Weick to describe sensemaking as always a retrospective process. For Weick sensemaking was a recursive activity; an “infinite stream of events and inputs that surround any organizational actor” (Weick et al., 2005:p411) akin to the “redrafting of an emerging story”(Weick et al., 2005:p415). This concept of an evolving story was central for those scholars who see sensemaking as a process of language and narration. In contrast, others have argued that sensemaking can be future-oriented (Gephart et al., 2010, Kaplan and Orlikowski, 2013). Gephart in particular, in the ethno-methodological school, argued that in sensemaking is a continuous process without beginning or end and that the past, present, and future were considered simultaneously (2010).

These positions each reflect the tendency towards a micro-level focus of the extant SP literature. Processes of reflection, for example, must be located at the level of an individual or a small group. In this thesis, sensemaking is an active process in a dynamic relationship with networks and rules; it is located in a wider context discussed in 2.5.3 above. This has implications for the temporal nature of the sensemaking process. In a wider context, where actors are distributed across levels and networks, the enactment of day to day business involves sensemaking over longer time periods. In BF, the simplistic assumption that actors follow “cognitive ‘how-to’ rules” (Beckert, 2010:p617) implies that past experience provides a blueprint for future action. If and how this works as a sensemaking mechanism alongside networks and rules is something I intend to problematise in this thesis.

NHS workers share an embedded shared history; historical continuity is a feature of organisational culture (Segar et al., 2014). In wider contexts, such as the commissioning field in this study, there is an opportunity to test the impact of legacies on

sensemaking. In the data legacies appeared to impact on future-orientated sensemaking, and this in turn appeared to be linked to the mood that the network adopted in response to new rules. There is evidence to support mood as both shared and contagious (Barsade, 2002). Legacies impacted on levels of optimism, pessimism, or anxiety across whole networks. SP scholars have increasingly emphasised the importance of emotion (Maitlis et al., 2013), which has become a widening research area (Gioia and Thomas, 1996, Huy, 2002, Kiefer, 2005, LÜScher and Lewis, 2008, Maitlis, 2005, Maitlis and Sonenshein, 2010, Sanchez-Burks and Huy, 2009, Vince and Broussine, 1996). In organisational studies SP literature the focus has tended to be on negative emotion and the impact on resistance to change. Brown and Starkey (2000), for example, have argued that at times of organisational change sensemaking was based on the defence mechanisms of actors, and these had an important emotional element being triggered when people felt threatened. There has been a study that challenges this, questioning the validity of labelling negativity at times of change as emotional. Balogun et al. (2010) problematised the term “resistance” and questioned why it was used. Their findings suggested that some emotions were seen as acceptable (for example commitment, enthusiasm, the emotional repertoire of quality, innovation) and others were seen as unacceptable.

This thesis does not include an examination of the impact of emotion per se, but it is a necessary factor to consider when exploring the impact of legacies, future-orientation, and the nature of resistance, all of which are features in the empirical chapters and discussions. By exploring the link between sensemaking, legacies and anticipated futures within a distributed networked field, I aim to draw out the underlying influences on the dynamics of field change across a multi-levelled environment.

2.5.5 Distributed sensemaking

Sensemaking in wider contexts and distributed sensemaking are directly related concepts. Distributed sensemaking remains an under-developed and under-theorised area, with existing studies (Fisher et al., 2012, Kendra and Wachtendorf, 2006, Stigliani and Ravasi, 2012) tending to conceptualise it as a language-based, cognitive process, again linked to one-off situations, and where the distribution is of a number of individual actors. In a discussion of sensemaking and complexity, Weick uses an unexpected outbreak of disease in the West Nile (Weick, 2005) to identify the circumstances in which different actors held pieces of information which only made sense when put together (in this case in the form of the correct diagnosis of the disease). Distributed sensemaking has therefore been conceptualised as the process of bringing together individuals each of whom holds a different slice of information.

By linking the concept of distributed sensemaking and BF it is possible to explore how sensemaking happens in wider contexts with multiple networks. The concept of distributed sensemaking is a potential tool by which to explore how tensions within and between sensemaking types in networks affect collective action. SP literature has tended to be focused on the impact of senior leaders (Gioia and Thomas, 1996, Gioia et al., 1994). Gioia and Chittipeddi (1991) used the term "sensegiving" when describing a linear process in which senior managers directed others through stages of envisioning, signalling, revisioning and energising. Scholars have recently broadened the scope to consider the impact of middle managers. (Balogun and Johnson, 2004, Balogun and Johnson, 2005, Huy, 2002) describing their role in mediating between top managers and employees on the frontline to affect both cognitions and actions (Maitlis and Sonenshein, 2010). Lockett et al (2014) have argued that it is more than a position in a hierarchy that makes for an effective sensegiver; social status and social capital are also likely to be important. Maitlis and Christianson (2014)

included a summary of sensemaking concepts which include: sense-breaking (Pratt, 2000:p464, Vlaar et al., 2008), sense-demanding (Vlaar et al., 2008, Weick, 1969:p40), sense-exchanging (Ran and Golden, 2011:p421), and sense-hiding (Monin et al., 2013:p262, Vaara and Monin, 2010:p6). Given that SP has tended to have been applied at the micro level, then these concepts also have been developed in relation to that level. Change that affects a field with many actors distributed in multiple networks needs to be managed and organised. It is likely that in this wider context approaches to sensemaking will be different from those used in micro-level contexts and/or one-off events.

Organisational development (OD) is important in the enactment of rule change in networks. OD has been described as “a system wide application and transfer of behavioural science knowledge to the planned development, improvement, and reinforcement of the strategies, structures, and processes that lead to organization effectiveness” (Cummings and Worley, 2009:1-2). Sensemaking scholars have written about OD in relation to planned large scale change initiatives (Bartunek et al., 2011). OD techniques are commonly used by public sector organisations, and by studying how OD is used in a longitudinal multi-levelled change it will be possible to explore its impact on a distributed pattern of actors.

Sensemaking in a wider context is organised in networks. Are patterns of distribution apparent? What approaches to sensemaking employed in a distributed wider context? What are the implications of this for existing concepts of sensemaking? These are issues that I explore further during this thesis.

2.6 Conclusion: research questions

Section 2.2.3 sets out the first research question:

- Why and how did GPs enact their commissioning duties in the ways that they did?

This question was overarching, with two constituent dimensions derived from SoP and Medical Sociology literatures. These were: *changes to the profession*; and *history and legacy*. These formed two thematic codes in data analysis as described in detail in *Chapter 3: Methodology and Methods*.

In order to theorise this empirical question, I intend to use BF in combination with Weick's SP. This is incorporated into the thesis as a second overarching question:

- How does sensemaking influence field change within the context of networks and rules?

In addressing this second question, I aim to contribute a descriptive definition of the analytic category cognitive frame in BF. In order to do this I conceptualise sensemaking in a dynamic relationship with networks and rules. I explore this relationship using three analytic co-ordinates: *wider contexts*, *temporality*, and *distributed sensemaking*.

The next chapter is a consideration of the methodology and methods used to address these research questions.

Chapter Three: Methodology and Methods

3.1 Introduction

I graduated from Sheffield University in 1985 with a degree in English Literature. I have always had a love of stories since my English literature days, and have built many of my work techniques on drama, narrative, characterisation, and plot. Ellis and Böchner (1996:p18) describe the researcher as “storyteller” using “narrative strategies to transport readers into experiences and make them feel as well as think”. During the writing of this thesis I aimed to present my data in such a way that it would tell a story. I wanted the study to be useful, and this firstly meant understandable to the people it would affect. Ellis and Böchner (1996:p28) describe the need to “not only to write about [people who work in health services] but to write *to* them as well”.

The empirical fieldwork was undertaken as an attachment to a CCG which was a direct descendent of a Health Authority where I was director of commissioning almost fifteen years ago. There were potential pitfalls arising from my recent NHS past especially with regard to bias. I would need to address this issue upfront and seriously if my conclusions were to be considered valid. The study for me was a personal journey, during which I learned about my own reasons and reasoning; emotions and preferences, and values and prejudices. I learned how to reflect upon these in order to understand how they affect my relationship to and interpretation of the world. Related to this was my decision to use the first person where it felt natural to do so. After all “my subjectivity [is] the basis for the story I [am] able to tell” (Glesne and Peshkin, 1992:p104). It was crucial that this subjectivity was a declared and examined one, helping to produce a “thick description” of NHS commissioning (Geertz, 1973). I have endeavoured to use my past experience to enhance quality along the lines described by Easterby-Smith who

argued that “proximity to the life worlds of those studied” is a measure of quality in qualitative research (2008:p423).

In response to a CLAHRC advertisement for a PhD to look at Commissioning and Mental Health I submitted a research proposal to examine how commissioning addressed the needs of vulnerable people. At the outset I thought of the project as a way to help solve a practice problem, with little understanding of what a PhD really involved, and with scant awareness of what a “theoretical contribution” comprised. I wanted to explore how the multiple levels of organisation of commissioning in the NHS affected how services delivered to vulnerable people. I had left a job as a primary care trust Chief Executive in 2003 as a consequence of taking up carer responsibilities, and had negotiated a move into the local mental health trust. During my time in the trust I had been struck by the degree of frustration expressed by psychiatric staff regarding referrals and care undertaken by GPs. I realised from my own experience as a primary care manager that this seeming lack of understanding of mental health was linked to the case-mix of patients that presented in GP surgeries. My informed impression was that GPs managed a complex clinical environment with a skew towards caring for elderly people and children. As I thought more about this complexity I increasingly felt it was important to try and unpack how it affected clinical practice, specifically the treatment and care of vulnerable people. Rather than use the labels mental illness or mental health I used the term “vulnerable” in order to encompass those dimensions that might not be technically classed as illness such as addiction, behavioural and personality disorders, and low level coping problems which were a significant population as far as the GPs were concerned.

The first empirical research decision I made was to conceptualise GP commissioning as being at three levels. In this way I would be able to separate GPs as referrers, as service planners, and as partners in inter-agency arrangements. These levels formed the basis of the nested case study that I eventually conducted. As already outlined

in *Chapter Two: Literature Review*, the focus of my study shifted as my immersion into the field deepened, and data analysis began to yield early findings. There were several pivotal research decisions that were made as the study evolved, and without exception in all of these theorising and analysis were intertwined.

This chapter is an account of the methodology and methods of the study. Silverman says that the most important question any researcher should ask is “what kind of focus on my topic do I want to achieve?” (Silverman, 2010:p13). The focus here was twofold. The first aim would be a contribution to the generation of theory (Eisenhardt, 1989). A second aim was to produce knowledge out of this theorising which would be useful and relevant in the world of practice and policy. Methodology and methods would need to support these aims.

3.2 Choosing a methodology and methods

Before I made my methodological choices, the core philosophical issue of how to approach the production of meaning and knowledge needed to be confronted. Was I a realist, or an interpretivist, or somewhere between the two? (Cunliffe, 2011, Hammersley, 1992, Morgan and Smircich, 1980).

During my studies of English literature and subsequent lifelong reading I had been particularly interested in point of view, and how individuals construct different versions of the same events. Works such as *Ulysses* (Joyce, 1998), *To the Lighthouse* (Woolf, 2000), and *A Chain of Voices* (Brink 1983) are not so much stories as a sequence of perspectives about the same events or locations seen from different vantage points. People interpret and construct meanings all the time, but, for me, this does not extend to a pure relativism where the world only exists because human beings are here to interpret it. Martyn Hammersley wrote on this problem:

“Faced with this apparent contradiction within ethnography, there are two obvious candidate solutions: to apply either realism or

relativism consistently across the board, to both ethnographic method and to the social life that is studied....neither of these is satisfactory.” (Hammersley, 1992:p45)

He continued to make the point, linking it to purpose:

“If it is true that what ethnographers produce is simply one version of the world, true (at best) only in its own terms, what value can it have?.....In the words of one of the advocates of anti-realism, we may have to conclude that “there are as many realities as there are persons” (Smith John, 1984). If this is so, what is the point in spawning yet more versions of “reality”, especially given the relative costs of ethnography compared with, say, armchair reflection?” (Hammersley, 1992:p49)

Given that one of my aims was to have practical application of my findings in the real world, I needed an ontology that allowed for a real world in the first place. Pawson and Tilley recognised that the positivist-interpretivist polarity was too bluntly drawn, and that concepts of realism can be developed to position between the two ends (1997:p55). Miles, Huberman and Sabaña (2013), whom I drew on for data analysis, also recognised this problem. They believed that social phenomena exist not only in the mind, but also in the world, and that it is possible to examine these social phenomena to find reasonably stable relationships amongst the messiness of human interaction. It is possible to identify sequences and patterns that can be described as the underpinning constructs. They describe their epistemological position in the paragraphs below:

“We label ourselves *pragmatic realists*. We believe that social phenomena exist not only in the mind but also in the world – and that some reasonably stable relationships can be found among the idiosyncratic messiness of life. There are regularities and sequences that link together phenomena. From these patterns, we can derive the constructs that underlie individual and social life. The fact that most of these constructs are invisible to the human eye does not make them invalid. After all, we all are surrounded by lawful physical mechanisms of which we’re, at most, remotely aware.....

“.....Our tests do not use the deductive logic of classical positivism. Rather, our explanations flow from an account of how

differing structures produced the events we observed. We want to account for events, rather than simply document their sequence. We look for an individual or a social process, a mechanism, or a structure at the core of events that can be captured to provide a causal description of the most likely forces at work.” (Miles et al., 2013:p6)

Hammersley also shared these views, based on the acceptance that people constantly interpret, but also that their interpretations reflect real and potentially shared experience. He developed a concept of “subtle realism” (1992:p51-54). The word “subtle” differs from “pragmatic” in that he emphasised the need for detailed checking and triangulation of information. I determined to share Hammersley’s position and adopt a “subtle realist” point of view.

So, having determined my ontological and epistemological position, my next choice was the methodology I would employ. There were several main influences on this. Firstly, my former working life needed to be central, especially in regard to its effect on my study. Secondly, pragmatically, I had pre-existing friendships and networks upon which I could draw not least of all in regard to access to study sites. This needed to be turned to methodological advantage as I had a unique opportunity to occupy, as researcher, the world I previously lived in as manager. Thirdly, the methodology should allow for a realist ontology whilst accepting that individual perspectives and interpretations were important as was the case in subtle realism. Taking these facts together, and based on descriptions of what qualitative methods work best for which type of situation (Creswell, 2007, Creswell, 2009, Cunliffe, 2011, Glaser and Strauss, 1967, Glesne and Peshkin, 1992, Hammersley, 2012, Silverman, 2010, Thorpe and Holt, 2008), my decision was to combine CSR with an ethnographic data collection strategy. CSR would allow me to exploit my advantage in terms of access, and ethnography provided a framework for me to be reflexive, and to participate as I observed the field in order to tell its story. Each of these elements is discussed further below.

3.2.1 Case Study Research methodology

As already explained in *Chapter One: Introduction*, I think of GP-commissioning as happening at three levels. I designed my fieldwork to enable observation at and across these levels.

CSR methodology is designed to study a specific area in-depth, and to describe and explain the case in its present day context by investigating a number of dimensions, over a certain period of time, and through a number of methods (Gomm and Hammersley, 2000). This could not be achieved through a historical investigation, since contemporary events were the focus of interest (Yin, 2009:p11). CSR was compatible with ethnography, specifically participant ethnography, which is discussed in the next section.

The choice of CSR methodology was on theoretical rather than representational grounds. Even at the point of deciding to use CSR I was conscious that issues of generalisability of the findings were likely to be raised. Miles, Huberman, and Saldaña emphasise that case studies are about the minute detail and the story that it tells:

“Because case study researchers examine intact settings in such minute detail, they know all too well that each setting has a few properties it shares with *many* others, some properties it shares with *some* others, and some properties it shares with *no* others.”
(Miles et al., 2013:p34)

Later in section 3.3, I describe how I made the decision to use a single case study and the implications of this for generalisability of my findings and conclusions.

3.2.2 Ethnography and reflexivity

Having decided to undertake a case study, the next decision was about the design and conduct of data collection. Scholz and Tietje (2002:p241) described the “experiential case encounter” where the researcher participates in the case. My past as a manager made it inevitable that my own history, opinions, and emotions would be present, so my data collection strategy needed to take this into

account and to turn it to advantage. Michael Agar in *The Professional Stranger* says:

"New issues abound, but they still boil down to the same old problem of one human being trying to figure out what some other humans are up to"(Agar, 1996:p2)

He went on to use the term "halfie" anthropologist (Agar, 1996:p21, Fox, 1991) to describe the state of being half a researcher and half a part of the world being studied. All ethnographers find themselves in this position to some extent, but for me I was also part of the history of the world I was about to study. I had to learn to practice the art of de-familiarising myself with a familiar world. Wolcott says:

"We console ourselves that where ethnographers once sought to make the strange familiar, today's ethnographer more often needs to make the familiar strange" Wolcott (2010:p96)

An advantage of using ethnographic methods was that I could embrace and examine this familiarity, whilst at the same time developing distance as I consciously identified and reflected upon my subjectivities. Agar (1996:p7) described this as "the paradox of professional distance and personal involvement". It would also give me a way to handle the divisions I would feel within myself. I would be returning to a territory I had left behind and to some extent felt rejected from, personal feelings would emerge, creating a tension between the professional researcher on the one hand, and the personal ex-NHS manager on the other. This division of self was described by Bott (2010) in relation to her research on time-share selling and lap dance clubs.

"What I had not anticipated beforehand, nor fully appreciated during data collection, was the sensation of being so divided between my 'personal' and 'professional' 'selves'; only on reflection do I really recognize the significance of the divide.(Bott, 2010:p170)

"Who are you to do this?" asks Agar (1996:p91-103) warning that "Ethnography is really quite an arrogant enterprise". In practice, and especially to start with, I found this thinking about myself a

difficult thing to do. It felt self-indulgent and ego-based. As an NHS manager the "I" is buried. Managers strive to the "we" or the "it". There are exceptions to this, but in the most part they aim to promote standardisation and compliance. Reflexively I recognised this in myself, ironically noticing that this was a key component in why I found reflexivity itself to be counter-intuitive. In the end I realised how crucial it was; if I could not escape being a "halfie" then I would exploit it, and build it centrally and absolutely into my approach.

As an ethnographer it was appropriate to employ both participant and direct observation, augmented by other methods. A happy coincidence of participation was that my empirical work would be enjoyable, possibly even therapeutic. I had found leaving the NHS difficult as well as freeing. Denzin (1997:p.xiv) describes ethnography as a "moral, allegorical, and therapeutic project", and I began to see how this could be so for me. Ethnography would allow me to construct a version of events which included my personal examined self.

"When ethnographers like me make texts, try as we may to report and represent accurately, we necessarily invent and construct the cultures we write about. We cannot help but read something into what is there, because we are there with it" (Ellis and Bochner, 1996:p20)

This would be built into the design and process of the study. I would talk to people along the way, share texts, and let them help me find ways to control my opinions. Essentially my study would be a reflexive exercise that would result in a story (Agar, 1996:p17). Auto ethnographic vignettes could be used to increase "representational richness" (Humphreys, 2005:p840). Agar's *The Professional Stranger* was updated in 1996 to include a new chapter describing how ethnography had changed since its first publication in 1980. He distinguishes between old "encyclopaedic" ethnography" and newer "narrative" ethnography based much more on telling stories (Agar, 1996:p9). Agar metaphorically described the old as a

disc floating above whereas the new was like picks on a guitar. Like a piece of music a narrative ethnography depended on showing where the links are in such a way that those who read it feel something “snaps some connection together” (Agar, 1996:p15). I decided to use ethnographic methods with the intention of writing a narrative ethnography which would help practitioners “snap connections together” as they enacted their day to day working roles.

3.2.3 Why not quantitative methods?

My study uses qualitative methods only. I did consider whether a quantitative dimension would enhance my analysis, but in the end concluded that this would not be the case. Because I already knew from my life in practice that GPs contained their language and emotions as a result of the potential for others, especially patients, to give heightened significance to their messages, I knew that data would exist in the realms of the tacit, inferred, and even absent. In order to understand the impact of the commissioning role on these doctors it would be necessary to look in depth at how they used cues to make sense of the continual changing context of events, policies, and expectations (Weick, 1995) in order to develop a shared understanding of their context. The implication of this for my study was that I would be seeing the formation of meanings as they emerged. This was not a basis for “systematic and standardised comparisons and in accounting for variance” (Silverman, 2010:p13). The material did not lend itself to the testing of structured hypotheses, or the relationships between defined variables. The aim of the study was not, for example, to compare the spending plans CCG one, two, and three, or to explore the co-variance of two forms of HWB as they set priorities. Rather it was an exploration of a developing area, with an eye to how individual histories and motivations affected the enactment of new commissioning roles. The data simply would not be amenable to quantitative analysis. Further, the field included such a variety of individuals, groups, and

agencies, that it would be impossible to determine sample frames and strategies (Silverman, 2010).

3.3 Study Design

3.3.1 Overview

In this section I describe the initial design work prior to entering the fieldwork site. In practice, the study continued to be designed as empirical findings emerged and the theoretical framework was refined. The key text I used to guide the design was Yin's *Case Study Research, Design and Methods* (2009). Yin's intention when writing the book was to enable case study researchers to apply rigour in order that their findings and conclusions could be credited with increased validity.

At the initial design stage, my research questions were derived from SIT and were designed to interrogate the topic identified in my initial research proposal, which was the commissioning of services for vulnerable people. I wanted to investigate the pattern of complementary and conflicting interests between GPs and others. I expected to find that GPs were putting their own interests before those of patients, and that this would be explained as a structural phenomenon. Using SIT as my heuristic, I investigated my predictions which were, in fact, proved to be wrong in the early stages of analysis.

3.3.2 Case Selection

Before embarking on the detail of my study design, first I had to decide what my "case" would be. I had various options available to me. I could undertake a single case study at a large urban CCG. I could attempt to compare cases by studying two (or more) large urban CCGs. Finally I could study a geography of one large urban and several smaller suburban and rural CCGs. Table 3 below presents the detailed considerations prior to decision. It should be

acknowledged that, in truth, serendipity played its part (Wolcott, 2010:p44-65).

Table 3 Site selection considerations

Site Configuration	Research Design Implications
Single large urban CCG with boundaries coterminous with local authority	Feasible to observe across all three levels of commissioning. Single LA for HWB, eliminating potential blocks to access due to councillors' reluctance to be compared with another area. Minimal travelling time between sites allowing increased focus on data collection. Organisations had retained the same boundaries through reorganisation, minimising organisational flux, thus allowing stable opportunities for observations. CCG and LA were keen to host the research. This had been tested with an inter-agency executive level group who had given in principle agreement to the study at the point the PhD was commenced. Concerns about generalisability would be raised by the research community and might affect chances of publication. This could be countered by arguments about richness and quality of data. Reflexivity would need to be built in as core to design, due to previous roles held in the organisation.
Two large Urban CCGs	Still feasible to observe across all three levels of commissioning, but range and amount of observation in each site would be reduced. Data collection time would be reduced due to need to build networks across two areas, and increased need for travel. Findings would include comparisons, increasing strength for generalisability. Whilst links existed between the 2 CCGs, working relationships between the LAs were competitive and distant. Permissions to draw comparisons between LAs are difficult to negotiate due to political sensitivities. Reflexivity would be more complex as I had different levels of knowledge, relationships, and prior experience in each area. There was little enthusiasm from potential host site for expanding the scope of the study from my main host site.
One Urban CCGs; and 7 (or sample <7) small suburban and rural CCGs	Impractical to observe across all three levels as a single handed PhD researcher. Data collection time would be severely compromised due to need to build networks across two areas, and increased need for travel. Findings would include comparisons, increasing strength for generalisability. The sites would stretch across two second tier local authorities- one Conservative, one Labour – there was an expressed reluctance to have comparisons drawn. Reflexivity would potentially be more interesting, but also more complex as I had different levels of knowledge, relationships, and prior experience in each area, including having previously held a Director role on the patch. There was little enthusiasm for expanding the scope of the study from my main host site.

I was conscious that as a PhD researcher, I would be single-handed. Feasibility was a legitimate concern, and I knew that to secure the best chance of seeing across all three levels of the commissioning spectrum would depend on having good day to day relationships with participants and becoming part of the team. When weighing the factors shown in table 3, it was clear that the most appropriate and practically feasible option was the single site case study in an

urban area, mainly because it would give the best quality of data across the multi-levelled field (Yin, 2009:p47). Being split over multiple sites would mitigate against this. This did however raise an important concern regarding generalisability. Would just looking in one place give me data with sufficient power to extrapolate messages with wider applicability? The critical points to balance were multiple sites for comparison, or a single site for depth of analysis. I concluded that "thoroughness of its analysis" would be the best strategy for validity (Radnor, 2002:p40). In any case a sample of a few would be unlikely to be representative of others (Stake, 1995:p4), leaving me still with the issue of generalisability but with data quality also compromised. The perspective of MacLean et al. is that "the real issue is not that of generalisability but that of transfer" (2002:p202), and the best way for me to produce transferable knowledge was to make it the best it could be. I also drew from the ethnographers on this issue. Wolcott described his supervisor's reaction to one of his early attempts:

"By page 31, Spindler had seen enough generalisations. He started changing my every use of the word "they" to "he" to try to get me back on track. But reading half a page later he gave up on that approach and issued a directive in the margin: "Don't generalize. The heart of ethnography is singularity" (Wolcott, 2010:p17)

I would best discover the state of commissioning through observing its specifics in depth. As Wolcott continued:

"The argument for comparison is the belief that it can make a study stronger or more "scientific". What tends to happen instead is that those larger Ns serve as denominators: they reduce the time that can be devoted to each individual case. If you do three "little" cases, each one will get one-third as much attention as the one might have had if you had focused exclusively on it. That's okay if you want to look for a range of possible practices – but there goes context, for you are likely to find that you are doing little more than conducting a small survey (and let me assure you that ethnography is a very inefficient way to conduct a survey!) (Wolcott, 2010:p98)

It would seem reasonable therefore that insights could be used to extrapolate theory if I ensured my methods were detailed and

thorough. I opted for a single site and began to negotiate access. Having said all this, it is still likely that the single case nature of the study could be considered a limitation. In addition to the methodological arguments for the power of in-depth cases described above, I return to this theme in my conclusions chapter by critically reviewing my own conclusions as to validity and generalisability.

3.3.3 Protocol design and approval, including research ethics

A main building block of Yin's (2009) CSR is the creation of a comprehensive and precise study protocol, which gives clarity on what would happen in what timeframe. The protocol effectively delimits the study by setting boundaries across four parameters: the setting, the actors, the events, and the processes (Miles and Huberman, 1994).

The protocol for this study, included a description of the single site case and its three levels. It included provision for additional data to be collected in the seven neighbouring rural/suburban CCGs, two local authorities, the mental health trust, and the community services provider, and other local non-statutory partner organisations. It delimited the study time period to eighteen months from October 2012 to April 2014. This was subsequently extended to the end of September 2014. A variety of data collection strategies were included. Based broadly on Stake's (1995) embedded case study model, where embedded means a number of methods used in a single case study, the proposed methods included participant and direct observations; a personal reflexive journal, and fieldnotes; interviews including unstructured, semi-structured and focused; and document analysis. At the time the protocol was written thirty to fifty participants were anticipated. In the end sixty-one signed consent forms were filed for observations, and a further twelve for interviews.

The protocol was the document upon which university sponsorship and business school research ethics committee approval was based. In addition NHS Research and Development approval was secured.

In addition to outlining the parameters of the field work, the protocol also described arrangements to ensure the research was conducted to expected ethical standards. *Participant Information Sheets* (PIS) were included for approval. There were two versions: one for observations, and one for interviews and focus groups. Outlined in the PIS were the aims, scope, status, and time period of the study. It explained that the participant had been invited to take part because they had a role in commissioning, that participation was entirely voluntary, and that it was possible to withdraw from the study at any time, although data already collected would not be erased. It described what participation entailed, and clarified that there would be no payment as the study would take place during normal working hours. It indicated that the CCG had given its support for the study to take place, and gave assurance that reporting would be anonymised, that the site would not be identified, and that information would be kept confidentially. It described arrangements for encrypting and password protecting electronic data. Only I, the Chief Investigator, and regulatory authorities would have access to the data, all of whom were bound by a commitment to confidentiality. Personal data would be retained for three months following completion of the study. Other data would be kept securely for seven years. Reports and published literature would be shared with participants in order that there should be a chance to assess its accuracy and value. Finally, it included details of a CCG contact from whom further information could be obtained, or to whom complaints could be addressed. If an individual agreed to participate then consent was obtained via *Informed Consent Forms* (ICF). Like the PIS there were two versions of ICFs included in the protocol; one for observations, and one for interviews and focus groups. Duplicates were signed by both myself, and the participant, each retaining a copy for our records. Once consent was attained, the participant's name was entered on a register which was kept securely, and a pseudonym was assigned.

3.3.4 A developing theoretical framework

The pre-agreed protocol included broad details of the process of data collection, and how this would be timetabled. In practice the stages of the study were identified and structured in an iterative fashion as themes and opportunities for participation and observation began to emerge. The initial research questions operated as an outline conceptual framework which developed in an emic, abductive manner. The research focus and questions became honed and progressively inductive through a series of abductive shifts. This is what is sometimes called “progressive focusing” (Parlett and Hamilton, 1976, Scholz and Tietje, 2002, Stake, 1995:p9). Sometimes a funnel metaphor is used, to describe how an initial openness of approach is gradually narrowed as the emerging picture begins to take shape (Agar, 1996:p7). In his book *Case Study Research* Yin (2009:p130) emphasises that research design should “follow the theoretical propositions that led to the case study”. At the design stage, I followed this principle and, as described above, developed a protocol based on SIT. As my observations and analysis progressed I realised that an adjustment of my theoretical framework was indicated, as is very common in grounded ethnographic studies. Before describing the details of my fieldwork and data analysis in sections 3.4 and 3.5 below, in the following paragraphs I describe how the theoretical focus and related design of the research developed.

As already described above, the initial research proposal was to investigate the commissioning of services for vulnerable people, and by the time I had produced my first literature view in May 2013, I had determined to do this by using SIT. At the point I produced my first methodology and methods chapter in May 2014, I was seven months into my field work and was observing, analysing, and writing in a recursive process. By this point, as insights from the data began to be harvested, it was becoming increasingly apparent that a structural differentiation of patients, managers, and doctors

did not correspond with findings. Furthermore such an analysis would hinder the telling of the story that was beginning to be revealed. As will be explained in more detail in section 3.5, differences in the SIT categories of dominance, challenge, and repression could just as easily exist between groups of GPs as between GPs and managers. My initial expectation that I would find evidence relating to the repression of the interests of vulnerable people gave way to a more subtle and nuanced questioning strategy relating to the experience and action of GPs as they undertook their commissioning role. Although in the end I relocated my contribution to BF at the interface of SP, nevertheless, the SIT phase study was pivotally important in the identification of field dynamics.

The approach I used was increasingly emic, allowing theory to emerge from the data using grounded theory techniques (Bryant and Charmaz, 2007., Cohen et al., 2011:598-603, Creswell, 2009, Glaser and Strauss, 1967, Goulding, 2005). Although I had started with a structural framework, in response to the data-content, I made an abductive shift, described in 2.3: *Selecting the theoretical framework*, to include an interpretivist element in theorising, and to refocus the study on the experience and motivation of GPs.

3.4 In the field: The nature and collection of data

In this section I describe the conduct of the fieldwork. First I describe the timeline and phases. Following this, I describe my approach to sampling. Next I describe the nature and extent of observations. Finally I describe how I used interviews to triangulate the findings from the observations.

3.4.1 Timeline

The study was divided into four distinct phases. I have called these phases Establishment, Early, Middle, and Late. The Establishment Phase included the pre-entry and induction stages when I established my basic knowledge and presence in the CCG. The Early Stage included the use of concepts from SIT. Following first cycle

coding and analysis this shifted to the Middle Stage which included the use of concepts from BF. The final stage was focused on validation and triangulation of earlier findings. My main form of data collection was observation, both direct and participative. I used various methods to acquire and record the data including document analysis, a reflexive journal, and field-notes. I also conducted semi-structured interviews both to explore themes and to validate observations. The stages and methods are mapped in the Gantt chart in table 4 below.

Table 4 Study stages and corresponding data collection methods

	Establishment		Early	Middle	Late
	Stage 1 Pre entry June – Sept 2012	Stage 2 Induction Oct – Nov 2012	Stage 3 Participant and direct observation and first analysis (SIT and empirical codes) Dec 2012– May 2013	Stage 4 Continued observation and second analysis (BF) June 2013 – March 2014	Stage 5 Validation of findings: focused observation and interviews March – Sept 2014
Document Analysis					
Reflexive Journal					
Observation recorded in Fieldnotes					
Participant Observation					
Initial semi- structured interviews to explore ideas and themes					
Focused interviews to validate and refine observation					

3.4.2 Access to data

In order to conduct my study I needed arrangements to access data. Alongside collecting observational and interview data, I collected a library of documents. Some were national policy documents and directives, some were local plans, strategies and the like. The bulk of the documentary data was in the form of agenda and papers for meetings, and it was through these that I could observe the unfolding of “plot”. A key reason to look at documents was because they revealed underlying ideologies, approaches, values, and interests (McCulloch, 2011). Essentially, the approach to assembling my library of documents was no more complicated than writing lists of things I wanted to see, and obtaining them.

For observations, the sampling was focused on the identification of projects/initiatives and groups which I would observe, rather than on individual people, as this was a study of organisational dynamics. Sampling was purposive and reflected a process of funnelling (Ericson 1986) whereby my investigations started broadly and then became narrower and more focused.

For interviewees, sampling was purposive, and was generated through contacts made in the process of participant, and to a lesser extent direct, observation.

On occasions where it was impractical or impolite to interrupt proceedings for the purposes of gaining consent (for example observations of events were often in rooms containing fifty plus people, or of meetings of senior people where an insistence on form-filling would be to disregard organisational etiquette). I ensured that the meeting leader made participants aware of the capacity in which I was present, and advised that they could object to the use of data that related to them. No-one did object.

Whenever it was possible to take formal written consent a PIS was circulated in advance or given out at the meeting. I took signatures onto ICFs. My study file contains 61 signed ICF for observations which break down as 10 Executive GPs; 26 rank and file GPs, 9

practice nurses, 2 nurse managers, 4 practice managers, 7 CCG managers, 2 lay members, and 1 hospital doctor. A further 12 ICFs are on file for interviews (see Appendix 3).

3.4.3 The nature and extent of observations

The principal method of data collection was observation. Gold (1958) developed a classic categorisation of observation into four types, based on a spectrum. *Complete participation* is when the true identity and purpose of the observer is concealed. A *participant as observer* (now known as participant observation) is where the observer participates in the day to day activities of the field but there is mutual awareness that this is a “field relationship”. An *observer as participant* describes the one visit encounter. Finally, the *complete observer* (usually now known as direct observation) is where the observer aims simply to watch, and ideally to be forgotten about by those he or she is watching. Observations I made during the study were sometimes direct such as watching meetings, and sometimes participant. The ratio of direct to participant observation was constantly shifting along what Glesne and Peshkin (1992:p40) describe as the “participant observation continuum”.

During my time in the field, the majority of my observation time was from just being around the place. I recorded day to day events, and conversations in a research journal. I made friends, participated in social activities, and became a confidante for a number of people. In total I was located in the CCG for over a year, and have over 300 recorded hours of informal observation time when I was located as a member of staff in the CCG offices. In addition I spent 202 hours of time observing in meetings (see table 6 below).

In section 3.4.1 above I described how the study divided into four phases which I termed establishment, early, middle and late. In sections 3.4.3.1 – 3.4.3.4 below I outline the approach to observations in each of these phases. In section 3.4.3.5 I provide

the detail of networks observed, type of participation, participants, and how this related to the study phases.

3.4.3.1 Establishment phase (June 2012–November 2012)

The establishment phase consisted of time in preparation before entering the field, and the early period of induction to the field.

In the pre-entry stage I began to explore websites relating to the study site and make connections with potential participants, but did not formally begin to visit the field on a regular formal basis as a participant observer. During this stage I began to understand or “facet” the case (Scholz and Tietje, 2002), gathering basic knowledge, sourcing relevant documents, identifying key players, and identifying and examining major issues. One specific exercise I undertook in this pre-entry stage was to analyse the publically available committee papers for the HWB into a summary document.

In the induction phase, which began in September 2012, I began to establish a presence in the CCG, to undertake exploratory observations, and to negotiate permission to observe meetings. I was allocated a desk in an open plan office in CCG headquarters, and became one of the team. In order to gain access I had offered to be useful and undertake pieces of work to help out with day to day pressures. I was asked to work on the CCG OD plan for the company secretary. OD in this plan included those activities designed to bring the new CCG organisation into being, and to establish it as a collaborative of its member practices. Also as part of my negotiation of access to HWB I had shared the summary analysis of papers that I referred to above. Officers responsible for administering the HWB recognised its usefulness and I was consequently asked to prepare the preliminary audit for a peer review exercise. Fortuitously these were both projects that gave me an overview of key networks that I could potentially observe, and, since I had been helpful, generated goodwill going forward.

3.4.3.2 Early phase (December 2012–May 2013)

At the early stage, and guided by the SIT dynamic of relationships between doctors, managers, and patients, I negotiated the opportunity to observe situations where it was reasonable to anticipate this dynamic could be seen. My hosts were helpful in this respect, and asked me to lead the CCG response to the NHS Annual Planning Guidance, Everyone Counts (NHS Commissioning Board, 2012), as a participant observer. In order to formulate a response to this guidance lead managers would work with commissioning GPs to produce plans that responded to local patient need. To this end, I held weekly meetings with four assistant directors of commissioning, and found myself the centre of a hub of activity to co-ordinate the CCGs statement of priorities in the form of a “plan-on-a-page”; it was a national requirement that each CCG’s complex set of priorities should be displayed on one side of A4. This required a distillation exercise involving wide consultation, providing me access to a wide range of meetings and contacts with commissioning managers and GPs.

As well as undertaking the Everyone Counts planning task, I also began to undertake direct observations in a number of key networks. These are detailed in the summary tables in section 3.4.3.5 below.

3.4.3.3 Middle phase (June 2013–March 2014)

During the early phase I had collected, coded and analysed data simultaneously, and had begun to realise that SIT codes were not consistently applied in occupational groups. It was during this stage of field work that I made the shift from SIT to BF. In response I refined my sampling strategy in order that I could observe the interplay of networks, rules and cognitive frames. My data collection strategy continued to rely on both participant and direct observations. I arranged to participate in the Integrated Care Programme (ICP) which was a project to coordinate health and

social care services. I also arranged to directly observe meetings where new competition rules were being assimilated.

3.4.3.4 Late phase (April 2014–September 2014)

By the late stage, I had identified major themes and how they related to the BF categories. The research focus at this point was one of probing, testing out concepts with participants, and validation or modification. The main research method at this point was interviews (see 3.4.4). I continued to use direct observation to check the validity of theoretical constructs. In order to do this I revisited key networks such as the CCG Professional Cabinet (PrC), and the Governing Board (GB).

3.4.3.5 Summary and breakdown of observations

In this next section I summarise the field work in tabular form. In table 5 I detail the main networks, and how they related to the three levels of the case study. I also show how networks relate to the various study phases. In table 6 I give a breakdown of observations by level, hours, participation and observation type.

Table 5 Main networks and relevant study phases

Local Medical Committee	This was a GP professional network independent of the CCG. GPs pay a statutory voluntary levy to their LMC which then acts to represent their interests in local planning and policy matters.	Middle
Facilitated Learning Events (FLE)	These events had the same constituency as the Total Members (TM) meetings. The content was focused on GP and practice staff learning. The events that I attended followed a format where staff groups were separately taught about their distinct role in emergency care.	Middle
GP-groups	The CCG divided its practices into four GP groups. These met monthly. Each group organised differently. These groups were variously attended by GPs, practice staff, and CCG managers.	Early and middle
Governing Board	This consisted of CCG managers, executive GPs, lay members, and independent clinicians from hospital and community services. This was the overview body for CCG, and business relating to strategy, governance, and procurement was signed off here.	Early, middle, and late
Health and Wellbeing Board	This was a statutory committee of the local authority. It included senior representatives of local agencies whose work impacted on health and wellbeing.	Early, middle, and late
Integrated Care Programme	This was a sub-programme of the HWB. It consisted of a programme board, a programme team, and various workstreams.	Middle and late
Planning and Prioritisation Committee and planning teams	The CCG had a network of "planners" which included commissioning managers, finance staff, and GP executives. The Everyone Counts planning guidance was responded to in this network.	Early
Professional Cabinet	This consisted of executive GPs and CCG directors. It was the key meeting where the manager to doctor discussions would take place.	Middle and late
Total Members Meetings	This was a CCG wide arrangement whereby all practices met together, and took part in setting the strategic direction for the CCG. It would typically be attended 150 + practice staff.	Early and middle

Table 6 Observations by level, hours, participants, and type

Meeting/network	Observations	Participants	Type of observation
Operational Practice Level (66 hours)			
Guru GP group	8 Gurus meetings, including 4 ordinary meetings, 1 AGM and 3 practice managers meetings.	GPs CCG managers	Direct with an element of participation arising from presenting Everyone Counts, and involvement in Integrated Care
Principled Collaboration GP group	4 meetings	GPs Practice nurses Practice managers CCG middle managers	
Chamber GP group	4 Meetings	GPs Practice nurses Practice managers CCG middle managers	
New World GP group	5 meetings including 1 focus group	GPs Practice nurses Practice managers CCG middle managers	
Strategic Collaboration Level (84 hours)			
Total Members	2 meetings	GPs (100 +) Practice nurses Practice managers CCG middle managers	Direct
AQP	3 Events	GPs (100 +) Practice nurses Practice managers LMC managers CCG senior managers	Direct and participant
Professional Cabinet	4 meetings	Executive GPs CCG senior managers	Direct with participation relating to Everyone Counts
Governing Board	8 meetings including one AGM and one development session	Executive GPs CCG senior managers Lay members Independent nurse and doctor	Direct
Facilitated Learning Events	2 Events	GPs (100 +) Hospital doctors	Direct
Creation of CCG Organisational Development Plan	Desk based activity	CCG senior manager	Participant
Everyone Counts Planning Process Planning and Prioritisation Committee	1 Initiation meeting 2 Resource allocation and prioritisation committees 6 team meetings with managers	Executive GPs CCG senior managers CCG middle managers	Participant
Interagency Strategic Partnership Level (52 hours)			
Health and Well Being Board	4 meetings	Full board membership	Direct
Integrated Care Programme	1 CDG event 7 ICP meetings 3 Process and Procedures Group	ICP programme team, including LA, Castlereach, and GP representatives	Participant
HWB peer and follow up Organisational Development sessions	4 meetings 3 sessions.	Full HWB board membership	Participant

3.4.4 Interviews and direct questioning

Because my study was so dependent on observation and therefore dependent on my interpretation of those observations, it was crucially important to use another method for triangulation. Radnor describes the need for interviews to supplement observations:

“Watching and listening can give us a sense of the social life of others. We can begin to recognize patterns of behaviour and the quality of relationships by observing the interactions between people. But if we want to understand what makes them do what they do then we need to ask them.” (Radnor, 2002:p48)

I asked direct questions in order to validate my interpretations of participants’ ideas. I did this at all stages of the research, although the bulk of formal transcribed interviews took place in the late stage of the study. Semi-structured interviews took place throughout the study with the majority between April and September 2014. A schedule of interviews with dates is provided at Appendix 3.

Glesne and Peshkin (1992:pp81-82) in a chapter called *Making Words Fly* describe how high quality interview data depends largely on the human relationship and listening. Because I was known to people in the field it was important that I be reflexive in conduct and subsequent analysis of interviews. I was conscious that as an ex-manager there was a danger that interviewees would endow me with authority. In order to counter this, I consciously emphasised that I was there to mine their views and opinions rather than to give approval or disapproval. I encouraged interviewees to share what they really thought, not just what they thought was appropriate to their occupational role or what they thought I wanted to hear. I conducted the interviews as discussions, especially when asking questions of someone who had a tendency to reserve opinions.

In the early stage I undertook four interviews. Two of these were spontaneous, unstructured, and non-directive, and initiated by the interviewees. A GP with an interest in training, development, and safe-guarding issues (Dr Lovett in future chapters), and a research orientated practice manager self-selected to be interviewed in this

way. These were akin to informal chats, recorded in writing, rather than digitally, and were useful in informing the development of lines of inquiry. I also conducted formal recorded and transcribed interviews with the director of finance and a primary care manager at this stage. For these I used general questions from the topic guide that had been included in the protocol approved by the University and NHS included at Appendix 4. This was derived from SIT and was focused on interests and the relative influence of doctors, managers, and patients in the commissioning process.

For interviews in the middle and late stage of the study I prepared in-depth individual topic guides based on emerging theoretical constructs and which took into account the position of the interviewee in relation to these constructs. Whilst remaining within the parameters of the agreed study protocol, I used the interviews to probe further the major empirical themes of: the establishment of new organisations, history and legacy, changes to the profession, competition, and integration (see section 3.5.2 and 3.5.3 below).

3.5 Data processing and analysis

3.5.1 Guiding sources, and training

Guiding principles for the analysis of data were drawn from Miles, Huberman and Saldaña's *Qualitative Data Analysis; A Methods Sourcebook Edition 3* (2013), a revision of Matthew B. Miles and A. Michael Huberman's (1994) original seminal textbook. This later sourcebook was updated by Johnny Saldaña following the deaths of the original authors. It incorporated recent developments in qualitative research techniques, including the advancement of computer aided data analysis, whilst remaining faithful to the ideas in the earlier work. In addition, I also referred extensively to *Qualitative Data Analysis with NVivo* (Bazeley and Jackson, 2013). My analysis was undertaken using version 10 of NVivo, a qualitative data analysis software package. I received initial training in the use of NVivo from both CLARHC- NDL and Nottingham University

Business School. I became an active member of a LinkedIn NVivo user group, and a regular attendee at the NVivo drop-in workshops run by the university's Graduate School.

3.5.2 Data processing and preparation

My study was of a single case using qualitative methods. On both these counts the power of my data would need to be firmly established if my findings were to be successfully defended. This was something that I was aware of from the outset. To this end I ensured that I was thorough and systematic in three ways. Firstly, I recorded my observations conscientiously and in detail. Secondly, I followed an ongoing systematic discipline of data analysis. Thirdly I asked direct questions of participants in order to probe further developing concepts (see 3.4.4 *Interviews*).

My tools for capturing observational data were simple, consisting of pens, pencils, and spiral bound notebooks. I used the same notebooks to create two types of notes. The first were jottings of observations which I would work on further within a few hours whilst events remained fresh in my memory, converting initial jottings into fully fledged stories. Before starting the study, *Writing Ethnographic Fieldnotes* (Emerson et al., 1995) was an invaluable read. I recorded chance interactions, as well as observations of formal situations. In my observational jottings I included descriptions of buildings, the fabric and equipment of rooms, views from windows, the clothes people wore, and rituals around food and refreshments. The same note books were also my personal research journal in which I recorded thoughts, ideas, and feelings. More often than not I worked on the jottings and wrote the journal at my desk in the offices of the CCG. I created the fieldnotes notes in Microsoft Word. Somehow the ambience helped me to capture the essence of my experience, as well as making me look busy when not working on the content of one of my participant observation projects. It was during this reflexive and reflective process, immersed in the

minutiae, that themes began to take shape. This is how ethnography works, says Wolcott:

“The precursor to finding themes is to identify patterns of behaviour, and the precursor to that are the minute observations of specific instances of behaviour. – the little vignettes that we enter into our daily fieldnotes.” (2010:p40)

An awakening for me was that there were so many things that as a manager I had previously failed to notice. I had the feeling of entering a familiar world with new eyes.

Interviews were recorded digitally, and then transcribed in full as Microsoft Word documents. Interview transcripts and fieldnotes were uploaded into the NVivo database, as were the field documents that I had collected. I would then further reflect using the memo and annotations functionality of Nvivo in order to create “analytic notes” (Glesne and Peshkin, 1992:p49). These analytic notes were informed by my journal entries.

3.5.3 Structuring and coding the data

3.5.3.1 Sources, and first and second coding cycles

For the purposes of data analysis I used coding concepts from Miles, Huberman and Saldaña (2013). The structure of my NVivo data base and subsequent coding progressed through several iterations, and was done in parallel with my data collection. As already noted in *Chapter Two: Literature Review*, data analysis and theorising were interwoven processes.

The first analytic step was to decide the main categories of the NVivo database. Experts advised to use the function “sources” as the basic building block. The list of sources should be simple and remain constant in order to anchor the more flexible processes of analysis. My four “sources” were OPL, SCL, ISPL and Interviews. The next step was to attribute data to the sources. There were analytic decisions to be made even at this point. For example were CCG-wide meetings of all GPs to be classed as OPL or SCL? Was the

ICP an OPL, SCL, or ISPL source, since it had ramifications at all levels? I decided that activity that could be separated into its GP group dimensions would be coded at OPL, undifferentiated CCG-wide activity would be coded at the SCL, and activity accountable to the HWB would be coded at ISPL.

I began the analysis with a fine-grained reading. This was a cumulative process, extra sets of notes being regularly added as the fieldwork progressed. I used coding techniques from Miles et al. (2013:p73-81). I began by coding holistically (large chunks of data), and simultaneously (applying more than one code to each chunk of data). The codes used in the first cycle were a combination of descriptive and values codes. Descriptive codes are a label to identify a topic or category. Value codes relate to actors' values, attitudes, and beliefs.

3.5.3.1.1 First coding cycle: Codes derived from Structural Interests Theory

My initial intention, as described in *Chapter Two: Literature Review*, was to develop theory based on the SIT pattern of dominance-challenge-repression between doctors, managers, and patients. Drawing heavily on Yin's (2009) case study analysis technique of 'pattern matching', I had derived a matrix using a combination of descriptive and value codes. The codes are identified and defined in table 7 below.

Table 7 Structural Interests Theory codes

Main codes	Definition	Sub codes
Descriptive Codes: occupational groups		
Doctor	Relating to doctors including medically qualified managers	
Manager	Relating to non-medical managers	
Patient	Relating to patient representatives, or staff specifically advocating for the patient	<ul style="list-style-type: none"> • Patient view point • Advocate view point
Values Codes: relative influence		
Dominance	A dominant group would be secure, and would not need to actively assert dominance. Evidence for dominance would be those situations when decisions and outcomes favoured the interests of a dominant group without effort expended to achieve this	<ul style="list-style-type: none"> • Outcomes favouring a particular group or network • Behavioural or attitudinal indications of assumed dominance
Repression	Evidence of repression would be occasions where a group appeared to have had little or no influence on the outcome of decisions. In addition members of that group may appear unheard, and may express feelings of frustration or powerlessness	<ul style="list-style-type: none"> • A decision outcome unfavourable to the groups interests • Attempts to influence with little or no impact. • Attitudes of frustration • Attitudes of passivity
Challenge	Evidence for challenge would be those circumstances where one group of actors openly critiqued and/or required change of another group.	<ul style="list-style-type: none"> • Questioning and critique of another's opinion or position

Yin's model works on the basis of testing predictions, and my predictions were as follows. Firstly, I anticipated finding evidence of the repression of patients' interests. Secondly, I anticipated finding examples of GP-strategies to protect their own financial and/or workload interests. Thirdly, I anticipated that I would identify patterns that correlated to distinct categories of manager; doctor; and citizen or patient, and that doctors would be either challenging or dominant.

I investigated the correlations of the descriptive and values codes across the three levels, using NVivo query capability. There was no correlation of doctors and dominance at the SCL and the ISPL. The only level at which doctors attracted the code dominance was at the OPL where the GP groups Gurus and Chamber attracted the label repression whilst the GP group PC attracted the label dominance. In other words, in those instances where doctors were coded as dominant it appeared to be in relation to other doctors rather than managers or patients. At the ISPL doctors at the HWB were labelled

repression whilst LA members were labelled dominant. There was overlap between the codes repression and challenge linked to doctors at all levels.

The correlation between the codes repression and doctor was an unexpected finding, as was the relationship of dominance and repression between groups of doctors. Also unexpected was the absence of doctor dominance other than at the OPL, and then only in relation to other doctors.

These unexpected findings triggered an abductive shift from SIT to, eventually, BF (see 2.4). At the time I noticed these patterns I was not yet in a position to determine a new way to theorise. The second coding cycle described in the next section was an important next step in this respect.

3.5.3.1.2 Second coding cycle: descriptive codes derived from the empirical setting and Medical Sociology literature

My second coding cycle was the application of descriptive codes derived from my empirical observations, and my reading of the Medical Sociology literature. I had already identified two further descriptive themes from the Medical Sociology literature (see 2.2.3). The first of these was the importance of *history and legacies*. The second was the main *changes to the profession* i.e. hybridity, restratification and the delimitation of clinical autonomy.

Coding was systematic, but also fluid in that ideas and insights were simultaneously captured in memos and annotations which led to the identification of three further codes. These were *establishment of new organisations*, *competition*, and *integration*. Data labelled *establishment of new organisations* related to the processes to set up the CCG, the HWB, and associated structures. For the codes competition and integration it is useful to use examples from the data to illustrate, especially since these data include instances of confusion or ambiguity with the potential to trigger sensemaking. These examples are shown below.

Competition

The code *competition* was originally identified through a process of open coding. One of the rules introduced in the HSCA 2012 was the extension of competitive procurement processes. It was apparent that the ambiguity associated with the co-existence of imperatives to compete and to co-operate caused confusion, concern, and even fear. There was an ever present awareness of the perceived inappropriateness of European competition law, designed to control anti-competitive processes at the level of large-scale industry, applying to the small general practice businesses. There was a general sense that competition was not the best mechanism to secure health care. Some examples of the reaction to competition in the data are shown below:

Competition data example 1

Dr Strong: Okay. (Sighs). I think that it is a problem, a problem that is brewing. The bureaucracy around competition, tendering, awarding even fairly basic contracts by getting a quite qualified provider is causing problems in the supply side. It's too complex for small practices, and that's evidenced by the fact that it's just simply not applying, so there's a range of services that they're either now not providing or not being paid for providing. So that's making life hard for those small practices, making life hard for patients of those practices and there's a huge overhead in procurement, and it's been estimated the Government takes up 10 percent of the total costs of the service that you're trying to procure and I think that it is, I know why we're doing it, I can understand the legal reasons, I understand all the procurement rules and laws and so on, but I think that it is [*swearword*], bureaucratic, wasteful, inefficient, unnecessary. A completely different model of running health services if I were Health Minister
(*StrongInterview*)

Dr Strong is an executive GP with a long-standing involvement in GP commissioning. This extract shows a concern that competition was too complex for small practices, and that the competition initiative was inefficient and costly.

Competition data example 2

Dr Whitbread: "Dermatology, an interesting consequence of the modern world. It was being suggested that the staff move onto TUPE contracts. Consultants don't want to move to [the treatment centre]." (NWfocusgroup1)

Dr Whitbread is the GP chairman of the CCG. This example shows that there were concerns regarding the interface of the NHS and the private sector, especially in relation to employment. NHS staff did not want to leave NHS employment.

Competition data example 3

Dr Johnson: "Where Drs are less skilled at using business speak, then what they say doesn't get heard. This cluster has a practice development focus, whilst also concerned with affordability. Both practices are very focused on the future of society. This includes the multi-ethnic focus that is central to both our ethos."

Practice manager: "We are not afraid of AQP.....hear the fear of competition." (NWfocusgroup1)

Dr Johnson is a GP who attends meetings of a small GP-group called New World. This extract shows actors talking about the fear of competition generally, illustrated in this case by a denial.

Competition data example 4

Since the AQP process there were lots of little providers dotted about everywhere. There was a lot of worry about this in the room, especially regarding continuity of records. How would a scan be compared to an earlier or later picture? The mood of the meeting became one of agitation during this item. The key worry though was access to previous scans, and electronic communication. (PC fieldnote 1)

This extract shows worry about the operational implications of services being provided outside of the NHS, especially with regard to diagnostic results.

Integration

The code *integration*, like competition, was originally identified through a process of open coding. It was apparent that actors saw integration as a panacea. Whenever there was a need to simplify or streamline services the word "integration" would be used indicating

that actors saw it as a panacea to solve all problems to do with the need to co-operate across organisational or professional boundaries. Because the term was used non-specifically there was data that suggested confusion about what integration meant. There was also data that suggested suspicion that the term could be used to obfuscate a hidden intention to cut costs. Some examples of data are shown below:

Integration data example 1

For the fourth time I heard Sarah do the integrated care presentation. She began by saying this is the only way of addressing the needs of the elderly and people with LTCs. The idea is that people would manage at home, get help when they needed to, and would come out when they were ready to. "We need to reconfigure teams, simplify processes, make access easier, and be more proactive. We need to be less task focused, and buck passing, and more holistic" (*PC fieldnote 1*)

Sarah is the project manager for the ICP. This is an example of integration being seen as a solution for multiple problems, when there was no real evidence that it would work out that way.

Integration data example 2

Sarah gave a presentation about integrated care "It's such a huge transformational change". Dr Kerala commented that the groups were health dominated. "Will this process help hospital discharge?" he asked. Sarah confirmed that this was the hope "The hospital transition is part of the vision". Dr Whitbread pointed out the link with Efficient Economy, a programme to deliver nationally required savings across the health and social care community. "This is a delivery programme for EE" confirmed Sarah. Dr Whitbread added "It's a substantive change, how will we explain it to our patients", and "all the change streams in the system.....there's a slight risk of lots of things happening and not being co-ordinated". Tramell (a lay member who used to be a LA member) pointed out the risk of a "knock on effect of the City Council budget cuts.....anything the Council Officers don't believe is a statutory duty will get cut". Cat, who has a background in working with general practice, commented that working with "64 independent practices is a bigger problem". (*GBfieldnote2*)

Sarah is giving a presentation about Integrated Care to the GB. Dr Kerala is the GP executive lead for integrated care. Cat is the CCG Chief Executive. In this extract integration is put forward as a solution for hospital discharge problems. There is also an acknowledgement that there are risks attached, that it will be complex to involve all the practices, and that it will not necessarily be well funded, particularly given the LA needs to save money.

Integration data example 3

Cllr Lennon: "All I get is some tablets from the Doctor, I don't need to get integrated care. I can have as many tablets as I like now I'm 60" (*HWBfieldnote8*)

This is an example of a LA member being unconvinced that integration was necessary, and was an indication to me that it was not seen by all as the solution to all service co-ordination problems.

I was particularly interested to explore the impact of competition and integration existing as contemporaneous policy directives. During the coding process, further sub-codes were applied as I identified more subtle distinctions in the data. The codes are identified and defined in table 8 below.

Table 8 Codes derived empirically and from Medical Sociology

Descriptive Code	Definition	Sub codes
Establishment of new organisations	Relating to discussion that focused on the mechanics of setting up new structures and networks in response to the new rules associated with HSCA 2012	<ul style="list-style-type: none"> • CCG establishment • HWB establishment
Changes to the profession	Relating to how the GPs as a profession were organising, rewarding, and monitoring its leaders and members.	<ul style="list-style-type: none"> • Clinical leadership • Clinical autonomy • Restratisation, • Hybridisation,
History and legacy	Evidence or absence of evidence of the impact of history	<ul style="list-style-type: none"> • Fundholding legacy • Non-fundholding legacy • NHS Family • History of migration
Competition	Relating to the introduction of or the response to market based commissioning mechanisms. This included data relating to new initiatives introduced by HSCA 2012, and also pre-existing examples of competition in the procurement of health care initiatives.	<ul style="list-style-type: none"> • HSCA 2012 initiatives • Pre-existing initiatives • Responses and attitudes of actors to competition
Integration	Relating to the inter-dependency of services, and inter-organisationally based delivery of services. At the time of my research Integration was a contested phrase. It was taken to include integration of health and social care services. For the purposes of coding, I also included those occasions when health services were interdependent between separate health care organisations, including between GP surgeries.	<ul style="list-style-type: none"> • Health and social care integration • Primary and secondary health systems integration • Integration across primary care and primary and community health services

At the OPL I began to see a correlation between the patterns of dominance and repression and patterns of professional changes in the GP-groups. PC attracted the label dominance, and also had a high degree of restratisation. The Gurus attracted the label repression and not restratisation or hybridisation. Repression, dominance, and challenge also appeared to correlate to the nature of the legacy that the group shared. At the ISPL, GPs attracted the label repression, whilst Public Health and LA members attracted the labels dominance and challenge.

3.5.3.2 Moving forward with data analysis: transforming aggregate patterns to theoretical inferences

3.5.3.2.1 Implications of first and second coding cycles

The analysis using the SIT concepts of dominance, challenge, and repression had revealed important insights into the relative influence between doctors, and between doctors and other actors. Furthermore these relativities were correlated to differences in

legacy and the implementation of changes to the profession, as doctors responded to new rules. If SIT was not to be the basis for theorising, then the next step was to decide what the theoretical framework would be. The way I approached this was to step back from analysis and review the emerging story first by level, and then by code.

3.5.3.2.2 Theoretical Inferences by case study level

What follows is a series of three tables (9-11), one for each level of the nested case study. Each table includes a summary of the data content by second cycle codes: establishment of new organisations; history and legacy; changes to the profession; competition; and integration. The SIT categories are now longer presented as separate codes; instead instances identified as dominance, challenge, and repression are now incorporated under the five second cycle headings. Alongside each data summary are associated theoretical inferences. I have used writer's prerogative to present these by using the terminology of BF, although at the time they were initially identified I used words like "group" and "meeting" instead of network, and "policy" and "directive" instead of rule. My intention in using BF language at this stage is to make transparent the rationale for the choice of theoretical framework.

Table 9 Operational Practice Level theoretical inferences

	Summary of data content	Theoretical inferences
Establishment of new organisations	CCG establishment did not result in change to GP group networks.	<ul style="list-style-type: none"> At the operational level, pre-existing networks endured rule change.
Legacy	<p>There was an OPL-wide shared legacy of belonging to the “NHS Family”.</p> <p>Within this, GP-groups each had differentiated shared legacies. These legacies related to</p> <ul style="list-style-type: none"> Fundholding Non-fundholding legacy History of migration <p>The GP group with a non- fundholding legacy appeared dominant especially in relation to the network with a fundholding legacy. In the Gurus group there were examples of doctors feeling powerless and overwhelmed linked to the legacy of small practice business units.</p>	<ul style="list-style-type: none"> Networks reflected established relationships between people who had worked together in the past. In turn these related to previous experience of responding to rules together. Some networks/legacies had more influence than others.
Changes to the profession	Linked to legacies, see above, GP group networks had different patterns of adoption of changes to the profession.	<ul style="list-style-type: none"> The distribution of actors within networks was a product of the different patterns of hybridisation, restratification and the approach to clinical autonomy.
Competition	<p>Competitive processes were not enacted at this level.</p> <p>Tightly coupled relationships within and between NHS networks prevailed despite separate commissioner-provider roles.</p>	<ul style="list-style-type: none"> Competition rules not enacted at operational level. Tightly coupled relationships prevailed despite rule change that implied separation.
Integration	Data coded as “Integration” at OPL related to access to services for referring GPs. These were other NHS services (including community services) rather than health and social care integration.	<ul style="list-style-type: none"> At the operational level, integration meant the daily interface with other services and the practices.

Table 10 Strategic Collaboration Level theoretical inferences

	Summary of data content	Theoretical inferences
Establishment of new organisations	Data included discussions in meetings, as well as specific OD interventions to enact the establishment of the CCG. The arrangements in the new CCG replicated those of the outgoing PCT as far as the rules allowed.	<ul style="list-style-type: none"> The establishment of the new organisation was enacted at this level. Time was set aside to discuss new rules, and to reinforce new and existing network arrangements. OD interventions were important. Networks remained intact as far as the rules allowed.
Legacy	Within the CCG leadership team, GPs and managers conceptualised the "NHS as a system". This aligned with the legacy in the non-fundholding GP-group (PC). It was also linked to the NHS Family legacy.	<ul style="list-style-type: none"> The historically embedded network of the NHS Family and the wider NHS system were important.
Changes to the profession	Executive GPs leaders were distinguished from the rank and file in a stratified arrangement. These leaders encouraged compliance. Rank and file GPs might grumble, but did not resist. Certain Executive GPs exerted greater influence than others. This was evidenced through: their relative influence in priority setting related to Everyone Counts; and their prominent leadership roles in OD interventions designed to influence the rank and file. GPs from the dominant GP-group (PC) had the greatest influence.	<ul style="list-style-type: none"> An elite group of hybrid leaders encouraged compliance from rank and file doctors. Leaders communicated expectations about how followers should respond to rule change. Verbal expressions of resistance were antecedents to compliance with the expectations of leaders. Members of one GP group appeared to exert more influence than members of the others.
Competition	Doctors were identified as having an inherent conflict of interest resulting from dual commissioner-provider role. Doctor-leaders and managers adopted differentiated positions during implementation of the competition rule with doctors challenging managers on the appropriateness and efficacy of competition. When rank-and-file doctors were required to compete they retreated into a uni-professional network to consider implications. Initial challenge gave way to compliance.	<ul style="list-style-type: none"> Actors within networks actively adopted differentiated positions when considering the impact of competition rule, including separation of doctors and managers, and uniprofessional retreat of GPs. Dual roles of provider and purchaser were identified as conflicting. Doctors showed little resistance when competition rules impacted them.
Integration	When problems in service continuity arose as a result of competition, these were solved by co-operative efforts across NHS Family. The NHS Family network was actively nurtured using OD interventions, which stressed the integrated interdependent nature of healthcare.	<ul style="list-style-type: none"> The NHS Family network provided a counterpoint to the competition rule and was the basis for co-operative problem-solving. Tightly coupled relationships of the NHS Family network were actively nurtured using OD.

Table 11 Interagency Strategic Partnership Level theoretical inferences

	Summary of data content	Theoretical inferences
Establishment of new organisations	Two predecessor committees were merged into the HWB giving the impression of continuity. However responsibilities and individuals changed. There were examples of specific OD interventions to establish new arrangements. These included an external peer review, and internally instigated development sessions. There were also items about set-up at the HWB itself.	<ul style="list-style-type: none"> Pre-existing networks were merged and changed, giving the impression of continuity were in fact this was disrupted significantly. Time was spent on establishment including external and internal OD interventions.
Legacy	Actors had no shared legacy. Even though some individuals had previous experience of working together, the new rules had disrupted the organisational forms that underpinned this, for example Public Health was transferred to the LA.	<ul style="list-style-type: none"> The multi-agency partnership consisted of individuals with either an absence of or a disruption to networks with shared legacies.
Changes to the profession	<p>The distinction between GPs and PH doctors appeared to be lost to partners. All doctors were simply "medical". LA members challenged the perceived dominance of the "medical model" on the basis of democratic legitimacy. LA members were the dominant interest when it came to resource decisions. In strategic discussions at the HWB, GPs were relatively passive (compared to OPL and SCL) tending to follow the lead of the DPH.</p> <p>In contrast, in the ICP, GPs took an active role in designing systems to integrate health and social care acting as hybrid manager-clinicians. Despite active involvement, geographically based networks were put in place, despite objections from GP leaders.</p>	<ul style="list-style-type: none"> Democratic representatives challenged the medical model of the doctors. In fact the LA members established themselves as the dominant group having most influence over resource allocation decisions GPs were passive in multi-agency strategic discussions. In contrast, when planning to operationalise those strategies, GPs enacted hybrid doctor-manager roles and engaged enthusiastically in service design GPs had limited influence in strategic and operational decisions.
Competition	Competition did not feature in discussions at either the HWB or in the ICP. The focus was on integration.	<ul style="list-style-type: none"> Rules with significant relevance in individual agencies would not necessarily have relevance in a multi-sector setting.
Integration	<p>There was significant overlap with "Changes to the Profession". Data coded fell into two main areas.</p> <p>1) Discussions about the integration of organisational strategies, including examples of agreed joint priority areas and associated action plans.</p> <p>2) Integration of health and social care services. This was a joint priority area, and was enacted using project management in a set of focused networks with a project manager who "brokered" disagreements.</p>	<p>Integration meant two things:</p> <ul style="list-style-type: none"> Integration of strategies, including priority setting in multi-sector network. Integration of operational services. This was coordinated by individuals placed to "broker" disagreements <p>See also "Changes to the Profession" above.</p>

3.5.3.2.3 Theoretical inferences by code

The next stage was to consider the inferences by code across the levels, which I discuss below. Each section begins with a tabular presentation of the theoretical inferences for that code.

Establishment of New Organisations

Table 12 Theoretical inferences: establishment of new organisations

OPL	SCL	ISPL
<ul style="list-style-type: none">• At the operational level, pre-existing networks endured rule change.	<ul style="list-style-type: none">• The establishment of the new organisation was enacted at this level.• Time was set aside to discuss new rules, and to reinforce new and existing network arrangements.• OD interventions were important.• Networks remained intact as far as the rules allowed.	<ul style="list-style-type: none">• Pre-existing networks were merged and changed, giving the impression of continuity were in fact the rule change meant that networks were significantly reconfigured.• Time was spent on establishment including external and internal OD interventions.

A review of the data associated with the code *establishment of new organisations* revealed different approaches at each of the three levels. At the OPL the establishment of the new organisation did not result in a change to networks, with the implication that changes in rules do not affect networks at all levels, in this case, a rule change implemented at the strategic level did not result in changes at the operational level. The establishment of the new CCG was enacted at the SCL, where it was the focus of significant activity, including protected time to discuss new rules and to reinforce network arrangements. Internally driven OD activities were important in supporting this process. As far as possible, pre-existing networks were preserved. At the ISPL, a significant amount of activity took place to establish the HWB. The merger of previously existing committees meant that at first glance it appeared that networks had been preserved, however in fact the new rules had required significant reconfiguration of responsibilities and networks. OD interventions were used, including external interventions, to support establishment. The theoretical implications of this were:

- Rules were not enacted at all levels.

- Structures were preserved through rule change where possible, although sometimes changes to networks could be obscured by this seeming continuity.
- Where networks were changed by rules, then OD processes were used to reinforce these changes.
- The nature of the OD processes differed between levels.

History and legacy

Table 13 Theoretical inferences: history and legacy

OPL	SCL	ISPL
<ul style="list-style-type: none"> • Networks reflected established relationships between people who had worked together in the past. • In turn these related to previous experience of responding to rules together. • Some networks/legacies had more influence than others. 	<ul style="list-style-type: none"> • The historically embedded network of the NHS Family and the wider NHS system were important. 	<ul style="list-style-type: none"> • The multi-agency partnership consisted of individuals with either an absence of or a disruption to networks with shared legacies.

A review of the data associated with the code *history and legacy*, showed that history had an impact on how actors interpreted rules at all levels. At the OPL GP-groups interpreted their commissioning duty based on their members past experience of working together. Each GP-group had a distinct legacy. These differences resulted in a disparity of influence when it came to priority setting and resource allocation. At both the OPL and SCL there was a shared legacy of NHS Family. The historically embedded network of the NHS Family and the wider NHS system were important. The multi-agency partnership consisted of individuals with either an absence of or a disruption to networks with shared legacies. The theoretical inferences were:

- Legacy affected how actors interpreted rules.
- Legacy impacted on priority setting and resource allocation
- In a context with multiple partners, shared legacies were less likely to exist.
- Networks could include individuals with a shared legacy, or a previously shared a legacy that was now disrupted.

Changes to the Profession

Table 14 Theoretical inferences: changes to the profession

OPL	SCL	ISPL
<ul style="list-style-type: none"> The distribution of actors within networks was a product of the different patterns of hybridisation, restratification and approach to clinical autonomy. 	<ul style="list-style-type: none"> An elite group of hybrid leaders encouraged compliance from rank and file doctors. Leaders communicated expectations about how followers should respond to rule change. Verbal expressions of resistance were antecedents to compliance with the expectations of leaders. Members of one GP group appeared to exert more influence than members of the others. 	<ul style="list-style-type: none"> Democratic representatives challenged doctors. LA members established themselves as the dominant group having most influence over resource allocation decisions. GPs were passive in multi-agency strategic discussions. In contrast, when planning to operationalise those strategies, GPs enacted hybrid doctor-manager roles and engaged enthusiastically in service design. GPs had limited influence in strategic and operational decisions.

A review of the data associated with the code *changes to the profession* showed different patterns of adoption at each of the three levels. The OPL was a largely uni-professional network of GP practices, organised into four sub-networks called GP-groups. Differences in the adoption of hybridisation, restratification, and the approach to clinical autonomy resulted in different patterns of relationships and leadership within each of the networks. Members of one GP group appeared to exert more influence than members of the others with impacts at both the OPL and the SCL. At the SCL an elite group hybrid doctor manager leaders encouraged compliance from rank and file doctors. GP-Leaders communicated expectations of how rank and file doctors should respond to new rules. Rank-and-file doctors showed some resistance in the form of challenge and grumbling; this was an antecedent to compliance with the expectations of leaders. At the ISPL, GPs, who operated as hybrid elite leaders at OPL and SCL, were passive in multi-agency strategic discussions. In contrast, when planning to operationalise those strategies, GPs enacted doctor-manager hybrid roles. GPs however appeared to have limited influence in either strategic or operational decisions. The LA members challenged perceived dominance of the

medical model. In fact the democratic model espoused by the LA members appeared to have more influence as evidenced by the outcome of decisions. The theoretical implications of this were:

- There were differences in patterns of adoption of changes to profession demonstrated in GP networks
- Across the CCG wide GP network, hybrid doctor-managers led and encouraged compliance from the wider constituency of professionals.
- Doctor-manager hybrids were passive in non-clinical settings.
- At the ISPL, perceived medical dominance was challenged by democratic representatives. Outcomes of decisions suggested that the democratic model had the greater influence.

Competition

Table 15 Theoretical inferences: competition

OPL	SCL	ISPL
<ul style="list-style-type: none"> • Competition rules were not enacted at OPL. • Tightly coupled relationships between NHS commissioners and providers prevailed despite rule change that implied decoupling. 	<ul style="list-style-type: none"> • Actors within networks adopted differentiated positions when considering the impact of competition rule. • Dual roles of provider and purchaser were identified as conflicting. • Doctors showed little resistance when competition rules impacted them even in their own uni-professional network. 	<ul style="list-style-type: none"> • Rules with significant relevance in individual agencies would not necessarily have relevance in a multi-sector setting.

A review of the data associated with the code *competition* showed that this rule had a different impact at each of the three levels. Competition rules were not enacted at the OPL, rather there existed a general awareness of the rule change, and examples of differences in anticipation of impact between GP-groups networks. Tightly coupled relationships between NHS commissioners and providers continued to exist even though the rule change implied a decoupling. At the SCL, managers and doctors within the same network actively adopted differentiated positions as part of a process of examining the implications of competition rule from

different perspectives. For the GPs, dual roles of provider and purchaser were identified as conflicting. Rank and file doctors showed little resistance when competition rules impacted them. Rules with significant relevance in individual agencies would not necessarily have relevance at multi-agency level. The theoretical implications were:

- The competition rule was only enacted at one level. It was not relevant at the ISPL, and at the OPL there was awareness without specific actions being necessary.
- Rules could result in conflicting roles.
- There could be differences of opinion between sub-groups of actors in a network. Debate between the sub-groups could be a mechanism for the implications of new rules to be explored.
- Co-operative embedded networks survived rule change, and enabled shared problem solving when the implementation of new rules had unforeseen detrimental consequences.

Integration

Table 16 Theoretical inferences: integration

OPL	SCL	ISPL
<ul style="list-style-type: none"> • At the operational level, integration meant the daily interface with other services and the practices. 	<ul style="list-style-type: none"> • The NHS Family network provided a counterpoint to the competition rule and was the basis for co-operative problem-solving. • Tightly coupled relationships of the NHS Family network were actively nurtured using OD. 	<p>Integration meant two things:</p> <ul style="list-style-type: none"> • Integration of strategies, including priority setting in multi-sector network. • Integration of operational services, coordinated by individuals placed to "broker" disagreements

A review of the data associated with the code *integration* showed a different impact at each of the three levels. At the OPL the GPs were interested in the integration of their own services with other health and social care services. The focus tended to be on NHS services including community nursing services. At both the OPL and the SCL, tightly-coupled colleague relationships, especially between GP practice teams and attached community nurses, were preserved even when commissioning rules implied these relationships should

be more loosely-coupled reflecting separated market roles of commissioner and provider. In other words, GPs selectively occupied the role of commissioner. At the SCL, tightly coupled relationships across the integrated NHS Family network were actively nurtured using OD. Actors in this integrated network worked together to solve unintended problems arising out of the implementation of the competition rule. At the ISPL integration meant two things. The first was the integration of strategies, including priority setting in multi-sector network. GPs were relatively passive in relation to this form of integration. The second was the integration of operational services. This operational integration was organised as a project and coordinated by individuals placed to “broker” disagreements. GPs took active roles as hybrid doctor-leaders in relation to this form of integration. The theoretical implications were:

- Integration meant different things depending on the nature of the network thinking about it.
- Within the NHS, integration was the relationships that existed between healthcare services. The integrated NHS Family network was actively nurtured using OD techniques.
- In the interagency environment integration could be of strategies, or of services. GPs were passive in relation to the integration of strategies, and active in relation to the integration of services.
- GPs acted as hybrid doctor-managers in relation to integration of health and social care services.

3.5.3.3 Implications for the theoretical framework

In section 2.3 I described how I made the decision to use BF following a recognition that patterns in my data co-incided with its analytic categories. Table 17 is a presentation of the theoretical inferences identified in 3.5.3.2.3. Beckert integrated rules, networks, and cognitive frames into one framework. Sections

3.5.3.3.1 -3.5.3.3.3 are descriptions of how the theoretical inferences aligned with Beckert's analytic categories.

Table 17 Theoretical inferences by code

Establishment of new organisations	<p>Rules were not enacted at all levels.</p> <p>Structures were preserved through rule change where possible, although sometimes changes to networks could be obscured by this seeming continuity.</p> <p>Where networks were changed by rules, then OD processes were used to reinforce these changes.</p> <p>The nature of the OD processes differed between levels.</p>
History and legacy	<p>Legacy affected how actors interpreted rules.</p> <p>Legacy impacted on priority setting and resource allocation.</p> <p>In a network with multiple partners, shared legacies were less likely to exist.</p> <p>Networks could include individuals with a shared legacy, or a previously shared a legacy that was now disrupted.</p>
Changes to the profession	<p>There were differences in patterns of adoption of changes to profession demonstrated in GP networks.</p> <p>Across the CCG wide GP network, hybrid doctor-managers led and encouraged compliance from the wider constituency of professionals.</p> <p>Doctor-manager hybrids were passive in non-clinical networks.</p> <p>At the ISPL, perceived medical dominance was challenged by democratic representatives. Outcomes of decisions suggest that the democratic model had the greater influence.</p>
Competition	<p>This rule was only enacted at one level. It was not relevant at the ISPL, and at the OPL there was awareness without specific actions being necessary.</p> <p>Rules could result in conflicting roles.</p> <p>There could be differences of opinion between sub-groups of actors in a network.</p> <p>Debate between the sub-groups could be a mechanism for the implications of new rules to be explored.</p> <p>Co-operative embedded networks survived rule change, and enabled shared problem solving when the implementation of new rules had unforeseen detrimental consequences.</p>
Integration	<p>Integration meant different things depending on the nature of the network thinking about it.</p> <p>Within the NHS, integration was the relationships that existed between healthcare services. The integrated NHS Family network was actively nurtured using OD techniques.</p> <p>In the interagency environment integration could be of strategies or of services. GPs were passive in relation to the integration of strategies, and active in relation to the integration of services.</p> <p>GPs acted as hybrid doctor-managers in relation to integration of health and social care services.</p>

3.5.3.3.1 Rules

Firstly it was possible to identify differences in the impact of rules at each level, whether those rules were in the form of national policy directives, or local agreements. Not all rules were enacted at all levels, and where possible network structures were preserved through rule-change. Historical relationships and legacies could be preserved or disrupted by rules depending on whether networks survived the change. Rule changes appeared often to be the trigger for interpretive processes which were reflective of legacies. When rules included the requirement to establish new organisations or bodies, OD processes were used to guide associated interpretation

processes and reinforce network structures through which rules would be implemented. It appeared from the first and second coding cycles that rules were an important factor in how and why GPs commissioned as they did.

3.5.3.3.2 Networks

Secondly, it was possible to identify the impact of networks at each level. Networks could survive rule changes. Networks appeared to be the basis of group responses to rules rather than occupational groups, although of course these could coincide. Networks provided the relationship and context necessary for legacies to be shared, and in turn legacies were a defining factor in the way members of a network would organise themselves, and interpret tasks and duties. Actors would reshape networks to consider the implications of new rules from various perspectives. There were differences in networks: some were loosely coupled and others tightly coupled. It appeared from the first and second coding cycles that rules were an important factor in how and why GPs commissioned as they did.

3.5.3.3.3 Cognitive Frames

Thirdly, the importance of interpretation was evidenced. In the spatial arrangement of networks that made up my field, it was apparent that perspectives on the interpretation of rules were developed in those networks. The relationships of actors in networks and the relationship between networks were both important dimensions in the interpretation of new rules. History and legacy affected how actors interpreted rules. In NHS settings, hybrid-doctor-managers had an important role in helping actors decide how to think. Finally, OD processes were used to help and reinforce interpretation processes when rules changed.

3.5.3.3.4 Third cycle coding using BF; and writing as analysis

The next step was to run a third coding cycle using BF. The codes and definitions are described in table 18 below.

Table 18 Coding definitions for rule, network, and cognitive frame

Rule	Networks:	Cognitive frame:
External regulatory and legal frameworks which serve to boundary the actions of individuals and organisations. This could include formal policies and directives as well as external regulatory rules.	Any form that was used to organise people into groups (usually based around meetings), including those that linked actors with an interdependency of task, and those that were based on professional or organisational allegiance.	Opinions, feelings, thought processes, influence, dominance, repression, challenge.

At the time I ran this third cycle of analysis, my main analytic method was my writing. The stories that I would tell, and the links between them, were becoming increasingly clear. It was in the process of writing and reviewing the stories that I made a further research decision. This was to conceptualise “cognitive frame” as an active process, and it was at this stage that I also incorporated the sensemaking concepts into the analysis.

I did this in a number of ways. Firstly, I structured findings using the SP analytic co-ordinates of wider contexts, temporality, and distributed sensemaking (see 2.2.3-2.2.5). Secondly I weaved into the stories the key tenets of and triggers for sensemaking described in section 2.5.1. Thirdly, I incorporated a number of key concepts from the literature that had particular relevance in this study. These are shown in table 19 below.

Table 19 Sensemaking concepts important in this thesis

Qualities of actors	
Sensegiving	In organisational studies the term sensegiving refers to the way in which leaders or managers use influencing techniques to shape the sensemaking of organisational members. (Gioia and Chittipeddi, 1991, Maitlis and Lawrence, 2007, Rouleau, 2005)
Actors with social position and/or social skill	Some actors have a unique impact on others derived from their social positions, enabling them to be effective change-agents. (Lockett et al., 2014) Socially skilled actors are those who act, not in self-interest, but in order to gain co-operation from others by helping them to attain ends. They will show flexibility in doing this, and will adjust goals. Their focus is always on the collectivity. (Fligstein, 2001:p113)
Sensemaking types	
Prosocial sensemaking	In a study of an employee support programme Grant et al.(2008) used the term "prosocial sensemaking as a theoretical term to explain non-self-interested behaviour. This includes affective commitment between employees and towards the organisation, and identity of being caring.
Market sensemaking	Kennedy (2008) used the term "market sensemaking" in a study of the media's role in developing new markets. It is used to describe sensemaking when new markets are being created (Maitlis and Christianson, 2014).

3.6 Conclusion: displaying the data in the thesis

Miles, Huberman and Saldaña (2013) emphasise the importance of bringing evidence alive in the mind of the reader, arguing that this is how qualitative analysis convinces:

"Qualitative data are a source of well-grounded, rich descriptions and explanations of human processes. With qualitative data, one can preserve chronological flow, see which events led to which consequences, and derive fruitful explanations. Then, too, good qualitative data are more likely to lead to serendipitous findings and to new integrations; they help researchers get beyond initial conceptions and generate or revise conceptual frameworks. Finally, the findings from well-analyzed qualitative studies have a quality of "undeniability". Words, especially organized into incidents or stories, have a concrete, vivid, and meaningful flavour that often proves far more convincing to a reader – another researcher, a policy maker, or a practitioner – than pages of summarized numbers." (Miles et al., 2013:p4)

In chapters five to seven I have displayed the data using story-form in an attempt to maintain the readers' interest as the pages turn. Each chapter follows the same presentational structure. I did consider whether to present my data organised systematically into thematic categories, and theoretical concepts discussed in the

earlier parts of this chapter. This, however, would lose the compelling narrative which I considered important to communicate to readers, especially in the light of my research questions:

- Why and how did GPs enact their commissioning duties in the ways that they did?
- How does sensemaking influence field change within the context of networks and rules?

Both of these questions imply the need to describe events and associated thought-processes of the actors. How else would I successfully communicate why and how GPs did what they did, and how their sensemaking processes worked in relation to their networks, and the rules that affected them, if not through telling the story of unfolding events? I needed to create plot and characters to add depth and life to my theorising. To this end, I present the data in such a way to maximise impact using the story telling that Ellis and Böchner (Ellis and Bochner, 1996) advocate. The data displays take the form of extended “pieces”. The stories are intended to be evocative and descriptive, and to transport the reader to the situation being described. The intention of this approach is to allow the data to convince of the arguments that I later propose in the findings and conclusions chapters that follow.

It is in order to have the creative freedom to use this story-telling approach that I have provided the fine detail of the steps of analysis in the preceding sections of this chapter. I hope that in this way I have allayed concerns regarding the validity of my conclusions. These narratives weave in observations relating to the five empirical themes. Throughout the stories I have used sensemaking concepts to describe roles and actions, juxtaposing these with the mechanisms of networks and rules.

The final section of each chapter, *Theoretical implications*, is a discussion organised into the SP analytic categories of wider context, temporality, and distributed sensemaking. This is designed to provide the connection between my arguments and the process

of data analysis. Table 19 is the proforma for a tabular matrix of the theoretical implications of the empirical data, which is presented at the end of each chapter. The matrix structure is a map of the main thematic categories (side headings) and the SP co-ordinates (top headings). Each cell in the matrix table includes a distillation of the analysis using BF and SP concepts.

Table 20 Proforma summary matrix for data display

Case Study Level			
	Wider Contexts	Temporality	Distributed Sensemaking
Establishment of new organisation			
Legacy			
Professional changes			
Competition			
Integration			

Chapter Eight is a discussion of the findings of the previous three chapters. In this chapter I draw together the findings across the three levels, and present the theoretical contributions of the thesis. Before presenting and discussing empirical findings in Chapters five to eight, in the next chapter, I set the scene by giving an overview of Castlefield as a field.

Chapter Four: Introduction to the empirical chapters; Castlefield as a “field”

4.1 Introduction

In this chapter I outline the concept of “field” as used in BF. I also set the scene for the following empirical chapters by offering a profile for each of the three case study levels. I conclude by summarising the main rules impacting on each of the levels at the time of the study.

4.2 The intellectual roots of Beckert’s “field”

Beckert used the concept of field in order to develop his integrated framework. He explains his reasons for this:

“.....markets are constituted and demarcated from one another by the mutual orientation of actors towards each other, an orientation that is organized by the social forces identified. This understanding of markets as fields encompasses conceptualizations that view markets as realms of interaction structured by institutions *or* by networks *or* by local cultures. More importantly it allows to investigate the interrelations between these forces based on a unifying conceptual framework. Each of the three structuring forces contributes to the social organization of market exchange by shaping opportunities and constraints of agents as well as perceptions of legitimacy and illegitimacy” (Beckert, 2010:p609)

It is important to note that Beckert did not attempt to develop the concept of “field”. For him it was a mechanism by which to conceptualise the three way dynamic relationship between networks, rules, and cognitive frames. Beckert acknowledged rather than critiqued the work of those who first developed the concept of field notably Bourdieu (1977, 1990), Lewin (1997 [1951]), DiMaggio and Powell (1983) and Fligstein (2001). He mainly drew on Fligstein’s conceptualisation of field in which he emphasises the importance of socially skilled individuals. Since Beckert’s paper was issued, Fligstein and McAdam have published a book *The Social*

Theory of Fields (2012) in which they describe their model of a “strategic action field”. The authors argue that the classic Bourdieuan concept of field is too focused on the individual. Within their model Fligstein and McAdam include concepts of fields embedded in fields, and describe these in hierarchical terms. Fligstein and McAdam are especially interested in the notion of *social skill*, and the way in which certain individuals influenced field change. They also argue that the *broader field environment* needed to be understood. Especially important in a strategic action field are *episodes of contention*, and the achievement of *settlement*.

“If the field is more orientated toward the pole of settlement, conflict will be lessened and the positions of actors more easily reproduced.”(Fligstein and McAdam, 2012:p12)

Beckert argued that by using the concept of field it was possible to shift the emphasis of analysis away from the act of exchange and towards the dynamics of the three social forces.

4.3 Castlefield: a field on three levels

The empirical setting for this study was the health economy of Castlefield, a City in the midlands of England. *Health economy* is a term in common usage in NHS circles, which remains undefined and is used flexibly to describe the organisations which provide healthcare in a local area. The term “economy” refers to the relationships and interdependencies that exist between organisations that plan, procure, and provide health and care within that geography. More recently the term “health and care economy” has come into usage reflecting the mutual interdependency of health and social care services. There is no single organisation or governance arrangement for a health and care economy. The health and care economy in the city of Castlefield included a large acute hospital, a community health provider, a mental health service, an ambulance provider, GPs, and a unitary LA, as well as an active voluntary sector, and various private sector organisations. Castlefield was a concentrated inner city area, with a population

that was ethnically diverse, young, and deprived compared with the national average. GPs served over 300,000 patients.

The study took place in the period immediately preceding and during a time of statutory change to the NHS. The Health and Social Care Bill 2010–2012 was enacted by the Lords on 20th March 2012, and came fully into force on 1 April 2013. The empirical work of this thesis is centred on the set of field rule changes that the HSCA 2012 contained. The controversy surrounding the passage of the Bill through parliament was intense. The rhetoric associated with it was about the improvement of services and patient experience, although many were members of the public and the NHS were of the opinion that its real purpose was different. In the original bill there were proposals to significantly increase the role of competition through an enhancement of the role of Monitor, the economic regulator. The extent of the opposition to this and other aspects of the bill resulted in a parliamentary pause during which time the proposals to introduce competition were toned down and focused on the prevention of anti-competitive behaviour (Hudson, 2013). A significant change was that an initial proposal to allow any willing provider to provide NHS services was amended to “Any Qualified Provider” (AQP). This was enacted through an initiative by which to decide which providers were qualified and to place them on a register (Asthana et al., 2011). The establishment of CCGs continued largely unchanged, although the original proposal to introduce these in the form of GP consortia was amended to allow for a less uni-professional focus and to maintain the role of managers. Proposals to transfer public health duties to LAs survived the Bill phase and were enshrined in the Act.

For the purposes of the study I have conceptualised the health and care economy of Castlefield as a three levelled field.

4.3.1 Operational Practice Level

The first level of the field was the OPL. Commissioning at this level was the routine business of the consulting room. A GPs day job was

to offer a consulting service to individual patients within their surgeries. As already described in 1.3.1 when a GP made a referral, offered a treatment, or signed a prescription he or she was allocating NHS resources.

There was no such thing as a typical General Practice in Castlefield. These varied in size more than tenfold. Some operated from rented buildings, whilst others owned the property. Some practices served challenging and disadvantaged communities, whilst others were in affluent areas. The concentrated urban nature of Castlefield meant that it had more than its fair share of problems when it came to poverty, alcoholism, and drug-related illness and crime. This meant that in certain areas there were problems in the recruitment of GPs. It also meant that it had a higher than average proportion of single-handed practices, and practices that operated out of rented premises in health centres. In other words, it was a typical inner city area.

When the HSCA 2012 was implemented, it introduced a rule that applied to all GP practices alike across England. All were contractually required to be a member of a CCG and to appoint one healthcare professional to liaise with that CCG.

4.3.2 Strategic Collaboration Level

The second tier of the field was the SCL. Where the OPL was the activity of individual practices, the SCL was an arrangement whereby these practices operated as an aggregated body. The organisational arrangement for this strategic role was the CCGs that were established during the period of the study. As a collective they developed a Castlefield-wide health strategy to meet the needs of their patients. They directly allocated health resources through designing services and letting contracts with organisations that provided healthcare to their registered patients. Where GPs provided services over those included in their core contract, these would also be planned and contracted at this level.

The new field rules that applied at this level were that all GPs must shape and agree the CCG strategy and have voting rights regarding the GP leaders, and that AQP and other competition mechanisms must be used to procure services.

4.3.3 Interagency Strategic Partnership Level

The third tier of the field is the strategic partnership level (ISPL). At this level representatives of the SCL became part of a Castlefield-wide inter-sector public partnership. Representatives of the organisations in the health and care economy were statutorily required to meet as HWBs. HWBs are intended to have strategic influence over commissioning decisions across health, public health and social care. They have loosely prescribed membership and functions, and were formally established on 1st April 2013 . They have the status of committees of upper or single tier LAs, and have the right of veto on CCG commissioning decisions. An associated rule change was the transfer of public health staff and duties from PCTs to elected LAs.

Castlefield HWB had the characteristics of a public policy strategic partnership (Sullivan and Skelcher, 2002:p24). It was a forum for deliberation but did not have decision making power. It was accountable to wider stakeholders via the communication mechanisms of the partner organisations. The HSCA 2012 prescribed a core statutory membership of at least one elected councillor, a representative from each CCG whose area falls within the LA boundary, the local authority directors of adult social services, children's services, and public health and a representative from the local Healthwatch organisation. Beyond this discretion was granted to appoint further members. The membership of Castlefield HWB was widely extended. There were more than twenty members in total (see Appendix 4 for full membership).

4.4 The empirical chapters

In the next three chapters I present findings regarding how rules introduced by HSCA 2012 were interpreted and implemented at each of the levels. Section 3.6 above contains a detailed explanation of how data is displayed in each of these chapters. In the empirical chapters, I use observations of GP- commissioning to show the dynamic between cognitive frames, networks, and rules. From now on I use the term sensemaking when considering cognitive frame. For ease of reference, table 20 below contains a reminder of the rules by level.

Table 21 Summary of field rules by level

OPL	GPs have to be members of a CCG, and in Castlefield this means joining a subnetwork GPs have to hold a commissioning budget, out of which they will “pay” for their clinical referrals and prescriptions.
SCL	All GPs must shape and agree the CCG strategy and have voting rights regarding the GP leaders. AQP and other competition mechanisms must be used to procure services.
ISPL	HWB must be in place, established as sub-committees of the LA Public health duties (including budgets and staff) must transfer to the LA Arrangements for integrated care must be put in place based on localities.

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Chapter Five: Sensemaking, networks and rules at Operational Practice Level

5.1 Introduction

The prescribed model for collaborative commissioning in HSCA 2012 was that each GP practice should be a “member” of a CCG. As Castlefield was a large CCG with more than sixty individual practices, four sub-groups were put in place. These groups were called Chamber, Principled Collaboration (PC), The Gurus (a pseudonym suggested by one of the GPs, when I was struggling to think of a descriptive name); and New World (NW), all of which had existed in the organisational arrangements of the predecessor PCT. In the CCGs constitution (CCG doc 1) this arrangement is described thus:

The Clinical Commissioning Group’s (the “**CCG**”) membership is organised into groups of GP practices (“**GP-groups**”), which are based partly on geographical location and partly on inter practice relationships and culture.

This excerpt captures a compromise reached on a point of contention between doctors and managers. Managers would have preferred to organise practices according to geographical proximity in a locality-based arrangement. However doctors preferred to organise themselves in already established networks based on past experience of working together. In retaining this pattern of networks, their associated approaches to sensemaking were also preserved.

GPs in each practice had the option to choose the GP-Group to which it belonged. Those few practices without a preference were assigned to either Chamber, or PC. Chamber happened to have marginally more members in the east, and PC happened to have more practices in the west. Practices without a preference were attached, east or west, according to their location. The CCG did not make any attachments to the Gurus or NW. Although the written

rules as expressed in the constitution gave “geographical location” equal weight to “inter-practice relationships and culture”, in reality it was attitudinal convergence and social networks that determined who belonged to which GP-group. From my observations, it appeared that the shared history and/or perspective of the GP members influenced the way they made sense of changes in general and of the commissioning rules in particular.

In this chapter, I draw on observations of these networks in their monthly meetings each of which I observed on four occasions. GP-group meetings took place at lunchtime or in the evenings and include the sharing of food, encouraging the maintenance of a social network that formed the basis for sensemaking between members. Meetings had a common core agenda, but how this was interpreted was different in each of the four networks. First I analyse each GP-group in relation to its processes to make sense of commissioning rules. Next I use an example of cross-CCG budget-setting in order to illustrate and analyse the dynamic between different networks.

5.2 Chamber

Chamber was the largest group and included over 25 practices with a combined list of almost 160,000 patients. Its smallest practices were single handed with just over 2,000 patients, and its largest practice had nearly 14,500 patients. This was the only group that did not allow a representative from every member practice to attend its monthly meetings. Instead approximately a third of the practices were represented by a range of staff groups including practice nurses and practice managers, as well as doctors. The remaining practices were bound to the network through a buddy system. The group met in a hotel designed for conferences at the edge of Castlefield, easily accessible from main transport routes. Meetings took place in the evening between about 6.30pm and 9pm, and were held in a small room; the meeting table took up most of the space creating an intimate atmosphere. Food was served outside on

hot plates, and was eaten during the formal business. Doctors arrived hungry and often late, having driven across town after evening surgery. Between ten and fifteen people would typically be in attendance.

There was a predominant approach to sensemaking and sensegiving in this network. A number of the GPs that regularly attended meetings were previously fundholders, and this influenced which sensemaking cues were extracted from the commissioning rules. The group leader, Dr Baasit, now in his fifties, had led the Castlefield fundholder group as a younger man. Dr Conary, also in her fifties, had been a partner in a prominent fundholding practice. Dr Ibrahim was also a first wave fundholder. The GPs that attended meetings often referred to member practices as businesses, and they appeared to conceptualise primary care as a business sector, with themselves working on behalf of that sector towards common business goals. This was not dissimilar to the model used by Chambers of Commerce which draw representatives from businesses in a region with the shared aim of supporting enterprise and sustainability. There was no evidence that they identified as an elite with more status in a hierarchy, rather they interpreted their sensegiving role as one of peer-based guidance and encouragement.

The leader, Dr Baasit, had a personal interest in organisational behaviour and OD. I knew from my own experience that the term OD in the NHS is used imprecisely to cover a wide variety of activities connected with change, service development, and to engage and motivate staff. It usually involved focused time in groups, to support changes in rules. OD activities were often supported by a facilitator who helped groups to understand their shared objectives, and runs group processes to help them to plan how to achieve these objectives, whilst staying personally neutral. I first met Dr Baasit in the early 1990s when he had completed a Business Masters degree, and had developed a practice level OD programme ("The People, The Horizon, The Vision") designed to

help practices determine their future direction. Dr Baasit used to meet with practices and act as a facilitator. He appeared to draw on this background in his current role. He explained his approach to me using the words: "It's all about how to change behaviour" (*Chamber fieldnote 3*). The language he used strongly emphasised inclusion and the sharing of opinions and views in order to improve decision making. When faced with a difficult issue he used phrases that emphasised peer relationships in a collective often using "we", for example "We need to solve a puzzle" and "What can we do?" (*Chamber fieldnote 3*).

Other group members appeared to follow his lead. They spent time discussing and planning how to approach member practices, and emphasised the use of questions to encourage practices to think actively. For example when discussing the problem of patients not turning up for appointments, the action proposed was to ask each practice for its policy with the simultaneous posing of the question "What do you plan to do to be more proactive?" (*Chamber fieldnote 3*), prompting practices to self-direct improvement.

Dr Baasit, introducing cues from the wider commercial world, encouraged others to make sense by developing a business-like identity. He drew parallels with a well-known retail business with a mutual ownership model, in order to add emphasis that practices should think commercially and co-operatively at the same time:

"We are a John Lewis kind of organisation; we are the sum of our parts" (*Chamber fieldnote 2*)

Rewards were the result of aggregate performance achieved by each individual practice in the GP-group. Just as in fundholding, if referrals and prescriptions cost less than the CCG had budgeted then an element of the saving could be retained by the GP-group. Those GPs that were active in Chamber's inner circle were focused on ensuring that practices in the network collectively managed demand, and thus returned savings, a part of which could be spent on the priorities that the Chamber practices determined. When

talking about what might constitute an irresponsible referral or prescription Dr Baasit said:

“We don’t want to see any of our little businesses doing that sort of stuff”.....We are in a new world where budgets are supposed to matter” (Chamber fieldnote 3)

There were ambiguities implicit in the new rules however. The practices did not have control over their budgets in a complex health and social care system. Hospital activity was charged to practice budgets, and there was a frustration when these were impacted by forces outside of the doctors’ control. Dr Baasit’s frustration was articulated in the following words:

“What about the patients who stay in inpatient care? Social problems. Messing up my budget big time. Do we have an alerting system?” (Chamber fieldnote 3)

Dr Baasit wanted a warning system to let him know when patients were unable to be discharged because of a lack of social care facilities, just one example of the way that costs could continue to accrue with no way for the doctors to influence, let alone control.

The control of costs was a main sensemaking cue that Chamber doctors had identified. The ex-fundholders had experience of controlling clinical activity as a way to contain costs. A discussion of member practices’ activity formed the centre piece of every meeting. Bridget Jones, a manager from a medium sized practice based in a multi-purpose inner city health centre, produced a cross-network data set which she presented each month, and which formed the basis for discussions with individual practices through the buddy mechanism. Bridget’s data set consisted of a set of graphs which showed how practices compared in terms of prescribing, outpatient referrals, and emergency admissions, each presented in terms of the impact on the overall group budget. The group’s attitude of enquiry was one of critical curiosity, with a view to sharing tips and deepening understanding of problems. One fieldnote entry reads:

[Bridget] pointed to a sharp deterioration in one line "Emergency admissions obviously went mad." The same practice was showing an improvement over the same period on prescribing. Dr Conary commented "There are many reasons – the question is, do they know?" The Drs talked around what it could be. It could be a virus or some other reason... (Chamber fieldnote 3).

More importance was placed on patterns than snapshots. The dataset, and the questions raised when it was scrutinised, formed the basis of how Chamber practices interacted. Regular practice-based communication took place. Firstly, practices were made aware of the patterns of activity they were producing, and secondly informed challenge took place in the form of discussion between peers, coupled with an intention to learn from each other. Dr Conary said:

"The question "Why is that?" needs to be asked." And "Where practices are making big inroads we ought to find out what they are doing?" (Chamber fieldnote 2)

Inherent in the process of referrals and prescribing were both ambiguities and uncertainties – the system was complex and unpredictable at the same time. Chamber GPs knew that sensemaking could not depend on the accuracy of facts. Instead they attempted to understand and support - rather than accuse and blame. Dr Conary was especially influential in promulgating this approach. She had a personal interest in working directly with individual practices to help them improve. In addition to her work at the GP-group level, she also had devised and led a CCG-wide programme of practice visits. She described her approach to me in an interview:

Dr Conary: "Well I can see, practices are very isolated groups, they work very hard and they have their heads down dealing with difficult situations all day long and they may have short amounts of time with their practice manager to manage the practice but on the whole they don't have time to look wide, they don't have time to meet with other GPs in a relaxed way to talk about things.....I feel very much that there's lots of things that are happening that are positive and that can be helpful but actually the practices just don't

know about them and they're mostly feeling rather demoralised and no one's there to help them and I do feel that they need a structure. I really believe in the kind of independence and autonomy of individual general practices but the downside to that is they're isolated and feel easily demoralised because they're not appreciated and I feel a lot of them are really conscientious, hardworking people who are doing the best for their patients and put themselves out all day long and wear themselves out and are trying to be helpful and positive and help depressed people or people down on their luck to think more positive and think positive about the way for the future. All day long they're doing this emotional job and nobody's coming, and they're doing it because they feel motivated that they really want to serve the patients and feel good about themselves."

Adele: "That's a phrase I use all the time 'serve the people' whenever I'm trying to orientate."

Dr Conary: "Yes that's right, but the structures around are so complicated and so demoralising that they easily can feel very fed up and demoralised and that all this has been done to them instead of them being appreciated and I really felt that practices really needed people to go round to who could see the bigger picture and actually say this is what it's all about, here look this is your information you are doing really well on this and you know you've been better than other practices on this and well done because you're really working in a difficult situation. Maybe you're not doing so much on that and maybe you don't know how to do that so let me tell you about ways that other practices are doing it or how you can get more money to do that because, and employ somebody new or how you could find out where you get locum nurses or what the, you know why haven't you applied for this funding because it's there available, perhaps you didn't know about it, why haven't you referred people to these services because you don't know about them, let me tell you about them, let me tell you what other people have found in a positive way." (ConaryInterview)

This approach of looking for reasons for variation in clinical practice, and then offering support to and sharing insights between practices to improve is an example of prosocial sensemaking where actors in organisations care for each other (Grant et al., 2008).

The GPs that attended meetings were an inner circle of peer-leaders that offered guidance and encouragement to a wider circle. The continuation of collective sensemaking was highly dependent on the legitimacy of those in the inner circle as perceived by those in the outer. The conditions for collective sensemaking needed to be nurtured on an ongoing basis. Meetings often focused on how to sustain the trust and co-operation of member practices in the face of ambiguity and uncertainty. The fact that this was a sensitively balanced relationship was illustrated by a discussion about whether to write a letter to those practices whose referral and prescribing rates tended to be higher than others (*Chamber fieldnote 2*). Dr Baasit thought that a letter should be sent to the partners to inform them of their position relative to others. Chamber needed to be tough, he argued, in order to establish expectations of behaviour that would enable practices to survive in the future. He was afraid that being too soft would be a “disservice” in the long-run. In his view all partners needed to grasp that financial management mattered according to the new NHS rules for GP commissioning. The others disagreed. Writing a letter would be a step too far. They felt that to send a letter would be perceived as an expression of hierarchical power. Given Chambers’ GPs emphasis on working to influence rather than to direct most felt that face to face discussion would be more appropriate. Dr Kerala, another Chamber Executive GP (see 6.2.1) described the CCG’s relationship to the practices as “fragile”, usually only one GP in each practice acted as a point of liaison; a letter to all partners would cause offence. The Chamber doctors instinctively realised that an impersonal didactic approach would put at risk the trusting relationship upon which their approach depended.

Trust was only one aspect to this legitimacy. Two other dimensions that were actively nurtured in the sensemaking process were the quality of information; and patient centredness. Dr Clemence was a GP from a medium sized all female GP partnership. She, in

particular, strove to ensure that information was as relevant as it could be to the task in hand. One fieldnote reads:

There was a real appetite in the room to drill down further. Dr Clemence was clear, the figures needed to show day cases separately. They also needed to show non-elective admissions separately from A&E. This would enable the practices to look at patterns they could most affect. Dr Clemence continued to refine, thinking about sub category data. She was also interested to see if some procedures e.g. joint replacements could be isolated.

(Chamber fieldnote 3)

On another occasion she spotted the potential in an initiative for GPs to be paid twice for the same work (*Chamber fieldnote 4*). She quashed this immediately, and none of the other GPs objected. Chamber's discussions were consistently framed around whether patients' needs were being met. This appeared to be a fundamental shared value that underpinned the continued social approach to sensemaking in this network. Earlier in this chapter I described my observation that Chamber GPs had elected to work together because they shared a legacy as fundholders. This is only part of the story. Chamber GP-group included a high proportion of GPs that rented space in health centres in disadvantaged areas. This was an indication that these doctors were likely to identify as having a vocation to serve the poor. They would often criticise existing services according to how effective and compassionate they were for patients, often using examples and personal stories, drawn from operational clinical practice. Dr Baasit had a special interest in cancer services and often focused on the need for earlier diagnosis. South Asian people suffer a high incidence of bowel cancer, and he talked about the time he went on Asian television showing how to take a stool sample using a Gulab Jamun (squidgy brown Asian sweet) and a sample bottle (*Chance encounter fieldnote 2*). Practice nurses raised their concerns about gaps in services, for example the young people's obesity service served patients up to the age of thirteen, leaving a gap until the adult programme could be accessed at the age of eighteen. A particular frustration was access to

psychological therapies, for which there was a fifteen week wait.

One doctor said:

“We all talk about the patient centre – let’s not leave them wandering in the desert” (Chamber fieldnote 2)

The process for making referrals was often under scrutiny, especially as more contracts were let outside of the traditional NHS Family. It is difficult to pin down how membership of the Family is conferred. A number of organisations that were inside the NHS Family were not owned by the state. These included Castlecare (the provider of local community health services) that had recently become a social enterprise, and GP practices that were private partnership businesses. Some of these discussions were about how arrangements helped or hindered the day to day work of a GP, especially the general difficulty in dealing with information overload, and complexity of services. In one discussion about referring into a new non-NHS psychological treatments service (*Chamber fieldnote 2*), doctors said:

“We don’t get enough information.”

“If you want us to refer we need to know how.”

“We’re talking GPs, so big letters.”

Thus, the inner circle established legitimacy, by first establishing trust, working hard to make available relevant information, and by establishing moral purpose through a discourse based on serving patients. This legitimacy was the basis of how Chamber peer-guides nurtured ongoing social sensemaking, and succeeded in joint enactment of demand management with the associated accrual of savings across the wider network. The money saved could be spent on services that the network chose. This choice reflected their shared commitment to vulnerable patients. They invested in domestic violence education for practice staff, a carers support service through a local charity, and the development of a “recovery college” to provide emotional support for patients with long term conditions (*Chamber fieldnote 1*).

From these observations it is possible to draw out the implications for BF at the intersection of SP. When making sense of the commissioning rule, there were two main influences on sensemaking in Chamber. Firstly, sensemaking was influenced by a shared legacy; past experience of fundholding was a source of cues to interpret commissioning rules. Practice-level activity data was routinely scrutinised. Secondly, the needs of patients from disadvantaged areas was also a source of cues for interpretation of the rules. An active inner circle of GPs acted as sensegivers, guiding and encouraging the wider group. Continued co-operation with this model depended on legitimacy, which the inner circle consciously attempted to engineer using sensitive communication, high quality information, and a focus on vulnerable patients. Sensemaking was prosocial, with an emphasis on caring for and helping member practices. The inner circle sensegivers, especially Dr Baasit, used an established OD technique where practices were encouraged to develop a questioning approach in order to conceptualise commissioning duties for themselves.

5.3 Principled Collaboration

PC was the second largest GP-group which included around twenty practices and had a combined actual list size of almost 125,000 patients. Its smallest practices were single handed with just over 2,000 patients, and its largest practice had nearly 13,000 patients. Meetings took place in a modest hotel close to the City Centre. People from all practices and all staff groups were welcome; typically more than 30 people would attend. A hot meal with dessert was available. People would arrive early, collect their food, and move to eat it at the large horseshoe meeting table taking time to catch up and chat before the meeting began.

In Castlefield in the mid-1990s a group of GPs objected to the fundholding scheme, arguing that it created a two-tier service. They formed an allegiance based on a principle that the NHS should be

equitable. Many members of this group shared a legacy as non-fundholders, which influenced which sensemaking cues were noticed. Dr Strong, one of PC's leaders, was a founder member, and many of PC's doctors had been part of that early collaboration. The executive GPs, Dr Strong, Dr Lovett, and Dr Cooper, all white English men in their fifties, had known each other in non-fundholding circles for over twenty-five years.

PC GP-group was stratified with clearly differentiated hybrid-leaders who acted as directive sensegivers to the rank-and-file. Meetings were formal and tightly chaired. Discussions followed a pattern in which at least every other contribution was made by one of the lead GPs. When Dr Cooper, the chairman, looked to appoint a deputy he began by asking if anyone would like the role, at the same time adding "if not we'll knobble one of the boys" (*PC fieldnote 1*), meaning Dr Strong and Dr Lovett. Dr Strong was duly appointed unopposed.

Their focus was on national policy and healthcare as a system. This contrasted to the practice-based lens of Chamber GP-group. PC did not analyse individual practice activity as its mechanism for undertaking commissioning. Practices, their privacy intact, were left to self-manage. Dr Cooper once described the member practices as "grown up" (*PC fieldnote 2*). Comparison of practices happened through the CCG-wide practice visit programme under the leadership of Chamber's Dr Conary, and this is where practice level scrutiny began and ended.

PC leaders appeared to make sense of their own roles by adopting an identity as system-steward. As an alternative form of influence to that of fundholding, non-fundholders had collaborated with Castlefield Health Authority to design the local healthcare system, and to have stewardship for the health economy. The legacy of this could be seen in how PC doctors made sense of the current commissioning rule. Meetings focused on national initiatives, and pathways that crossed the boundaries of primary and secondary

care. The leaders interpreted their sensegiving role to be that of explainer and promoter of local and national policies, thus minimising ambiguity and confusion for the rank-and-file. The agendas of meetings were constructed to include both national and local topics.

Whilst PC doctors made sense of the commissioning rule by thinking about the wider system, discussions were usually about the impacts on primary care. When doctors discussed the effect of an initiative on their own practices they would often react with indignation and resistance to any proposed increase in work load or change to working patterns. An illustration of this was a discussion about the introduction of seven day working between the hours of 8am and 8pm (*PC fieldnote 2*). The doctors foretold catastrophic consequences with phrases such as “the end of the essence of general practice” and “the end of the family doctor”. When the patient representative spoke up to counter the prevailing GP opinion saying “providing there are good doctors who are caring and understanding, [patients] don’t mind”, the practice managers shifted to focus on the practical reality of finding enough doctors to cover the hours: “We’d love to do it if we could recruit GPs”. When this sort of reaction occurred, which it did frequently, the approach adopted by the leaders was to allow time for emotions to be expressed sometimes joining in as fellow doctors, and to then close the discussion by proposing a way forward which would always be accepted by the rank and file, if sometimes more grudgingly than others. It appeared that these leaders were in fact committed and adept at maintaining emotional discipline in order that a problem-orientated attitude would not become dominant. One way they did this was to show that they held two positions at once: that of affected GP, and that of leader and system-steward. As will be seen in the next chapter, this role of system-stewardship was also evident in lead doctors at the strategic collaboration level.

Members of PC-group spent time discussing local contracts for secondary care services. Issues that arose with local health care

providers were framed in terms of the contractual relationship that existed between the CCG and that provider. According to the letter of the new rules, the GPs had the upper hand over the hospitals and community providers - they were the paymaster who could specify the terms of a contract for services. An issue regarding the contract with Castlecare, the provider of community nursing services, became a topic of discussion over a cycle of three meetings. The first time it was raised was by a practice nurse. She framed an operational question in terms of the contract.

"There is a need to clarify what is included in the spec and what is actually being delivered." (PC fieldnote 2)

As later events would reveal, actually, this nurse was worried, and wanted to raise the alarm about an impending change. In an attempt to operate within the new rules and to minimise her appearance of struggle with ambiguity, she couched her concern in the language of contracts and specifications, with the consequence that the real operational impact of the issue was obfuscated. By the next meeting, a month had passed, and it was clear that Castlecare had made a unilateral change to community nursing services (*PC fieldnote 3*). The GPs had not agreed this in contractual terms as commissioners, nor had they or their practice nurses been consulted as affected clinicians. The reaction was emotional, doctors and staff were annoyed at the lack of consultation, and were protective of their affected colleagues and patients. One practice nurse described how a community nurse had been crying in her office. Another practice described a community nurse as "completely flummoxed". Rather than conceive this as a failure of commissioning, Doctor Cooper framed this in positive terms.

"This is an example where clinical commissioning can really work. We can give immediate feedback".

Duly, at the third meeting (*PC fieldnote 4*), two senior nurse managers from Castlecare were summoned to give an account. One of the Castlecare nurse managers began with their response, adopting a dominant, and unapologetic stance. She appeared to be

deflecting criticism by implying that the commissioner-expectation for involvement was unreasonable. She said assertively, that it was “inevitable that change [was] going to happen”. She then shifted to the next anticipated change, saying:

“The integrated care programme is rolling down the hill, which **you do** know about” [my emphasis].

Confronted with this assertive, challenging response the GPs appeared to feel intimidated. They stopped being commissioners, and became fellow community clinicians. The doctors and practice nurses said that community nurses were part of the team. The Castlecare nurses explained that the reason for the change had been in order to staff new care home teams that the GPs had commissioned. The strong words that underpinned the tone of the last meeting were replaced by more ameliorating language. Dr Lovett said:

“People like teams, and like relationships. Whilst you are within your rights, it would be nice to know”

These words indicate that Dr Lovett preferred to work in harmony with Castlecare colleagues, rather than thinking as a payer trying to get value from a contractor. In an apologetic tone, another doctor said:

“Our DN [district nursing] team are absolutely fabulous but they are run off their feet. I feel very protective to them.”

Until April 2011 the services now provided by Castlecare had been provided by Castlefield PCT. As part of an exercise known as “Transforming Community Services” all PCTs had been required to divest themselves of this responsibility. Across England there were now a variety of business models for the provision of these services. In Castlefield a Community Interest Company (CIC), Castlecare CIC, had been formed which delivered NHS contracts. The nurse managers began to share the difficulties they faced, focusing on the recent change of status from being part of the PCT to becoming a stand-alone social enterprise.

“Because we are a social enterprise, hospital nurses are put off working for us because their NHS pension gets frozen”

Sensemaking cues about an integrated health service were being extracted, which seemed more plausible in this context than a contractual relationship. GPs and other practice staff and Castlereach staff worked together on a daily basis in the same teams and buildings. There was an inherent ambiguity in GP commissioning because the doctors were both colleagues and buyers at the same time. The nurses made the GPs choose to be one or the other, and the more embedded personal NHS Family relationships superseded the contractual commissioner ones.

From these observations it is possible to draw out the implications for BF at the intersection of SP. Firstly, a shared legacy informed how this network made sense of the commissioning rule. Prominent leaders from early days of non-fundholding were present day leaders and sense-givers in PC. There remained a commitment to the principle of one NHS, which manifested itself in the conceptualisation of PC as one part of an interdependent healthcare system. The focus was outward to the wider healthcare system. However this was with an emphasis on the impact of system changes on General Practice. Secondly, leaders were differentiated from the rank and file, but did not interfere with operational business of practices. This appeared to be intentional and instrumental in the approach the leaders took to sensegiving. Leaders would switch into rank and file mode, expressing empathy when other doctors reacted with cynicism and resistance. They then would switch back into a prospective solution-orientated mode, encouraging other doctors to mirror this shift. Thirdly, members of PC did make explicit attempts to adopt the identity of “commissioner” separated from “providers” in a market-like distribution. However this ran counter to their usual way of making sense and extracting cues. In other words actors attempted to respond to new rules by adopting a market sensemaking in a culture with a legacy of prosocial sensemaking. However when

problems arose between commissioners and providers then all would draw on a deeply embedded legacy of collegueship across the inter-dependent NHS system in order to make sense.

5.4 The Gurus

This network consisted of 14 small practices owned by older Indian Hindu GPs. The total list size was around 30,000 patients. The NHS has always depended on migrant workforces, and the 1950s and 1960s saw a drive to recruit doctors from India. Doctors arrived with no more than three pounds in their pockets (*AQP fieldnote 1*), and began to work in single handed practices in disadvantaged inner city areas. This group was the most closely knit of the four networks. They shared a common cultural and religious heritage and the experience of migration to be doctors in deprived areas of Castlefield. In an interview, Dr Poona (*PoonaInterview*), the chair of the Gurus explained that overseas doctors were deployed into areas of medicine where there were recruitment problems:

Dr Poona: Yeah, well when I went to, when we came into this country I wanted to go in general surgery, there was no vacancy for me to go in general surgery. The job which I could get easily and could get it was ED, A&E and that's where I had to work. So I think back, why the hell did I do that? It's not that I didn't like it, I enjoyed it there also, but I was orthopaedic trained when I came to this country and I wanted to do orthopaedics and A&E was part of it, so I would, I couldn't go into orthopaedics, no vacancies for me to go into orthopaedics.....

Adele:it does seem like overseas Doctors were put into the jobs that the indigenous population didn't want. I can see that everywhere I look actually.....

Dr Poona:whatever name you might call it and that's the facts.....I'll leave it for you to understand and.....It's clear in front of you.....you can't avoid seeing it. Why is it that the inner city practices are being run by overseas, most of them, over the last say twenty years?it'll come to standstill because if you see all the inner cities it's being done by us, [Accident and

Emergency] was being done by us at that time and if they stopped it would have been terrible.

All of these practices were small. Some were single-handed. Some were husband and wife teams covering both the doctor and practice manager functions. A number of the practices did not employ practice managers, which meant that the administration in its entirety fell to the GP(s). The doctors were old enough to retire, with one exception – an anxious younger doctor worked in a surgery with his mother.

The meetings took place after a shared lunch in a local Indian restaurant. The atmosphere was familiar and friendly; these doctors were part of a network that went beyond the work-a-day. They belonged to a number of associations that brought them together – a group for deprived area doctors, the Castlefield branch of the Small Practices' Association, and a group for overseas doctors. Each of these met monthly which added up to a weekly gathering.

Dr Poona together with his friend Dr Ashok took the executive lead roles at the CCG level, and are described affectionately by one practice manager as "Tweedledum and Tweedledee" (*Gurus fieldnote 5*). They acted as a conduit between the CCG and the rank-and-file. Sensegiving was an act of communication; there was no evidence of these doctors operating in a directive hierarchical fashion. The meetings at first sight appeared disordered; the formal agenda being subject to deviations. Conversation flowed in a naturalistic way, and there was a sense of equality between all those present. There was no apparent gender hierarchy although men were in the majority.

At the meetings a great deal of time was spent in sharing stories from the surgery. There was a repeated theme regarding the problems created by new initiatives. Below are some examples to illustrate this:

About patients being sent to the hospital with the earliest appointment when they have suspected cancer: "That 2 week wait

is a bloody pain in the backside; you get appointments in Timbuctoo, not in Castlefield" (Gurus fieldnote 3)

About the Choice initiative, where referrals can be made to a range of hospitals: "I had a patient this morning for neurology. I started clicking all these buttons. I had to change the symptomology to get an appointment in Castlefield." (Gurus fieldnote 6)

About new partnership arrangements for children's services: "Three years ago we went through all this...set up all these Boards for young adults. Why are we doing it again? It failed miserably last time." (Gurus fieldnote 6)

At a practice managers meeting, about the move to electronic referrals and discharges which has been implemented early in Castlefield: "We get letters from Seasidetown and Nextown? Why can't we get letters from Castlefield"? (Gurus fieldnote 7)

They shared stories about the demands of patients, the cost of supplies and services, problems with computers, and many other operational concerns. The pressure to change caused various emotional reactions. These included frustration when required to make new systems work or to adapt to new ways of working; world-weariness when initiatives were tried that were similar to ones that had failed in the past; and a mixture of disappointment and cynicism when systems did not seem to work in the interests of patients.

The regular and social meetings, the shared ethnic heritage and history of migration, and the sharing of operational experiences meant that this network more than any other group had a shared way of making sense of new rules, and in the current context that was mainly to interpret them as burdensome, and sometimes threatening.

Change was laced with threat for this network. National policy for primary care, both existent and anticipated, was increasing the complexity of primary care medicine. When discussing a transfer of work from dietetics to primary care linked to new responsibilities in the management of diabetes, Dr Franklin, the network's wit, used it as an opportunity to make a wider point:

"That's why they call it drip feeding, little by little everything drips into general practice" (Gurus fieldnote 6)

Another doctor described the impossibility of keeping abreast of the range of knowledge now required, saying:

"People keep coming to teach me things.....all baby foods, and rabies this week" (Gurus fieldnote 1).

The complexity of 21st century general practice had led to a commonly held view, particularly amongst policy makers and managers, that small practices did not have enough doctors to cover and master the range of skills and knowledge required to deliver modern care. Small practice medicine was not seen as a viable model going forward and awareness of this contributed to this network's shared anxiety about the future. Small practices were also facing financial difficulties. All locum doctors were now entitled to be on payrolls and all staff must have the availability of a pension arrangement, adding to practices' overheads. A scheme called the Minimum Practice Income Guarantee, upon which small practices in deprived areas were reliant, was being phased out. These changes, coupled with the fact that many doctors owned buildings which were hard to sell as going concerns, meant that financial difficulties seemed inescapable. These factors, severally and in combination, meant the Gurus noticed cues that signalled an uncertain and worrying future.

Despite these worries, this network had a great capacity to take care of each other. The group was socially cohesive with long standing personal relationships. There was a willingness to talk about feelings of vulnerability which was not so apparent in the other GP-groups. Phrases included: "I am just completely lost" and "I haven't got the full grasp..." (*Gurus fieldnote 6*). One extract from a fieldnote reads:

Dr Ambala showed signs of going out of control. Dr Franklin stroked his back and said "it's alright" in a really gentle voice. (Gurus fieldnote 8)

Emotional support and emotional openness were incorporated into the social sensemaking processes of this network. On deeper inspection it became obvious that discussions that had at first seemed chaotic and problem-based were this way because the meetings were serving more than one purpose. The meetings were a space for members of the network to be emotionally vulnerable, and to provide and access mutual support. The extract below is a discussion about the introduction of a target for cancer screening which was in the process of being introduced.

"Cancer one [new target introduced by the CCG]." "How will we report back?" "What are we supposed to do?" "What do we report?" "Who to?" No one seemed to have an answer. The topic then moved suddenly into a review of Long Term Conditions and a concern about scanning and coding data "our staff have to put in." Dr Ambala said "We don't know what community staff have done" Dr Mani said "log in under someone else's name, and put own name at the bottom." Then the topic moved again; this time to the pink card system (a patient linked alert system for A&E to fast track an admission) – apparently patients were still finding it hard to get admitted. "Can we refer new patients?" (Gurus fieldnote 1)

This example is a series of seemingly unrelated questions, solutions, and comments. There are no conclusions or summaries. This was an opportunity to share concerns and anxiety. This was not about resolving problems, it was about sharing them. In his interview (*PoonaInterview*), Dr Poona described the sense of vulnerability that the doctors in this network feel:

Adele: Feel what? Sorry, what was that?

Dr Poona: Vulnerable.

Adele: And what does vulnerable mean?

Dr Poona: Vulnerable in the way that we are not being told that you're not able to provide a service, you are not up to the standard or up to the mark of providing that service to us because if we have to see say twenty patients then you've got one hour with us, we will cut short things..... there's a danger there and, of running short of time and not providing a service what the patient needs.....one problem, one appointment.....you have provide

holistic care for them, to say that mechanically one problem, one just thing there, what the hell he's going to do if he has got two problem or three problem or four problems and you will have more problems as we grow old. So that's where I think we are coming to that we will not be able to provide the service what is requested by, or required by us for the patients.

As well as being overwhelmed by change, and worried about the future of the small practice business model, some of these GPs at least, were experiencing an anxiety related to the safety of the care that they could offer – although this would not be admitted publically – and felt vulnerable as a result¹.

From these observations it is possible to draw out the implications for BF at the intersection of SP. This group did not have distinct and distributed roles; the leaders' approach to sensegiving was to simply provide a conduit between the group and the wider CCG. These doctors shared a multi-faceted legacy which informed their approach to sensemaking. Just as these doctors shared a legacy of working lives in parallel, they also shared a prospective concern about the future. This was a threatened network, and its primary focus was on how to navigate and survive an uncertain future. Strategic discussion was limited; rather members of the network enacted their sensemaking by demonstrating prosocial behaviours of mutual support, and problem-sharing.

5.5 New World

This was the smallest of the four groups and consisted of just two practices, with a list size of around 40,000 patients. One provided primary care on the site of Castlefield University. One was a new practice that has set up in close proximity to the train station to serve patients from all parts of the City. Both practices' patient

¹ It is important to note that there is no evidence to suggest that the care given by this group of doctors is in any way inferior to that provided by other GPs.

population reflected increased global mobility. The new practice, Station, offered services under a scheme called Alternative Personal Medical Services (APMS) aimed at a patient group that would find it hard to access the services of a traditional general medical practice. It offered these services from a newly converted building, and it was in a functional meeting room in this building that the lunchtime GP-group meetings took place, over sandwiches ordered in from a local caterer. Usually about eight people were in attendance including nurses, managers, doctors and a lay representative.

NW's lead GP, Dr Whitbread, was also the Chair of the CCG's GB. He was a partner at the university practice. With over 35,000 patients on its books, this was the largest practice in the CCG having more than twice the number of patients of the next biggest practice. The practice manager, a technology savvy young man, represented the practice in NW meetings thus allowing Dr Whitbread to focus on chairing and presenting commissioner business from the wider CCG. The practice focused on services for a younger than average patient population; for example it was developing a health app, had developed an award-winning eating disorders services, and sports medicine was a high priority.

Station practice was designed to provide services to a mobile and less-settled population. It was located adjacent to the railway station in a non-residential area. The partners espoused a social justice ethos, almost to the point of a brand. The issues that this practice raised during my observations included homelessness, healthcare of asylum seekers, and psychological well-being services. Because of its non-geographical nature, and its willingness to engage with inner city social problems, Station practice took registrations from local probation hostels, and other types of temporary accommodation. The number of patients registered with this practice was growing, recently accelerated by a closure of a nearby single handed practice (a member of the Gurus). The staff group consciously adapted working patterns in order to meet anticipated demand and cater for the lifestyles of its patients. For

instance the surgery opened on both Saturday and Sunday mornings, staffed by a practice nurse and a healthcare assistant, in order to undertake new patient checks.

This network did not share a long history of working together. A new, more prospective, approach to sensemaking appeared to be developing. This was the only group that was not doctor-dominated. Nurses and practice managers took part confidently in discussions as equals. It was evident that the individuals, especially the nurses and practice managers, communicated between meetings. It was often difficult to follow discussions as there was little need to explain or update as everyone, except me, knew the latest. A fieldnote reads:

The meeting doesn't really have a beginning. Chris, a young and dynamic practice manager starts to talk about Wi-Fi and patient feedback, and it would seem we have begun. The discussion, or chat, moved into discussion of readmissions and transfers between the two main acute hospitals. It felt like they just picked up where they left off last time. I tried to put my finger on why this was so different from other meetings. I think it must be related to relevance, and a sense of connection. They weren't arriving to dip into the CCG business. This was their business. (NW fieldnote 1)

In particular, the university practice manager took a lead on new initiatives, and acted as a sensegiver in this respect. He gave particular prominence to the importance of communications and communication technology reflecting the habits of the young, mobile, international patient group that his practice served.

Both practices shared an enthusiasm to improve services for patients, and were optimistic about the potential to do this in the future. Of particular focus was access to services, about which discussions would often be framed in terms of lifestyle and economic issues for younger and working age people. Long waits for physiotherapy services were discussed with reference to the ability of patients to continue working or caring.

"6 weeks is a long time to wait if you can't go to work. It's not an acute get back to work service." (NW fieldnote 3)

“Carers end up with back problems don’t they?” (NW fieldnote 3)

The doctors and practice staff were happy to use new contractual models if this meant better access to services for patients. They were happy for services to be provided by non-NHS suppliers if improvements were gained as a result (see 6.3 for evidence on GP attitudes to competition). Dr Johnson, a female GP from Station mentioned that the partners had received “an interesting private sector letter” thanking them for using the service. “You’d never get one of those from the hospital” she commented (*NW fieldnote 3*).

This network’s approach to sensemaking was confident and with a sense of moral purpose. This was demonstrated in incidences where CCG rules were challenged and disobeyed. It is not possible to decipher how much this happened as a consequence of Dr Whitbread allowing it, or from a moral principle that clinical staff should do the right thing, something that Station staff emphasised. One incident did evidence Dr Whitbread’s ability to bend wider CCG rules. It was not CCG policy to fund practice-based physiotherapists, but the university practice had one. When a CCG director challenged this, asking “have we really examined why it exists?” (*NW fieldnote 4*) Doctor Whitbread replied kindly “If you want innovation you have to take risks”, and thus closed any discussion, whilst ensuring his relatively young, sporty patient-population continued to have their physiotherapist on-site.

NW members always spoke about what was best for the patients in their clinical opinion, and would act on this whether or not it fell within the CCGs rules. An example (*NW fieldnote 2*) was the prescribing of Vitamin D, a deficit of which had other impacts including problems with bone health, heart function, and causing the onset of diabetes. Station practice had been part of a research study, which had revealed that a significant proportion of its population was deficient in the vitamin. Consequently, the practice had routinely tested patients that came to surgery, and found that “the whole population was deficient.” Tests were followed up with vitamin D prescriptions. As a consequence Station’s prescribing

budget was overspent. Despite the CCG prescribing advisors' efforts, Station continued with its approach of testing and prescribing, arguing that not to prescribe was more costly in the long-term.

The developing shared approach was to extract cues related to innovation and improvements in patient care including new technologies. Although these practices had been brought together for the purpose of secondary healthcare commissioning their attention was on the development of 21st century primary care. In NW secondary care commissioning was one of the less popular items on the agenda. Dr Whitbread, would "feedback" from his perspective as Chair of the CCG, describing progress with provider contracts and the status of strategies and programmes. An extract from a fieldnote (*NW fieldnote 3*) reads:

Dr Whitbread did his commissioning feedback. There was a long description of the issues which was very concentrated on the acute hospital, which he led the contract for. He talked about "the emergency rate threshold" and "mega-millions". The hospital had got to find £50 million of savings. "Pathology has joined with another county and will be provided in a shed off the motorway" said Dr Whitbread as an example of ways that economies of scale were being found. Only Dr Whitbread and the patient representative (a sociology professor) were really interested. Others present visibly sat back in disengagement.

Dr Whitbread routinely reported back on planning and contracting activity, but failed to engage the interest of others. Of all the GP-groups, this is the only one where these issues are presented in this formal comprehensive way, without an accompanying discussion about the effect on primary care. After a few minutes others in the room changed the subject back to their own clinical businesses.

From these observations it is possible to draw out the implications for BF at the intersection of SP. This was the smallest GP-group network with only two practices. It was formed because each of the practices served non-traditional niche populations and therefore did not have a natural fit with the other networks. Members of the

network were developing mutually supportive social working relationships outside of meetings. The sensemaking cues that this group chose to extract cues related to innovation and improvement in primary care.

Unlike the other GP-groups, NW did not have an established shared history of commissioning together, and therefore did not have an established sensemaking legacy upon which to draw. This appeared to allow them to be future orientated, with an enthusiasm to try new ways of doing things in order to improve services for patients. The ground for this prospective sensemaking was particularly fertile in this network, as its patient group (at both practices) was considerably younger than the Castlefield average. When making sense of their environment the actors in this network appeared to feel relatively unconstrained evidenced by the fact that they challenged, bent, and broke rules when they deemed such action to be in the interests of their patients. This was in part due to the fact that Dr Whitbread was the CCG chair, so was a protective presence in terms of negative consequences from the CCG, but it was also likely to be attributable to the fact that these were non-traditional developmental enterprises that extracted and bracketed cues related to innovation in primary care. This was reflected in the network's confident, challenging, and risk-taking shared identity, which was in contrast to the legacy-derived identity of the other GP-groups. Not only was their sensemaking confident and self-assured, but appeared to derive from a sense of moral authority based on a commitment to continually improve the quality of primary care services, and to fight for social justice.

5.6 Four GP-groups in one Clinical Commissioning Group network

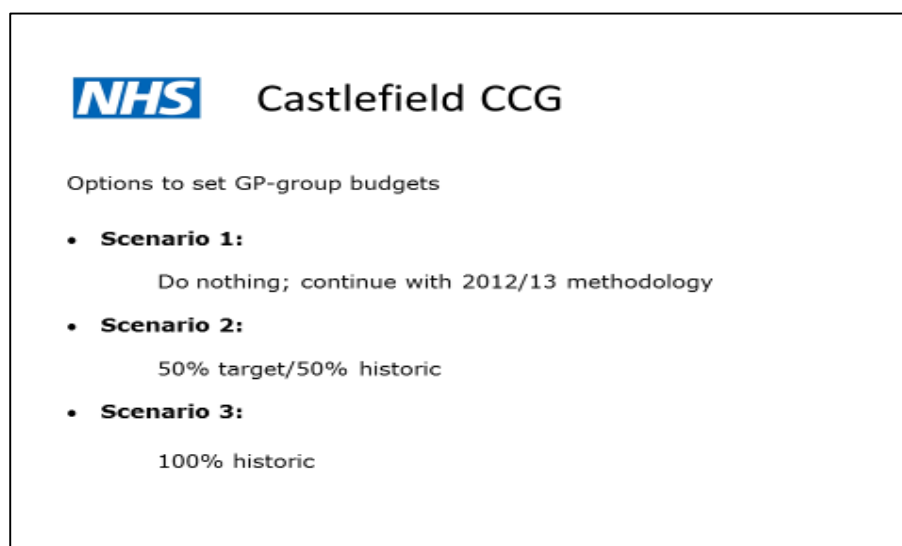
Earlier sections of this chapter were considerations of the different sensemaking styles associated with the four GP-group networks. In the distribution of networks in the health economy these were

positioned as sub-networks of the CCG. Most of the time the CCG functioned as a unified collaboration, but underlying this were tensions related to the different sensemaking processes of the GP-groups which from time to time would bubble to the surface. During my observations there was one exercise when an overarching decision about the four groups needed to be made which clearly exposed these tensions.

During the January and February cycle of meetings, the "Group Budget-Setting Exercise" happened. In previous years a nationally devised distribution tool, known as "the York formula", had been used for all practice-budgets in England. This year, 2013-14, this had been discarded, and instead local finance directors had been given discretion to set budgets locally. I was invited to attend a CCG GB development session (*GB fieldnote 4*), where budget-setting was on the agenda. As already discussed earlier in this chapter, Chamber leaders, in their sensegiving role, had extracted cues from their experience of fundholding, had encouraged individual practices to make savings to spend on priorities that the network would determine. Almost certainly as a result of this approach it had returned a very respectable under-spend on the 2012-13 budget. By contrast the hands-off approach taken by PC had returned a very significant over-spend amounting to almost two million pounds. I had observed Chamber GPs to have a quiet but deep felt pride at having achieved this position. Dr Baasit in particular was pleased to have outperformed PC. The Gurus had returned a slight under-spend. NW had overspent due, in part, to the practice of prescribing Vitamin D described earlier in 5.5. The level of PC's over-spend, because of its magnitude, was not something that could be turned around without intervention. Because of this, the finance team were preparing to rebase the opening budgets for the 2013-14 financial year, altering the ratios of the split between four GP-groups. Chamber, the Gurus, and NW, would get less money in order that the PC had a budget that reflected what its member practices had spent during the previous year.

At the development session, Conran, the Finance Director, began by talking about the budget setting formula. Three options were put forward for the 2013-14 budgets, on a PowerPoint slide (see figure 2)

Figure 2: Options to set GP budgets



This was presented as if it were a purely rational process, with no acknowledgement of the potential emotional impact on those GPs that had worked hard on budget management. Conran continued to build his argument. PC's two million pounds over-spend, if built into next year's opening position, would not incentivise the network to manage their finances since there was no prospect of working within budget. Conran described the three options. In scenario one each GP-group would open with a similar proportion of the overall budget as in the previous year. In scenario two part of the budget would be adjusted to bring the relative over-spend and under-spend positions closer together. In scenario three then the opening budget would be set at the level of the previous years' actual spend i.e. over-spends and under-spends would be cancelled, and the new budget would be based on the end of year positions.

During Conran's presentation Dr Cooper was aware that he needed to defend his financial management. "The point here is that at GP-group level we are doing well" he said, attempting to exonerate the

majority of PC practices by isolating the responsibility for the over-spend to certain practices within the network. He argued that PC had been underfunded in the first place, because the patients had greater needs:

“Present budget setting does not compensate for physical pathology or mental health pathology”

Conran deflected this point, knowing that it could not be argued on evidence. Conran’s argument was that budgets were a mechanism to affect behaviour, including clinical practice:

“Budgets set parameters; hold people to account; and incentivise and engage.....there is no point setting budgets that are over generous or overly penal.”

Conran explained that budget-setting methodology was subject to national review, but a new formula would take more than a year to develop, and even when it was ready it would be introduced via a gradual phasing programme. In the meanwhile the CCG needed to put its own house in order. As things currently stood, the extent of PC’s problem meant that there was no prospect of anything but a similar outcome next year. Unless shares were altered, PC had no chance of incentivising its practices to make savings. “We have no innovation fund whatsoever” said Dr Cooper. The consequences began to dawn on Dr Baasit who had not been party to discussions in advance, in contrast to Dr Cooper who evidently had. Dr Baasit, usually quiet in CCG-wide environments said with emotion in his voice:

“We are bigger, we are hard on our red [over-spending] practices, and they have come in line. We were robust in our practice visits. If there is no reward, it changes the game. It demotivates.”

At this point, the university representative, an accountant, intervened, saying he could see both sides. He was assertive, whilst holding eye contact with Conran. I suspect he too had been briefed beforehand. The intervention served to deflect Dr Baasit’s point. Somewhat insensitively Dr Cooper spoke up again, and the following exchange took place:

Dr Cooper: "Option 3 makes absolute sense to PC."

Dr Baasit: "If you do what you've always done..... It might demotivate my Chamber practices."

Dr Poona: "How will I go back and tell my practices?"

Dr Cooper: (sensing victory, and going too far): "It really disappoints me; the passion with which those leaders want to hang on to those under-spends."

Dr Whitbread: "I give millions each year which you're benefitting from." [Referring to a budget adjustment to reflect the younger healthier population]

At this point Dr Baasit had to leave to go back to his surgery. Just after he had left, the university representative proposed that option three be adopted, and this was agreed. Conran added a definition of how the savings element would be allocated in an attempt to soften the blow: fifty percent would be used to reward individual GP-groups, and fifty percent to fund Castlefield wide initiatives. He added that in strict cash terms the change in budget would not make that much difference, glossing over or failing to understand the impact that this budget-based rule would have on sensemaking in the GP networks. In Chamber this could jeopardise the legitimacy of the inner circle in the eyes of the wider group. The under-spend was the result of practices responding to the incentive that savings would be returned to spend on Chamber's own priorities, but had also resulted in a budget reduction going forward. Instead of being penalised, the over-spending behaviour of the GPs in PC network had resulted in a budget increase for the following year. Conran closed the discussion with a rallying call to the group, using language that minimised the impact.

"Let's make that marginal shift."

The remainder of the discussion was about how to take the decision forward, including how Dr Baasit would be "briefed". Dr Cooper sidestepped this one, saying "You guys decide the best mechanism".

Over the next few weeks during January and February the GP-groups were informed of these events in their monthly meetings.

Since the financial year had not ended, the possibility of practices gaming during the remaining few weeks was eliminated by Conran's pre-empting this and basing the following year's budgets on the end of December position.

The first GP-group to receive the news was PC, where the mood was celebratory (*PC fieldnote 3*). Where Chamber were the losers, PC were the winners. The announcement of the shift of the budget to an historical position prompted one doctor to say jovially "get spending" in a stage whisper, before finding out that the finance team had anticipated this reaction and intended to project the outturn based on the year to December. Even so, PCs opening position had just improved by nearly two million pounds. "I think the finance team did a fantastic job" said Dr Cooper.

The intended impact of this adjustment was not without tactics on the part of Conran. It was now up to the PC lead GPs to introduce financial discipline into its *modus operandi*. At the following meeting (*PC fieldnote 4*), in March, Dr Cooper introduced this challenge saying:

"It is now incumbent on us to project an under-spend for the first time in PC's history.....everyone happy with that? It's not all off to Harvey Nicks. We need to deliver an under-spend next year"

A paper had been put forward suggesting approaches to developing a proactive approach to budget management. The paper included thirty one suggestions, mainly about how to manage referrals. The difficulties of enacting peer challenge in this group were evident. The health system orientation in PC, with its hands off approach to individual practices, meant that this network was not accustomed to discussions about personal referral and prescribing behaviour. Doctors became disgruntled and problem-focused:

"A lot of these are admirable, but we are all at capacity, a lot of these will mean more work for GPs, we will need locums"

"I'd like some clarity about which patients we are supposed to look after. I've no idea which cardio and which diabetics are coming back."

Discussions carried on this vein for the rest of the item. Prescribing was challenged, including a large amount on prescribing for erectile dysfunction. The impact of chaotic patients was mentioned. 999 calls from nursing homes for infections was also blamed. At no point was the mechanism of practice by practice scrutiny and comparison suggested. By the next meeting in April, a plan for budget management had been produced but this was still largely based on making savings through the implementation of initiatives, rather than scrutinising referrals and prescriptions more closely and focusing on the financial consequences of day to day practice.

The next GP-group I observed receiving the information was Chamber (*Chamber fieldnote 4*). A middle grade finance manager, Alan, had been sent to present next year's budget. Only Dr Baasit and I had prior knowledge of what the report would contain. My observation note reads:

Alan went through the arguments. Dr Conary's face said it all. Dr Baasit shuffled papers around, looking down. The implication began to dawn. Dr Clemence realised that there was no chance of any behaviour change to alter the bottom line. [December outturn was used]. Dr Conary said "As a group we have been very proactive to promote the formula." This group of Doctors then began to see the implications this had for them as leaders. "The practices will be angry. We will lose credibility. How can this come as a *fait accompli*? This needs to be out for wider consultation." Questions were asked about why a part historic, part formula option had been discarded. This shocked discussion continued for some time. Eventually Dr Baasit began to lead the Doctors back to cohesion. "We are part of a wider city, that's important." "But", said others, "Chamber has been running at a 14% reduction" and "PC has been running with uncontrolled over-spends." Even Dr Conary, and Dr Kerala, also executive GP in the CCG, had not known until now, when I knew that PC had announced this victory to all its Doctors the previous week. "If we're going completely historic there's not much point" said Dr Conary. All the doctors gasped.

Chamber had worked hard to produce an under-spend, and would now find themselves disadvantaged the following year as a consequence. Alan argued that this was not significant in strictly

cash terms. Perhaps not, but in sensemaking terms this change in rules was extremely significant to the Chamber leaders. It altered the very basis of why the inner circle had felt justified and legitimate when guiding the outer circle to manage demand. This change made them feel powerless, and undermined; their confidence in themselves was affected. They quickly regrouped and reframed the interpretation, but an important issue was revealed. The sensemaking that held the network together was highly dependent on the inner circle retaining credibility and legitimacy in the wider group, and as such was vulnerable to rules being changed in this way.

The next group I observed was the Gurus who also were losers, albeit not to the same extent as Chamber (*Gurus fieldnote 4*). The Gurus had in fact managed their budget to spend almost exactly what was available to them. They had looked at practice-level data during the year to make sure they were not over-spending. They had not prioritised savings in the way that Chamber had, nor had they avoided seeing each other's position as PC had. When Alan, the same finance manager presented their budget, he attempted to argue that the redistributed budget, and the re-incentivisation of PC, would produce a greater overall saving to spend on CCG-wide initiatives from which everyone would benefit. These men and women were not to be fooled by the suggestion that a cut to their budget was a good thing, nor were they going to worry too much about it either. An exchange between Dr Franklin and Alan illustrates their lack of concern.

Dr Franklin: "What would the consequences of an over-spend be?"

Alan: "If our accounts are qualified, then our finance director goes."

Dr Franklin: "What's the consequence for us?"

[Silence, whilst everyone pondered the question]

Dr Franklin: "Bad boy"

In other words there would be no real consequences, other than a ticking off. These doctors were not emotionally invested in

commissioning. Primarily, they were concerned with surviving operational changes on a day to day basis. Nevertheless, they had managed their budget well, and would continue to do so.

The final group was NW (*NW fieldnote 4*). They received the information without comment. They were outside of the inter-network politics between PC and Chamber. They did what they thought was right clinically in any case, budgets were not a pre-occupation.

Comparisons can be drawn between the four distributed GP networks as they made sense of the budget setting rules. PC's focus outwards onto the wider healthcare system had a corollary effect of a reduced practice focus, resulting in a separation of network-wide business and the routine operations of individual practices which remained autonomous and private. By contrast, for Chamber close scrutiny of the operation of practices was the focus of the network, and probably as a consequence savings had been generated to spend on their own priorities. NW had overspent, partly due to Station practice continuing to prescribe Vitamin D in volume. The Gurus had returned a position very close to breakeven, having shared information during the year in order to keep a check on the budget. Ultimately the positions of these distributed networks were aggregated, and an overall exercise to set budgets for the following year was undertaken and budget shares were adjusted to reflect the previous years' outturn.

Important points about sensemaking in these distributed networks can be extracted from reactions to the rule changes. The PC GPs were celebratory when they discovered that their over-spending had resulted in a budget adjustment in their favour. The leaders understood that they were now challenged to manage the budget next year, but there was still no cross-fertilisation of ideas with Chamber. When the Chamber group received the news, the doctors were concerned at the effect on their legitimacy. This had the potential to undermine the basis of social sensemaking in the group,

since the compliant work of individual practices to generate savings had resulted in less money for the following year. Despite their views being marginalised at the development session, the lead doctors in Chamber appeared to accept the change with little observable complaint. Neither the Gurus nor NW showed much of a reaction. They did not have a legacy in commissioning, and were more interested in other issues anyway. The Gurus reassured themselves that there were no real consequences, and returned their focus to the more immediate problems that they faced on a day to day basis. Similarly NW continued to focus on primary care. There was no sign of cross-fertilising of sensemaking approaches across this distributed network, with PC leaders becoming more practice-focused and Chamber more politically aware in order to minimise the risk of integrity being seen as naivety. Whether or not actors whose sensemaking process is informed by a legacy would be able to cross-fertilise in a distributed system is a potential area for further research.

One question that this raises is, why did the CCG managers adopt a budget-setting strategy that rewarded the over-spending behaviour of PC and penalise the practices in Chamber especially when the cost-control of referrals and prescriptions was such an important commissioning objective? Conran's argument was that the only practical way to re-incentivise PC was to rebase the budget. However, as will be seen in the following chapter, PCs sensemaking legacy of enactment of commissioning at the level of NHS-as-system" was shared by GPs and managers alike at the SCL. This is explored in more depth in the following chapter.

5.7 Discussion: Operational Practice Level

5.7.1 Introduction

Below I discuss how and why GPs commissioned in the way that they did at OPL by identifying sensemaking processes within the context of networks and rules. The discussion is organised into

three sections: wider context, temporality, and distributed sensemaking. In each section the five themes identified during data analysis are discussed. These were: the establishment of new organisations; legacies; changes to the profession; competition; and integration. I conclude by presenting a summary in the form of a tabular matrix, the structure of which is themes (side headings) corresponding to the three analytic co-ordinates (top headings). The content of the matrix are concise statements consisting of the main implications for BF and SP.

5.7.2 Wider context

Of the three levels, this was the most contained; the organisational boundary was equivalent to the aggregate of the sixty plus general practices in Castlefield and their routine business. The requirement for practices to join a CCG was incorporated into national contracts for primary care. This national rule was loosely specified, and therefore there was scope for variation in its interpretation. Because the CCG did not exist in isolation; there was ample evidence of other influences on sensemaking, especially the wider NHS, and developments within the medical profession.

Sensemaking was within the context of a changing profession (see 2.2.1 -2.2.2). Forces impacting the profession were evident, including restratification and hybridisation, alongside the increased application of regulatory controls that affected autonomy. These forces affected each GP-group network in different ways and to different extents creating different combinations. These combinations in turn reflected how each GP-group interpreted rules with reference to previous and current national policies, for example previous fundholders drew on fundholding techniques to enact new commissioning rules. The Gurus continued to practice in the traditional small practice model with only limited evidence of restratification and hybridisation, and appeared to experience all change, including the increase of management and regulation, as a burden. Chamber's peer-management approach appeared to

evidence hybridity accompanied by very limited restratification; in this model *all* practices were expected to adopt management discipline not just a differentiated group of leaders. PC adopted a hierarchical stratified model with an elite group who represented and advised the rank-and-file by interpreting local and national policy on their behalf. In PC's model clinical activity rates remained private, and practices retained a high degree of autonomy. NW was different again. NW was significantly smaller than the others comprising of only two practices. A combination of size and the desire to value the contributions of all staff groups resulted in this group operating a non-hierarchical multi-disciplinary model.

Another significant external influence related to the industry-wide context. The staff who worked in the NHS had a deeply embedded approach to sensemaking which included co-operation and mutual problem solving across professional and organisational boundaries. The term NHS Family was used to describe this shared identity. This was not imposed; it is a commonly used term used to describe the inter-relationships of organisations and staff, as I knew from personal experience. The approach to sensemaking within the healthcare sector in Castlefield appeared to be derived from this shared identity, and can be conceptualised as a *prosocial sensemaking type*. The existence of this sensemaking type was evidenced by examples of mutual support and shared problem solving. The rule that GPs should commission was not new, but the HSCA gave this duty added emphasis and this affected field relationships within this Family. The example of the exchanges in PC with Castlecure nurses illustrated this. Castlecure had only recently become an independent organisation having previously been part of Castlefield PCT. Community nursing staff worked within the practices on a day to day basis. When actors on the CCG side communicated in technical commissioning language their meaning was obfuscated. These attempts were quickly abandoned for a return to communicating in terms of a collegiate relationship based

on affiliative, co-operative relationships between NHS clinicians across organisational boundaries.

The rules introduced an expectation that NHS commissioning would become more commercially orientated, with some mandatory procurement, but for the most part this was a loosely specified rule left to local interpretation. The national rules included a requirement to introduce competition into procurement processes. Procurement at the CCG was not the responsibility of the GP-groups, but there were examples of GPs anticipating what a new more competitive NHS might mean at operational level.

Integration at this level tended to trigger discussion about how GPs' own services dovetailed with other healthcare services at points of referral and discharge. Social care was not discussed, and was only mentioned in so much as information was received about the ICP.

5.7.3 Temporality

In this section I explore the link between sensemaking, legacies and anticipated futures as new rules impacted on the OPL networks.

GP-group structures from the predecessor PCT were retained in the new CCG. Each GP-group network had its distinct *sensemaking style* informed by its legacy. These differences affected prospective sensemaking in that the cues extracted reflected the distinct shared histories. Two of the four networks derived their approaches from previous versions of commissioning rules. Chamber had a style of sensemaking derived from fundholding, and PC from non-fundholding. In common to both was that these were earlier variations of rules relating to GP commissioning. It appeared that in circumstances where the rule was directly descended from earlier versions then sensemaking cues were directly extracted from that previous experience. Actors in both Chamber and PC focused their agendas on the substance of the new rule. Whilst derived from the same rules originating in the early 1990s, the legacies were different in each of these two networks, even though many of the original actors were no longer members. Chamber's inwards focus

on practices' profiles of clinical activity contrasted to PC's outward focus on system-wide concerns. Of the two remaining GP-groups, one had a more embedded legacy, and one had only a very short history of working together. Neither the Gurus nor NW appeared to be motivated by the substance of the rule itself but rather took part, albeit with very different feelings, because of the opportunity to be part of a network. The Gurus legacy was distinctly different from those of PC and Chamber in that the actors had not changed over time. These were individuals who had aged together, sharing an ethnic heritage, experience of migration, and life experiences as immigrant doctors working in small practices in deprived areas. Their sensemaking processes had not been handed on, and would in all likelihood end in the relatively near future as the last of them retired from practice. This informed their responses to the rule change, which they perceived as taking place within a wider context of multiple rules that threatened their business model. Their legacy was derived from a shared life and work history. Their sensemaking appeared to be prospective, and was anticipatory of a limited and difficult future. Their thinking was laced with emotions such as anxiety and world-weariness, and their repertoire of behaviour included the demonstration of mutual support and sharing survival strategies. By contrast again, the NW GP-group had no long-standing legacy to predetermine its members' ideas about how to commission. This network's process of sensemaking, compared to others, was optimistically prospective drawing on cues from an anticipated future that appeared to offer opportunities.

Whether or not actors had previous experience of working together appeared to influence their choice of allegiance in the present. Past differences in interpretation of predecessor rules persisted into the present, resulting in differences in sensemaking type. The fact that these differences endured, meant that it was highly likely that they would continue whilst so ever the networks remained in place, limiting the extent of prospective sensemaking. In my data the group with the least experience of working together appeared to

have the more optimistic prospective approach to sensemaking, creating ideas of a future with new and different ways to provide primary care.

Pre-existing organisational forms were maintained through rule change. Legacies derived from previous shared experiences (for example, commissioning, and migration) formed the conditions for sensemaking. Within the overall prosocial sensemaking type of the NHS Family, separated sensemaking styles existed at the level of the GP-groups.

5.7.4 Distributed sensemaking

In this section I explore how the spatial relationships within and between networks related to sensemaking when new rules were introduced.

The sensemaking style, the legacy, and the distribution of each network appeared to be inextricably linked, each having an impact on the others. Actors were distributed across the four GP-group networks, and in turn each GP-group had its own pattern of distribution. Decisions that affected these networks were collectively managed through cross-CCG structures described in the constitution and inter-practice agreement. Membership of the GP-groups was on the basis of self-selection. Selections appeared to be made on the basis of whether a legacy was shared with other members of the network.

The wider context of a changing profession was interpreted in different ways in each of the four networks resulting in different patterns of distribution in leader and rank-and-file relationships. Chamber developed an inner and outer circle based on a peer buddy system. GPs were encouraged to self-direct and to scrutinise their own clinical practice in order to manage demand. In other words, value was placed on the management of individual clinical practice meaning that all doctors were encouraged to adopt management strategies. The active GPs in Chamber, through a buddy system, emphasised facilitative one to one relationships. In order for this

mechanism to continue to be effective, legitimacy must be maintained and this was carefully nurtured through the quality of clinical information, patient-centredness and integrity.

PC-group operated more hierarchically. Differentiated leaders focused on national policy and the wider health and care field for cues on how to make sense of the rule. Often the leaders would step back into rank-and-file shoes and join the others in emotional responses to new rules. This was always a precursor to reinstating the distance, including a reminder to the others of the need for emotional discipline and to find a way of going forward. A tension in sensemaking could result from a dual identity as commissioner and provider. Members of PC attempted to adopt a commissioner identity using technical commissioning language. When they attempted to communicate with community nurses in this way, then the distribution into separate commissioner and provider roles was soon challenged by those nurses. Commissioner authority was discarded in favour of harmonious inter-professional relationships in the NHS Family. Not only was the NHS Family part of the wider industry culture and context but it also informed the distribution of relationships for sensemaking – these were people who had worked together over many years of service and who were conjoined through their shared patients. They had a shared legacy which would endure a rule that implied that their relationships should be re-patterned.

The Gurus' leaders did not separate themselves emotionally or hierarchically from the member GPs, they simply provided a conduit between the network and the wider CCG. They were preoccupied with change and extracted cues that made them anxious about operational change and managing the future. For The Gurus, whose shared history was much wider than commissioning, the future looked uncertain and threatening. Emotional support between peers became very important.

In NW, everyone was welcome to be directly involved. The chair of the CCG was also the chair of this group. At the SCL he acted as a hybridised leader, but this did not appear to transpose to this GP-group where he appeared to encourage an egalitarian multi-professional approach to sensemaking. It is not possible to say whether this is just because the group was small, and it is easier to be egalitarian when there are fewer people. The attitude was forward looking, and emotions of confidence, courage, and excitement and openness about changes ahead were apparent based on a commitment to high quality primary care.

The only point at which I observed the relative impact of the separate group styles was when it came to sharing a budget across the four groups. The decision of the CCG GB was to base the 2013-2014 budgets on the closing positions that the group's returned in 2012-2013, and thus rewarding an over-spend that had occurred associated with PCs systems-based hierarchical style and penalising Chamber's peer guide, practice focused approach. Why PC was treated leniently was possibly just because it was the only practical thing to do, but it could also be related to the importance of their sensemaking style at the SCL, as will become evident in the following chapter.

There appeared to be no dynamic of cross-fertilisation between these networks with different styles.

5.7.5 Summary matrix of theoretical implications

The theoretical implications identified in 5.7.1-5.7.4 are presented in a summary matrix in table 21. The matrix structure is a map of the main thematic categories (side headings) and the SP co-ordinates (top headings). Contents of the matrix are articulated using concepts from BF and SP.

Table 22 Operational Practice Level summary matrix

Operational Practice Level			
	Wider Contexts	Temporality	Distributed Sensemaking
Establishment of new organisations	National rules introducing CCGs did not specify operational arrangements for GP engagement.	GP-group structures from the predecessor PCT were retained in the new CCG.	Four networks (GP groups) formed a distributed mechanism for the management of clinical activity. Decisions that affected these networks were collectively managed through cross-CCG structures described in the constitution and inter-practice agreement.
Legacy	Actors had an embedded allegiance to the NHS Family with an associated prosocial sensemaking type.	Each GP-group network had its distinct sensemaking style informed by its legacy. These differences affected prospective sensemaking in that the cues extracted were different according to different shared histories.	Actors' selection of networks was informed by legacy relationships. Legacies informed the distribution of actors within networks (also see Profession: Distributed Sensemaking).
Professional changes	Changes to the profession (as described SoP and medical sociology) were evident in different combinations in the GP-group networks. These combinations in turn reflected how each GP-group interpreted rules with reference to previous and current national policies, for example previous fundholders drew on fundholding techniques to enact new commissioning rules.	GP-group networks had different expectations about what the future would hold. Sensemaking cues were drawn from an anticipated future as well as from a known past. For example the older group of migrant GPs was anxious about the future, and this affected their ability to think optimistically about the future.	Decisions about the distribution of actors in networks were informed by legacies, and these distributions differentially reflected professional changes. The four patterns of distribution where: <ul style="list-style-type: none"> • All GP- hybrids, non-hierarchical (Chamber) • Elite GP- hybrids, hierarchical (PC) • Leaders as conduit, non-hierarchical (Gurus) • Multi-professional hybrids, non-hierarchical (NW)
Competition	The rules introduced an expectation that NHS commissioning would become more commercially orientated, with some mandatory procurement, but for the most part this was a loosely specified rule left to local interpretation.	Actors had little in the way of past experience for use in retrospective sensemaking. Attempts were made to think prospectively regarding the impact of competition, most notably by the ex-fundholders.	No impact on distribution.
Integration	There were no specific rules about integration at this level.		Attempts by primary care nurses and doctors to relate to community colleagues as commissioners were abandoned in favour of NHS Family collegiality.

Chapter Six: Sensemaking, networks and rules at Strategic Collaboration Level

6.1 Introduction

In this chapter I focus at this CCG level – the formal rule-based statutory collaboration. I begin by outlining the rule that required the establishment of CCGs. In section 6.2 I focus on networks. I explore how the CCG-wide GP network was established, and consider how this was situated in a wider collegiate network that spanned the NHS. I present findings that suggest doctors from primary and secondary care have a tightly coupled relationship that underpins social sensemaking derived from an interconnected network based on professional identity. In Section 6.3 I consider the dynamic relationship of rules, networks, and sensemaking when introducing the new requirement to introduce competition into processes to award contracts for services. I present data relating to the introduction of competition rules in secondary and primary, and relating to actors' response to perceived conflicts of interest that result.

Observations were centred upon activities organised from the CCG headquarters. This was a pre-NHS Victorian Hospital. It had continued as a hospital until the mid-1990s when it became the headquarters for the District Health Authority and has continued to be the administrative hub for Castlefield health services for the ensuing 20 years. Many of the observations were in other venues – hotels with conference facilities were used for group events, and sometimes meetings were held in local community health facilities in an attempt to connect senior people with the neighbourhoods that they served.

6.2 Commissioning networks

The rule by which CCGs were established included a provision that final decision making power must be held by the collective membership of GPs. The outgoing PCT leaders, when deciding the organisational form for the new CCG, had put in place an overarching network to connect Castlefield GPs known as Total Members (TM). In this section I begin by considering the processes to establish the CCG. Next I consider sensemaking processes across the TM network. Finally I consider how TM's sensemaking was located within a wider network of the NHS Family, and why this had an important impact at times of rule change.

6.2.1 Establishing the Clincial Commissioning Group

In Castlefield, the CCG was established by the people of the outgoing Castlefield Primary Care Trust (PCT). As with the GP-groups described in the previous chapter, PCT organisational structures were retained wherever possible. The PCT's arrangements had been working well, and the rationale was that disruption should be minimised and organisational knowledge retained as far as possible. As a result sensemaking approaches and networks were also kept intact. The staff at the outgoing PCT were the designers of the organisational form of the CCG into which their job-roles transferred. The change, as far as the GPs were concerned, was minimal. An extract from the 2011-2012 annual letter from the audit commission read:

Castlefield CCG is in a strong position since it includes the same GPs as Castlefield PCT, covers the same geographical area, is coterminous with the local authority and will have some continuity of senior staff, reducing the risk of loss of corporate memory. The PCT is undertaking work to establish proper governance and financial management structures going forward. (CCG doc 1)

The rules that defined CCGs (each practice to be a member and to appoint a clinician to act on its behalf) were loosely specified. Because CCGs were new legal bodies it was impossible to avoid

making changes. The rule that the CCG should be a member organisation was formally implemented. A constitution (*CCG doc 2*) was developed which outlined the operational arrangements and decision making structures. This in turn was underpinned by an inter-practice agreement (*CCG doc 3*) that a partner from each practice was required to sign. This agreement bound the practices to abide by a Castlefield-wide interpretation of the national rules. It included how a practice should formally engage with the CCG, how finances and financial risk would be managed, how GP-groups would work, how innovation and development funds would be allocated, and how practice performance would be managed through a programme of visits. In accordance with the national requirement, ultimate decision making authority was reserved to the CCG membership, which was in turn delegated to the GB on a day to day basis.

The GB was similar to the Board of Castlefield's outgoing PCT. It included GPs, managers and lay members. The Chair was Dr Whitbread from NW, the smallest GP-group. The other GP-group Chairs had places at the table, and so did Dr Lovett who took lead responsibility for patient safety, safeguarding, research and education. Responsibility for the CCG and its operations on a day-to-day basis rested with its Chief Operating Officer, Catrina Cook. Other management directors at the GB were Maggie Smith, Director of Primary Care; Lisa Diggle, Commissioning Director; and Conran Shaw, Finance Director. In addition the GB had a Company Secretary, three lay members, and an independent nurse and doctor.

The HSCA 2012 included a rule that CCGs be led by GPs. In Castlefield a Professional Cabinet (PrC) was put in place to enact this. Each GP-group nominated executive GPs in numbers broadly proportionate to the size of its registered population. Thus, the different legacy-based sensemaking styles, discussed in the previous chapter, was represented in this overarching network. The

GP executives each had lead areas on behalf of the CCG-wide network (see Table 22).

Table 23 Executive GPs' lead work areas

Chamber, 160,000 patients, three executive lead GPs	
Dr Baasit	Chamber GP-group chair and CCG lead for cancer services and some large independent sector contracts
Dr Conary	Chamber executive, and CCG lead for practice visits programme, and the only female executive GP
Dr Kerala	Chamber executive and CCG lead for integrated care and long term conditions
Principled Collaboration, 125,000 patients, three executive lead GPs	
Dr Cooper	Principled Collaboration GP-group chair, and CCG lead for mental health services
Dr Strong	Principled Collaboration GP-group executive, and CCG lead for the Health and Wellbeing Board
Dr Lovett	Principled Collaboration GP-group executive, and CCG lead for education, professional development, research, and safe-guarding.
The Gurus , 30,000 patients, two executive lead GPs	
Dr Poona	The Gurus GP-group lead, and CCG lead for the contract with Castlefield community services enterprise
Dr Ashok	The Gurus executive and general advisory role in the CCG
New World, 40,000 patients, one executive lead GP	
Dr Whitbread	New World GP-group chair, CCG Chair, and lead for contracts with large local acute provider NHS trust

Through this mechanism of allocated lead areas, the GP-leaders formed a network with a built in inter-dependency. Individual roles were broadly aligned with the sensemaking context of the GP-group to which they belonged. PC-GP group conceptualised primary care as one part of a wider system. In line with this, Dr Strong led interagency work; Dr Cooper led the mental health portfolio; and Dr Lovett led on research, education, patient safety and safeguarding. Chamber GP-group conceptualised practices as small, individual businesses (see 5.2 above). Reflecting this, Dr Conary led the work on developing a programme of CCG practice visits to discuss and monitor business and clinical issues, and Dr Baasit led on contracts with the private sector. The burden of CCG leadership responsibilities was minimised for the Gurus; this group had limited capacity to be proactive given the significant problems facing small practices. Dr Poona led on the contract for community services but this was effectively shared with Dr Kerala (from Chamber) who led on service integration between health and social care. Dr Ashok held no specific brief, and was described as a special advisor. Dr Whitbread from NW was the Chair of the GB, and also took the lead on contracts with the main acute hospital.

This distribution of lead areas between the four GP groups did not result in a mix of those sensemaking styles identified in the preceding chapter. Instead one group's approach appeared to be adopted across the network of executive lead GPs and their manager colleagues. PC's focus on system management and design, its commitment to collegueship in the NHS Family, its separation of followers and leaders in order to manage resistance from rank and file GPs were all features that shaped sensemaking across the leadership network at this level, as will be evidenced in the scenarios described below.

6.2.2 The Total Members network

The inter-practice agreement set out a requirement that TM should meet twice a year. I observed two of these meetings (*TM fieldnotes 1 and 2*). The following paragraphs draw on observations from both these meetings. For ease of reading I have conflated the data in order to avoid a disjointed narrative.

Total Member meetings were held in a local hotel with conference facilities. Each meeting attracted about 150 attendees including GPs, practice nurses, practice managers, and CCG staff. These meetings were held in the evenings and were preceded by a buffet meal. People milled about, awkwardly balancing hot drinks and plates of food. During this pre-meeting time I chatted informally, and gained insight into the thoughts of the people who worked in primary care. I would find myself talking to practice managers about the impossibility of the keeping abreast of all the bureaucracy associated with change. Doctors told me they were intending to retire, many basing this decision on the fact that the government had recently limited personal pension funds. Others would ask me what I was doing, and when they found out I was researching their professional role would tell me how much more demanding the job of a GP had become over recent years. This was a group that was ambivalent to the latest rule change; they could see no reason to believe it would bring improvements especially at a time of reducing

funds and increasing demand. It was against this attitudinal background that TM meetings took place.

Before moving to describe the meeting itself, I would like to introduce Dr Lovett, the GP leader who was put forward as the facilitator for the meetings. Dr Lovett was an executive GP from PC GP-group. Along with others in PC, he had been a non-fundholder and interpreted commissioning as service and pathway design in partnership with hospital colleagues. Dr Lovett took a role within the CCG, along with Dr Conary, as the leader responsible for the professional development of doctors. He also took responsibility for education, research, and safe-guarding. This dry list of lead areas only tells part of the story. It does not give insight into the sort of man he was, why he was chosen to lead, and how he had an effect on sensemaking. His impact in the main was due to personal qualities: he was kind, to everyone, all the time. When he met me for an interview, he knew my son's father was unwell, and he began by giving me a bar of chocolate, a hug, and calling me "love". Many others would have experienced this type of interaction, and like me, would have remembered it. He was well-known as a GP educator and an able consensus builder. It came as no surprise to find that he was the facilitator at the TM meeting. He was an effective and trusted "sensegiver". The following excerpt from an interview (*Interview Lovett*) illustrates that he was aware of why he had been chosen:

Dr Lovett: "And I think that's partly to do with... well I think that's partly to do with I'm at the older end of it. I think I'm lucky enough to be reasonably respected because of my role in the vocational training scheme, the GP training scheme and education generally so they've seen me around, they've seen me in appraisals and hopefully they've thought that I was reasonable. I think that... I often think of myself, please don't think this is arrogance, it's just that you're asking me to answer the question."

Adele: "I'm asking you, I need you to tell me what you really think."

Dr Lovett: "Yeah, Yeah. I think I'm a bit of like the glue sometimes.....In that I often try and interpret which is... I try and interpret what I think someone is saying when they're not getting their message across..... I try and interpret for them so that they get their message across in the way that other people understand it if they're not doing it themselves, that's what I see my role as so I support them if they've got a good idea that for whatever reason isn't coming across to the people who are making the decisions."

Dr Lovett understood that he was drawing down reserves of previously earned goodwill and trust, and proactively facilitating the transposition of these feelings to the new CCG arrangement. He had personal qualities that allowed him to generate trust and commitment from others. Dr Lovett, and others, used TM meetings to skilfully influence how the wider group responded to the commissioning duties that HSCA 2012 introduced. The design of the evening was such that the rank-and-file were led through a process by which key hybrid-leaders communicated an expectation that positive, constructive attitudes should be adopted and resistant or negative reactions should be contained.

Now to discuss meetings of TM. On the way into the meeting room, attendees were given a table number, reflecting a pre-planned arrangement into groups. Sixteen circular tables were laid out "cabaret style" –each table, dressed in crisp white linen, seated ten to twelve people. When people had settled down in their seats, Dr Whitbread opened by giving a short welcome presentation announcing that the CCG was now official having been approved by the authorising body. Catrina Cook, the Chief Operating Officer gave an overview of the role and powers of the CCG. She told the members:

"You can remove the executive body – not at a whim.....as well as reserved powers, you have responsibilities.....It's only if we bring the Member organisation to life that we will be different to a PCT."

She was reflecting the difficulty member GPs were having in conceptualising the difference between the predecessor PCT and the new CCG. Whilst powers were handed to GPs under the new rules,

locally every effort was made to minimise the chances of these being exercised. TM meetings were part of a process to establish a co-operative sensemaking approach, whereby GPs exercised emotional discipline, and did not actively resist implementing the new rules even if they did not like them.

The meetings were structured to allow the wider membership to express their views, whilst at the same time reinforcing the position of the GP executives who represented them on a daily basis.

Following Catrina and Dr Whitbread's introduction, Dr Lovett took to the floor, as though it was a stage:

"Hello C-A-S-T-L-E-F-I-E-L-D. Good turnout. How would you measure a mid-life crisis? The average age of a male going to Glastonbury is 43." [He made a gag about the Rolling Stones]. 'It starts at 'I can't get no Satisfaction' to 'I like it, like it'. I can't answer what's the meaning of life? or why you're on the table that you're on."

In this extract, Dr Lovett used a number of techniques to let those present know how he expected them to behave. Dissent was dealt a pre-emptive blow in the Rolling Stones lyric "I can't get no satisfaction". By referring to "no satisfaction" Dr Lovett was letting the rank-and-file members know that he had anticipated their resistance before they had chance to express it. He continued by introducing a group-work exercise, designed around questions to elicit views on what the CCGs commissioning priorities should be.

Dr Lovett was the facilitator for the table at which I sat. This included a mixed group of doctors, practice managers, and nurses. There were a number of The Gurus present who displayed emotions of anxiety similar to those described in the earlier chapter (see 5.4). They described feelings of being overwhelmed, with nowhere to turn for help. One elderly Indian female doctor became very anxious and agitated about the electronic workload. "So many emails, so many replies, so much to read". Another younger doctor talked frantically about the complexity of primary care, using the example of a patient with rabies that he had treated that week. For the first few

minutes of the group exercise people expressed increasing levels of hopelessness, which peaked in the following contribution from an older Indian doctor:

"This is a whole bloody waste of time, The [referral screening service] is always sending referrals back.....All we want is life to be simplified so we can look after patients.....Once upon a time we were the guardian lions, now we are the lambs threatened with the mint sauce and the fridge."

This highly emotive contribution was a crescendo and a turning point. The complainants, all of whom were members of The Gurus, had exhausted their points. Dr Lovett seized this as his moment to facilitate the shift in tone. He had allowed space for people to express resistant, anti-rule feelings, but now began to encourage a change to constructive, optimistic engagement with the set of questions... He asked actors to suggest areas for inclusion as indicators in the Quality and Outcomes Framework (QOF). This framework was a set of locally agreed targets included in the GMS contract in which targets were set, the achievement of which would trigger payments. "We do need people to make a suggestion, let's just try" he said, setting up a situation where resistance would require deliberate obstructive behaviour. A younger female Doctor was the first to follow his lead, suggesting clinical conditions where services could be improved: renal colic; dizziness and tinnitus; and dermatology. This had a snowball effect. An older doctor suggested that the availability of urgent slots for "ultrasound, gallstones, and thyroid" would mean that GPs had somewhere to refer when they were unsure. Another doctor suggested osteoporosis and pain management patients would also benefit from such an arrangement. Dr Lovett once again seized the moment and extrapolated from these examples to a general point about the ever-evolving nature of a GP's job. He counteracted resistance to change with the statement: "what a normal GP does changes every year." He emphasised his point with examples: a few years ago "missing a cancer" would not have seriously affected the outcome for the patient, but now it did; and in the past GPs did not manage people

with insulin dependent diabetes, and now they did. The emotional young doctor angrily made one final challenge: "Why should the government keep changing all of our contracts? Why don't we just quit?" Dr Lovett responded, not by answering the question, but by refusing to reinforce this catastrophising. He simply said, calmly "this is completely sortable if we work together." The hopelessness largely expressed by doctors from the Gurus GP-group was actively replaced by a focus on improving clinical care.

The next stage of the meeting was in plenary. Dr Lovett was once again the frontman. He introduced the executive lead GPs as "The new boy band" (seemingly forgetting the gender of the one female executive GP- Dr Conary), jokingly saying Dr Baasit was Jagger, and Dr Poona was Keith Richards. He continued with his earlier Rolling Stones reference "Can't get no satisfaction, but tonight you are" – a humorous challenge to any GP that complained about the evenings' events. Each group's rapporteur gave feedback to the wider group. In all the reports, it was evident that the small groups had decided upon a number of suggestions for CCG priorities, and had worked constructively on the issues that they had been asked to discuss.

This was an example of a hybrid leader appealing to doctors to comply with the external rules enshrined in HSCA 2012 and enacted by the CCG executive team; to do otherwise would be unprofessional (Evetts, 2003). In this way the rank-and-file doctors were encouraged to suspend their sensemaking in relation to the new rules, and instead to concentrate on identifying opportunities to improve patient care. This was a shift in the basis for cue extraction, with a corollary effect of shifting actors from a state of resistance to one of compliance.

6.2.3 The NHS Family

So far in this chapter I have discussed the establishment and organisation of the CCG, including how a shared sensemaking across the GP membership was promoted by socially skilled actors. If the co-operation of GPs was to be maintained then the benefits of

commissioning needed to be plausible propositions to the rank-and-file doctors. Key to this plausibility was the wider industry context, and the inter-professional, inter-organisational network, which is commonly referred to as the NHS Family. Its history dates back to the inception of the NHS in 1948. During my observations, GPs appeared to make sense of commissioning in two main ways. On the one hand, it involved the management of demand by controlling the level of one's own referrals and prescriptions – this was akin to the fundholding model and informed the sensemaking style of Chamber GP-group. On the other hand, it was the process of planning and designing the flow and balance of services in the multi-organisational, multi-professional environment of the NHS services. This form of commissioning underpinned the sensemaking style in the PC GP network, and was also the dominant style at the level of the CCG-wide collaboration. It was dependent on spanning organisational boundaries to work collaboratively in professional networks, where ideas could be discussed, and plans could be made and implemented.

Working in the NHS was very important to many doctors, and primary care was no exception. Castlefield City was a concentrated urban area. Commissioning GPs were clinicians who saw patients daily, and inner city doctors had reasons for working where they did. There were personal reasons why Indian doctors were now in England. Both Dr Kerala (Chamber) and Dr Poona (Gurus) told me that part of their own decision-making related to the NHS being free to patients:

Dr Kerala: "So when I came in 2001, 2002, to the UK, at that time I was very much frustrated with the Indian system where a person had to pay before getting even analgesia or treatment for severe burns. So I came for a short stint to see what was special [about the free British NHS].....I was staying with a few GPs and I saw them socially as well as work-wise, and I was doing shadowing in hospital medicine, but because I was living with GPs and seeing them work as well.....took a decision.....that rather than going into hospital medicine, I wanted to be a GP." (KeralaInterview)

Dr Poona: "My motivation was different [from that of his father who had spent some time in England], my son, the eldest son, when he was born he got a cataract in one of his eyes and as a young parent it was very difficult for me to, what to be done, what needs to be done therevery difficult, we weren't that rich that we could do that ...on our own and get the operation done and come here on a medical thing and go back, but the ultimatum for me was that if I could work for NHS...." (PoonaInterview)

It seems reasonable to extrapolate that this commitment to the English NHS as a contrast to the Indian system is shared more widely than these doctors. A further dimension to sensemaking by inner-city doctors seemed to derive from personal value-systems. Doctors would talk of their own vocation to serve the poor and disadvantaged. I will use the best articulated example to illustrate. The following is an extract from an interview with Dr Conary:

".....as I was coming toward the end of the medical school I was thinking really I was going to do medical missionary work probably is what I was kind of drawn towards although I'd still got general practice at the back of my mind. But then I met what became my husband who was at medical school as well and he wasn't at all interested in medical missionary work so we ended up not doing that and so then we got married and then I moved around with him until he got his permanent post here in Castlefield [as a psychiatrist]..... and while I was moving around I did work for quite a long time in psychiatry and they did want me then to train to be a psychiatric consultant in elderly psychiatric but I decided that I'd done all my training already in general practice..... I did apply for short term jobs in general practice particularly in inner city places because I felt that it probably would be more like medical missionary work kind of a Christian outreach to the most poor and vulnerable.....[describes finding out about a particular inner city practice, with a committed Christian senior partner].....So I went there and found he had a very strong Christian ethos as well and he had a very big heart to reach out to the most vulnerable and deprived people and to develop services and to provide high quality general practice to the most deprived, so that really fitted in with my ethos really of coming from a background that wasn't a posh background and I felt I had a lot of things in common with ordinary people and I could communicate

with ordinary people and I felt that my Christian ethos fitted well with helping develop that kind of practice.” (ConaryInterview)

Inner cities have a resident population with problems associated with urban deprivation. The incidence of certain problems such as alcoholism, poverty, and inter-generational worklessness are more common than in affluent suburban and rural areas. Individual doctors often choose to work in the inner-cities, motivated by a political or spiritual commitment.

What these doctors had in common - whether they were Indian migrants who appreciated working in a centrally funded model, or vocational doctors who wanted to work towards social justice - was a tendency to derive sensemaking cues that reflected their own valuing of the NHS and being part of it. The importance of the NHS Family was a theme in the previous chapter, especially in the system orientated PC GP-group. Here, I further unpack its influence on sensemaking. In order to do this, I use extracts from observations of two CCG-wide Focused Learning Events (FLE) (*FLE fieldnote 1 and 2*).

Castlefield CCG had established a programme of FLEs. Afternoons were set aside for practice staff to come together around specific topics. Each GP-group ran its own series; and in addition twice a year Castlefield-wide FLEs were held. These were open to all staff in the practices. I attended two Castlefield-wide events on the topic Emergency Care – it had to run twice in order that all 600 people who wanted to attend could be accommodated in the hotel venue. The programmes were identical and spaced a week apart. Again, in the interests of narrative flow, I have conflated the data from the two events. These were popular occasions, providing information and also a chance for people to interact socially. When I arrived, the foyer was bustling, and a Christmas tree was twinkling. People were happily chatting as they queued for lunch and mince pies. There were stands from local drug companies, and local NHS and voluntary sector services, all keen to tell GPs what they were doing. There was a busy, friendly, ambience.

The agenda was designed to allow people to consider emergency care from the perspective of their own role within a wider system. Separate sessions for practice nurses, practice managers and GPs were running in parallel. I sat in on the sessions aimed at GPs. On both occasions over 100 doctors were in the room, representing a spectrum of ages from new entrants to those on the brink of retirement. More than half were non-white. There were about twice as many women as men. People were wearing comfortable clothes, with anoraks and body warmers in evidence as it was a cold day.

The sessions were led by another PC GP-group executive, Dr Strong. He had been a non-fundholding pioneer, and had spent many years spanning the boundary between primary and secondary care. The agenda for the afternoon included inputs from two hospital consultants. These doctors together operated as sensegivers. Dr Strong had legitimacy amongst GPs due to his long-standing commitment as a lead commissioner, and the hospital doctors had legitimacy as recognised leaders in their specialisms.

Similar to the TM event, this was to be a facilitated afternoon, and would reinforce shared sensemaking derived from a shared social identity as an NHS doctor. Dr Strong reminisced; back in 1983 when he became a GP the "take" system was shared between the then two local hospitals which had since been merged. In those days, there had been approximately 30 GP admissions a day; now there were over 300. He had dug out some old discharge notes from a cardiac infarct patient. They had been sent home with a spray. Everyone laughed. It was a clinical in-joke that illustrated how vastly more sophisticated was today's medicine.

The first contribution was from Dr Hamilton, the lead consultant for emergency medicine at the local acute hospital. He began his input by emphasising that primary and secondary care doctors had shared values and tasks. Picking up where Dr Strong left off, he gave personal reflections on the nature of emergency medicine. Dr Hamilton told the GP audience that patients had slept all night in the

emergency department the night before, illustrating Dr Strong's point about the sheer number of people who needed care. Dr Hamilton then put the discussion in terms of the humanity of the patient.

"I make it sound like a process. It isn't, human beings are coming to hospital later. If you see someone at 10 at night, it's harder to get them home"

Dr Strong and Dr Hamilton together were demonstrating a joint approach to the design and management of the emergency system, united in a common task of response to acutely ill patients. The on-going sensemaking of this uni-professional network appeared to be synchronised in the fact that they identified and bracketed cues based on interconnected tasks and shared values. They treated the same patients, and were jointly responsible for clinical care. They shared organisational problems; the demand on emergency services was intense - primary care doctors have to adjust their practice when the hospitals are busy. They shared a sense of moral purpose, being responsible for very sick people when they are acutely ill. This cross-sector medical network was tightly connected, and would not easily be de-coupled.

Dr Hamilton related to GPs as peers, not as commissioners who paid his wages. Castlefield emergency care network, which included Dr Strong as one of its members, had developed a system of recognising warning signs. (Castlefield Emergency Medical Signals - CEMS), and Dr Hamilton was explaining how this worked. It was being used by hospitals, GPs, and ambulance crews. All in the room were engaged and attuned, as they learned about how to identify critical illness and get the right medical care in place quickly. Dr Hamilton used a case study of a woman with a very painful ear. A slide (figure 3)² was shown which showed the woman's vital signs, giving an overall score for CEMS. Dr Hamilton discussed which tests

² Pulse of 163, a temperature of 36, Blood pressure of 92/65, and a respiratory rate of 11.

would be indicated, and then showed a further slide with results (figure 4)³

Figure 3: Presentation of woman with painful ear

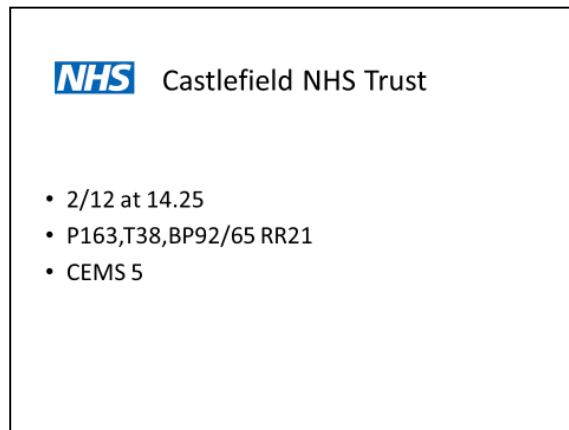
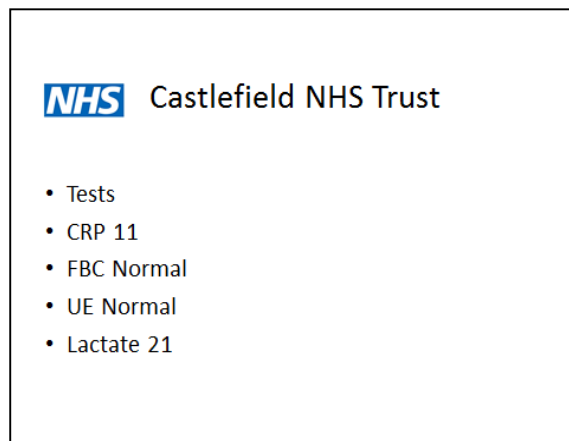


Figure 4: Test results for woman with painful ear



The patient needed to be admitted to the Ear Nose and Throat department. He asked the GPs what they would do. They started to give ideas, and concluded that they would treat as sepsis.

This discussion was different from any other I had witnessed during my many hours of observations, and, looking back, had only rarely been privy to in my years as a health service manager. The slides and the content of the presentation illustrated the core of shared

³ C-reactive protein of 11, a normal full blood count, normal urea and electrolytes, and a lactate score of 21.

sensemaking between doctors across the hospital and primary care boundary. The doctors were animated and engaged, talking in the language of diagnosis and observation. How would they decide what to do? How would they respond to this emergency? The shared approach to sensemaking was to extract cues that supported the collaborative endeavour of treating illness and saving lives. Dr Hamilton emphasised the importance of the primary care doctor in this:

“Dr, your patient has a CEMS of 5.....It shows some good stuff: good team work.....After all, you are GP consultants you are senior clinicians – you know who you’d like to admit to.....We are taking patients through a better process. It is more thorough. We do work brilliantly as a team.”

There was no discussion of pricing, contracts, or specifications. This was about clinical systems, managing demand, making the process work for the patient. Dr Hamilton underlined the importance of getting it right for the patient again.

“We did have septic people, sitting in a plastic chair, hardly able to hold their head up.”

Dr Strong and Dr Hamilton had done much more than simply explain an assessment process. They had personally modelled behaviours that displayed co-operation across an organisational boundary. They had accessed the network’s own language of science, diagnosis, and observation. They had distinguished the role of doctor from the role of commissioner, for the purposes of treating shared patients in inter-dependent pathways of care.

Dr Hamilton was a doctor rooted in acute medicine. His focus was on emergencies and the need for an urgent medical response. His relationship to GPs in the network was one of immediacy – working out a problem and addressing it quickly in order to prevent death or deterioration. The next presentation was by a community-based geriatrician. Dr Hamilton handed the baton to Dr Gibson, speaking explicitly about the NHS Family network, calling for an extension of openness and trust:

Dr Hamilton: "We have no walls. If no-one had walls that would seem like the sensible way to go"

Dr Gibson: "The whole NHS should be without walls – just trust each other a bit more."

This doctor illustrated a different aspect of the relationship between primary and secondary care. Medicine was about intractable on-going problems as well as emergency interventions. His focus was the management of older people with a complex set of conditions, often with social dimensions. Dr Gibson presented the Comprehensive Geriatric Assessment (CGA); a new process being gradually implemented across Castlefield's health and social care services. GPs were asked to consider two case studies at their tables, both of which were designed to illustrate the interdependency of GPs and other professionals from hospitals, community and social services. Dr Gibson explained that a comprehensive geriatric assessment needed to be multi-disciplinary. The product of the assessment was a "stratified problem list" in two formats, one reflecting the patient's own goals and priorities, and one reflecting the clinical critical path, and including a bespoke management plan. Dr Gibson posed a question to the assembled GPs:

"One of the problems is when it moves into the community. Who is in charge? And who else is involved?"

This question was designed to highlight the fact that care needed to be organised in a network. This plan would be multi-disciplinary, and the staff who would deliver it would be in a network based on interdependency of task even though actors would potentially never meet (McDonald et al., 2015). The following exchange took place:

GP: "This model is wrong. The CGA model doesn't fit with how GPs currently work."

Dr Gibson: "it's a wicked issue; it's a wicked issue; it's a wicked issue, I feel your pain, but we're with you all the way."

GPs pointed out that the current system of ten minute appointments did not facilitate this more bespoke approach to patient

management, such as the appointment system outlined above. Dr Gibson was not in a position to solve the problem, but his response illustrated a supportive relationship between hospital doctors and GPs. Doctors in the NHS Family were willing to work together despite operational barriers.

In summary, a shared sensemaking type existed across a fluid, difficult to define, network that is referred to as “The NHS Family”. Doctors, for various reasons, were deeply committed to the social insurance based national system of healthcare which is the NHS. Cue extraction for sensemaking tended to reflect this. FLEs were one of many mechanisms for the maintenance and development of the wider NHS network with its shared sensemaking type. At these FLEs the focus was on professional inter-dependency, shared work, and shared clinical responsibility. This was about sharing work and responsibility between hospital and primary care. Similar to TM, OD facilitation techniques were used including group work, which allowed time for individuals to air their concerns and conceptualise the information that they were receiving. Also similar to TM, respected doctor leaders led discussions and gave key messages. They acted as sensegivers emphasising the common bond of the medical profession and the shared nature of clinical aims and tasks.

6.3 Enacting the rules: extending competition

So far, I have discussed those aspects of commissioning that relate to the design of services and pathways, often undertaken in collaboration with actors from both commissioner and provider organisations. However, the formal technical dimension of commissioning was the contracting and procurement processes which governed how money was allocated and spent. The HSCA 2012 was controversial for many reasons, but none more so than its requirement to increase competition in the English NHS. This section is an exploration of the dynamic of sensemaking, networks, and rules when enacting the business of awarding contracts.

Sensemaking was triggered by the ambiguities related to the co-existence of competition and co-operation, and the dual role for the GP as provider and commissioner.

As my time with the CCG passed by and my understanding developed, it became apparent that this rule change would not be easily accommodated in existing sensemaking processes and networks, especially those of GPs and other clinical staff. The word competition in NHS networks was a loaded one. It was interpreted as a mechanism to spend money with organisations outside of the NHS who most probably would be profit-orientated. Competition in the NHS was not new. Competitive tendering processes had always been used. However, historically, organisations outside of the NHS Family had been awarded contracts to supply capacity in addition to, rather than as a replacement for, existing NHS provision. The HSCA 2012 changed the rules of the game. When the Act was at the Bill stage in parliament it allowed for "Any Willing Provider" to be given equal competitive advantage when services were put out to tender; this was subsequently amended to "Any Qualified Provider" to emphasise that not just anyone could provide healthcare. Whilst competition was not new, the concept of AQP was. Under this initiative a register of qualified providers would be compiled, and the patient must be given the choice, usually by the referring GP, as to which service he or she would like to use. The difference between this initiative and earlier ones was that it was potentially a mechanism to replace NHS Family members as providers. The NHS had existed for over 60 years. During this time the people who worked within it had developed a shared approach to delivering services to patients. It was based on facilitative interactions and joint problem solving across the complex network of organisations (hospitals, community, primary care services, as well as interfaces with other agencies especially local authorities) that provided healthcare. Relationships between organisations within the NHS Family were stable and mutually supportive; this included relationships between those organisations separately identified as

payers (commissioners) and providers since the introduction of the internal market in 1990.

6.3.1 Competition: Any Qualified Provider and secondary care services

At the start of my observations, a large scale re-tendering exercise was nearing completion. Previously Castlefield PCT had let a ten year contract for an independent treatment centre. It was located on the major acute hospital's campus. It provided outpatient and day case activity. The initial business case had been generated by the hospital as a proposal to extend its own capacity. However, it had coincided with a national drive to acquire additional capacity from the private sector. The contract had been put out to tender, and had been won by a private sector firm. Ten years on, it was time to re-tender. This time there had been three bidders for the contract, worth 40 million pounds over three years. One of these bidders had been the hospital. Amongst the commissioners, especially the GPs, there was consensus that the sensible thing to do would be to award the contract to the hospital, who employed the staff under a secondment arrangement anyway. This timing of this tendering exercise coincided with an NHS-wide programme to reduce spending. The NHS organisations in Castlefield were collectively required to cut back spending in real terms by 20 million pounds over a three year period. The privately provided treatment centre and the publically provided hospital were part of the same inter-dependent clinical network, one providing outpatients and diagnostics on behalf of the other. If these could be brought together into the same organisation then services and associated costs could be rationalised. This was not something that could be taken into account under the European Tendering rules. In fact, it would be explicitly anti-competitive. In the words of Conran, the CCG finance director:

"We have got to assess according to the quality of the bid rather than the impact on the health economy."(CC fieldnote 1)

In the end, the existing private sector provider won the tender. The hospital, relatively inexperienced in completing commercial tender applications, had not put forward a good enough bid on paper. Based on this and other experiences, the GPs were far from convinced that competition had delivered the best results for the NHS healthcare system. The introduction of competition included ambiguity which was a trigger for sensemaking. How could the benefits of competition be realised, whilst retaining the co-operative methods that underpinned interactions in the NHS Family?

AQP was introduced through a national initiative associated with another policy driver, Choice. Choice was a national policy to enable patients to choose where, how and by whom they were treated, and was enshrined in the NHS Constitution (Department of Health, 2015 [2012]). A new rule was put in place in the form of a directive (Department of Health, 2011). All CCGs were required to select three services for which they should compile registers of qualified providers. Referring GPs should give patients access to these registers in order to choose their service provider.

My observations began towards the end of the tendering exercise, when contracts had been let. In Castlefield community podiatry, ultrasound scanning, and psychological therapies now had AQP registers which included a number of private sector providers. I observed a discussion at the CCG GB meeting (*GB fieldnote 5*) which was held in public. It became apparent that the trusting co-operative shared approach to sensemaking in the NHS Family network did not equip commissioners to guard against pitfalls inherent in a competitive environment. The discussion was based on ambiguities relating to the requirement to open services to the market, and the duty of commissioners to make sensible decisions on behalf of their population.

Tender specifications had not been specific enough; as absolute specificity had not been needed in the past. In podiatry, new

providers did not have premises from which to offer their services. Lisa Diggle, the Commissioning Director reported:

“We do want to offer choice, but choice in suitable locations”

The “learning” was that in the future specifications would pin down the need for patient accessible locations. The procurement of ultrasound diagnostic services had also presented problems. Due to a shortage of radiographers the local hospital had been unable to bid. National private sector organisations had put in multiple bids across the country. Every CCG in England had gone out to tender at the same time, the result of which was a shortage of applicants who could be qualified. Dr Cooper, baffled by this situation, pointed out that a planned ultrasound service at the treatment centre would have been more sensible:

“This is very much the market. We have a sparkling Treatment Centre [based at the hospital] with a transport connection....If we had a vision that we wanted diagnostics there..... In terms of our infrastructure, our city, our patients, common sense....this ought to guide our commissioning decisions.”

Market forces had not delivered this self-evident sensible outcome. Lisa reported a conversation with hospital managers. They were sorry that they had not been able to bid to provide the ultrasound services. They were recruiting more stenographers so that they could bid the next time the contract came up for renewal. Dr Kerala, who was standing in for Dr Baasit, had a surgery near the hospital. He reported a conversation with a patient:

Doctor: “Would you like to go to [choice of two sites at the other side of town both of which involved a bus ride past the hospital]”

Patient: “What happened to the hospital?”

The discussion continued, with the managers attempting to argue the benefits of services being provided privately. They found it hard to defend the principle of competition; after all, they too, shared the NHS Family sensemaking type. The main advantage that they identified was the transfer of clinical risk to the private provider. Managers had a different expectation upon them generated from

the Centre. This required them to be uncritical of NHS hierarchy. They were there to defend and implement policy, and not to question or undermine it. In contrast, the doctors did respond critically, and as operational professionals with patients who were directly affected, they pointed out problems, particularly for those patients. One doctor said:

“One of the providers we’ve just qualified is intending to provide services out of the back of a lorry” [laughter]

The conversation petered out, with Dr Whitbread thanking everyone for their hard work. Significantly, at the end of the discussion, it was noted that waiting times had improved, a major positive outcome resulting from having a wider range of providers. This positive aspect was not discussed, probably because the tension in sensemaking in part resulted from the fact that none of the leaders had yet decided whether competition was a good or a bad thing. They were grappling with the ambiguities inherent in the tension between competition and co-operation/integration. This was a time of trial, error, and critique.

6.3.2 Competition: Any Qualified Provider and primary care services

During the fieldwork, a number of primary care services were put out to tender. GP practices operate as small businesses. The majority of GPs work in the NHS through a contractual arrangement known as General Medical Services (GMS). These contracts cover core primary medical services, and they could be added to under an arrangement known as Enhanced Services. Some Enhanced Services were nationally determined, but there was scope to develop local services to address specific problems, and a number of services were provided this way in Castlefield. When my observations began the decision had been made to put certain Local Enhanced Services (LES) out to tender using the AQP rule. I first heard about this at a TM meeting where Dr Whitbread explained that this was being done because “current arrangements are

probably illegal" [my emphasis] (*TM fieldnote 1*). Some services that most people would consider to be basic primary care services such as phlebotomy and treatment room (for example suture removals, ear irrigation, and wound care including dressings) were to be included. This would mean GPs would have to tender to continue to provide services that they already delivered. This disrupted established assumptions. GPs comfortable position as protected, established providers within the safety of the NHS network was under challenge. This was an occasion when sensemaking amongst the GPs was triggered. The requirement to compete was ambiguous. The GPs found it difficult to understand why they were being invited to tender for services they already provided, and the leaders found it difficult to clarify what the benefits of this tendering exercise would be. These points are illustrated in the data presented below.

The following paragraphs relate to two events designed to prepare GPs and others to tender under the AQP rule. The first was a briefing for all potential Qualified Providers, including GPs, hosted by the CCG. The second was an event to help in the preparation of bids, organised by the Local Medical Committee (LMC), an organisation whose job it was to represent the interests of GPs.

6.3.2.1 Clinical Commissioning Group event

The CCG briefing (*AQP fieldnote 3*) was held at a local hotel close to a junction of a major motorway. Tea and Coffee were available, but the usual relaxed networking time over food was not part of the afternoon's proceedings. Smartly dressed business people were milling around alongside GPs. The atmosphere was subdued; there was none of the friendly chatter that I associated with gatherings of the NHS Family network. Tables were set out cabaret style in a large room, holding approximately 100 people. I sat on a round table with people who were strangers to me; I subsequently discovered they were from community pharmacies and other pharmaceutical businesses.

Even though practices are legally independent businesses, they operate as a set of related managed clinical units, where their “boss” is the commissioning health organisation in their area whatever it may be called at a particular time, and was presently the CCG.

Maggie Smith, the Director of Primary Care, opened the meeting. She introduced two solicitors who were there to outline the legal aspects of the process. The material was technical, and many people in the audience looked puzzled. What was covered quickly, if not glossed over, was that there was no legal imperative to go out to tender. The decision to proceed in this manner had been taken locally. However once this had been decided and the process had begun then European procurement legislation did pertain. The solicitor emphasised the potential for legal challenge; and looking at the faces in the room this was causing alarm amongst the GPs. The sharply dressed solicitor in his mid-thirties left the doctors in no doubt of the potential ramifications, which could affect all the services that were covered by the contract between a practice and the CCG.

“Courts can decide to make a Declaration of Ineffectiveness – the contract could be set aside”

When the solicitor had finished his presentation, one of the GPs in the audience began to ask questions, based on the fact that he had noticed that the value of the contracts when split down to practice level was too small to trigger a tendering exercise under European law. The following interchange took place:

GP: “If every contract is small at practice level then why do we have to do it?”

Maggie: “There are ways to stop deliberate disaggregation”

GP: “But that’s irrelevant”

Maggie: “No it isn’t, we can talk about that at the break”

GP: “But these are contracts for our services”

Maggie: "They're not your services. They are public services. It's tax payer's money."

This excerpt shows a significant departure from the trusting prosocial shared sensemaking type that underpinned the network of the NHS Family. Doctors were not to assume that they had any more entitlement to continue to provide these services than a commercial pharmacy.

Maggie outlined the steps bidders would need to take. Despite the fact that this was a mixed audience, much of the content was aimed at the GPs, indicated by phrases such as "write as if you don't know us". Termination letters giving notice on existing contracts would be sent to the GPs, and then the procurement process would begin. Scoring would be on a pass/fail basis. Once contracts for LESs were in place, any breach would have consequences for the whole GMS contract that each practice held with the CCG, as Maggie assertively pointed out:

"If you say you're doing three days phlebotomy and you're not, then your whole CCG contract will be in breach.....Have you all got it then? You know what to do?jog on.....It's scary, it really is, if we need to suspend service we've both lost, we don't want to scare you."

Clearly, there was an intention to scare practices despite this denial. The fact that Maggie stated that this new arrangement would be used to ensure doctors fulfil the terms of their contract is an indicator that she intended to monitor more closely than current arrangements allowed. This was followed by a discussion regarding the potential for a large single provider to win the tenders. One doctor pointed out that this would make management of the contracts easier. The reaction of the GPs at this meeting was muted. Other than the odd question, they were quiet. They were mulling over the implications that this had for their services, patients, and income. The contractual rules here were being wielded as a threat to GPs. The presence of solicitors contributed to a climate of intimidation. GPs were to act as if they were unknown to the CCG.

During the proceedings described above, Maggie was acting as a sense-demander. The GPs appeared to act subserviently, despite the fact that they were technically the commissioners under the terms of their own contract and CCG constitution. GPs had an embedded history of responding to the directions of authority, it has served them well in the past. GPs, including their leaders, had learned to comply with the demands of authority. They appeared to be unequipped to resist the change in field rules from a protected single prosocial system to a competitive market. The doctors were required to act competitively if they were to continue to be paid to provide certain established services. Despite the ambiguities it raised, they were compliant and obedient.

6.3.2.2 Local Medical Committee event

Local Medical Committees (LMCs) are statutory bodies that represent the interests of General Practitioners in their interactions with local organisations such as CCGs. LMCs have been in place since 1913 (Lancashire and Cumbria Local Medical Committees, 2015) and have a statutory function to support and promote the interests of GPs in their dealings with CCGs. A number of the staff at Castlefield LMC, including the Chief Executive, had seen GP commissioning develop through all its embodiments since its introduction in the 1990s. Castlefield LMC intended to help GPs prepare to submit bids to be included on the registers of Qualified Providers. Jim Wood, the Chief Executive of Castlefield LMC, told me in an interview that this initiative was causing considerable concern amongst the GPs.

“in terms of general practice themselves, the things that is of most immediate concern to them is things like enhanced services which have now been you know a subject to this ridiculously overblown competitive regime where you know for a contract of, which individually may amount to no more than you know £70,000 or £80,000 a year, are having to jump through these ridiculous hoops which were designed to regulate major European contracts shall we say.” (WoodInterview)

Even though he was not an apologist for the AQP initiative, he considered it inevitable that GPs would have to bid, and an event was organised to support them in doing this. I managed to get an invitation to attend, using my long-standing connection with Jim. It was held in a modest hotel on the edge of Castlefield City Centre (*AQP fieldnote 3*). This was exactly the same cohort of GPs as TM, but the terms of engagement with the LMC were different; a more self-interested approach to sensemaking might well be revealed. It would be here, if anywhere, where GPs would talk about how much money they were likely to make. If money was their motivation this is where it would be declared, since the LMC had an established and legitimate purpose to get the best deal for GPs in their patch.

Jim began with a presentation, explaining that AQP was linked to the Choice initiative. Jim explained that when a GP decided that a patient needed one of the services offered under AQP then, regardless of whether or not he or she was a "Qualified Provider", the full choice would need to be offered to the patient. The GP would be obliged to "offer Virgin or Boots or another practice" Jim said, using large-scale multi-nationals to emphasise the point that this was a market-place. Jim's presentation was followed by facilitated group work, led by a manager from one of Castlefield's practices who described some of the operational considerations of offering services as one amongst several Qualified Providers. Qualified Providers would be obliged to offer services to any patients that chose them, even if this caused a capacity problem in the surgery. "Practices need to work out if this is worth their while" the practice manager cautioned. The group work involved discussing the requirements of the pre-qualification questionnaire (*CCG doc 4*), page by page. Tables of 10 to 12 people each had a facilitator. I facilitated the table at which I was sitting. I had anticipated the discussion to be about money, but this was far from the case. Instead, the topics were operational continuity, safety, and protecting services for patients. A problem-solving approach to making sense of this initiative was apparent. Various tangible

problems were identified. Audited accounts were required, but since practices were legally partnerships, not companies, these did not exist. Public liability would be an issue since patients from other practices would be potential users of services; “you might all have your patients going to someone else, and others coming to you” said one practice manager. At an operational level, this was not going to be a straightforward exercise.

The full group reconvened into plenary session. Some GPs representing more entrepreneurial practices were keen to show that they were prepared to compete:

GP: “We’ve got screens that upsell our enhanced services.”

GP: “Our practice has just developed the first app.”

GP: “It will be on a resell basis to other practices.”

Despite the fact that some people were eager to show willing, most people focused on the hurdles that would need to be overcome.

Various clinical questions were asked:

GP: “If you remove a lump or bump, what do you do about the histology?”

GP: “What would you do to confirm patient identity?”

There was particular concern about treatment room services. Practices that just did simple wound care, leg ulcer dressings, and removal of stitches would have to stop as the specification required a wider range of services. One Doctor said “It’s just not fair on the patients.” Everyone agreed with this, and signalled their intention to continue to do it on an unpaid basis in order to serve their patients in the way that they thought was right. In this private environment away from the CCG leaders I had anticipated the GPs would focus on the negative impacts of AQP, because there were significant downsides for the doctors, not least of which was the effort required to produce tenders and the potential loss of money and resultant confusion as new services were implemented. I was surprised that a stoically compliant, and patient-centred sensemaking appeared to be the response.

After these events the bidding process for LESs went ahead in the background. One issue did cause problems and was discussed at PrC (*PrC fieldnote 4*). The GPs were not bidding to provide phlebotomy services; the specification included a requirement to visit patients' homes to take blood and this was off-putting. Dr Whitbread shared his fears with me informally after the meeting, his facial expression betraying a mixture of worry and embarrassment. He thought that there was a good chance that there would be no phlebotomy service as a result of this tendering process. In the end the situation was rescued by Castlecare who agreed to provide domiciliary phlebotomy under a separate contract. The established NHS Family network had provided the environment for the situation to be salvaged. Other adjustments were made, for instance ear irrigation was disaggregated from the treatment room service and again put into a separate contract with Castlecare. So, what had started as a competitive process, ended up as one in which the mutual supportive behaviours associated with the NHS Family network were reinforced.

Later, on reflection, Jim Wood conceded that this mixture of co-operation and competition had in fact improved services:

"Well I understand what the issue is with home visits.....until recently was....a mixed model where some practices sent all of their bloods to the community service who were commissioned to provide a service. Some provided it themselves and were paid for that service. Some provided it themselves and weren't paid for those services and some were paid to provide a service but still sent their patients to the community service. So it was a mess. And the Castlefield CCG decided having looked at it and looked at previous attempts that had failed to resolve this sort of mess that the only way to do it was to cut through it by making Any Qualified Provider. And their aim is simply to ensure that there is an adequate service that patients can access whether it is provided by GPs or whether it is provided by the community services."

(Woodinterview)

So despite reservations about the process being disproportionate to the problem, with hindsight, Jim did agree that a problem had been

solved. About a year after the exercise had begun, I interviewed Maggie. She told me that she had deliberately put the GPs into a position where they had to compete in order to induct them into the new rules that would govern healthcare in the future:

"I think the issues for GPs is they've seen it as a threat, and this is what we've got to get their head round, is for them to see it as a benefit. Because as organisations, they need to get more money in. The only way they can get more money in is by bidding for business. So in Castlefield....I put all of the enhanced services out to AQP and they were in a room, and we are one of the only CCGs who done it, but again I went to them and said, you've just got to trust me, you've got to do this. And this is where, and the local enhanced services GPs were paid pittance for delivering a blood test that, in a community contract, or an acute contract, they were paid 25 pounds for doing it. Why should a GP be paid 2 pounds and somebody else be paid 25? What are they doing differently? Nothing. So.....I gave a fair price for a fair job, so whether it be phlebotomy, wound care, I put them all out to AQP, but what I have said to GPs is, yes, I'm putting them out to tender, but this is the price now that we're going to pay for it, whether you be a GP or a community services or an acute provider, it's a fair price for a fair job. And GPs are financially benefiting from that and what we find now is, they were nervous of it to begin with, but now, they're specialising enough in those services and they're bringing people in and they're delivering those services within 24 hours. They couldn't have done that before procurement." (SmithInterview).

This interpretation was developed with the benefit of hindsight, especially given the significant problems that needed to be managed along the way, such as the lack of bids for phlebotomy. It showed that as Commissioners, both managers and GPs, became more experienced and assimilated what they had learned about competitive processes, a new approach to sensemaking had been forming which incorporated competition whilst preserving the co-operative principles of the NHS Family prosocial sensemaking type.

6.3.3 GP commissioning and conflicts of interest

Inherent in the model of CCG commissioning, where GPs are simultaneously commissioners and practising clinicians, was the

potential for conflicts of interests. This was especially so when competition rules applied. People were acutely conscious of this. The term “conflicted” was coined to describe this state. At the beginning of meetings, those present would declare their personal interests in agenda items. At a national level, an attempt had been made to avoid these conflicts by keeping contracts for primary care at a regional tier. Nevertheless, since providers of secondary and primary healthcare are so interdependent, it was difficult, if not impossible, to maintain this separation. Inherent in this dual role was ambiguity which triggered sensemaking.

An example to illustrate how these conflicts could arise is the GP Out of Hours (OOH) services which were re-procured during the time of my observations. About fifteen years previously a community benefit company had been established which GPs themselves owned. It included an OOH emergency clinic, and the capacity to make home visits. Local GPs provided this service on a rota, supplemented by locum doctors. The contract for these services had reached its end-date and it was put out to tender, meaning that GP commissioners were the current owner-providers of the contract that was up for renewal. I attended a PrC (*PrC fieldnote 2*) where this was on the agenda. The executive doctors obviously felt uncomfortable with the fact that they were potentially the ones that would destabilise this GP enterprise. The first part of the discussion related to why OOH services were being commissioned by the CCG at all, given that the commissioning of primary care was done at the regional tier. “Because it’s urgent care” Catrina explained. “But its primary care” said a doctor, to whom Catrina replied “Its urgent care, so it’s our statutory duty.” Because OOH services fell outside of the core contract for general practice, it classed as urgent care, and contracts were let by the CCG. In the end, a lay member from the GB convened the procurement process, and the contract was successfully re-issued to the GP co-operative, but not without considerable anxiety on the part of the GPs and the staff of the OOH service.

The question of defining how a conflict might arise was subject to much agonising. Catrina was rigorous in ensuring that interests were declared. At the beginning of one Board meeting Dr Whitbread declared his own shares, his wife's shares, and shares of his partners in the OOHs organisation (*GB fieldnote 6*). Catrina said anyone who had previously held shares and who worked there would also be "considered conflicted". Dr Cooper had declared at a previous PrC meeting that he had "flogged" his shares and now worked there (*PrC fieldnote 2*). Cat described the concept of an "ethical wall" which allowed GPs to say what they "believed is in the interests of their patient" but "separates them from procurement decision". The concept of anticipating a future conflict was discussed - since all GPs may at some stage in the future might have an involvement in an OOH business then all should be considered conflicted in relation to the immediate decision that needed to be made.

The state of being "conflicted" was such a preoccupation that a GB development session (*GB fieldnote 8*) was dedicated to the subject. It was led by two solicitors. One began with an overview:

"Having the declaration is only the start. It's what you do with it. It would be like you as a Doctor making the diagnosis but not deciding what to do with it.....It's not just actual conflicts, its potential conflicts as well.....There is no statutory definition of conflict.....it could even include your trustee position on a charity."

Technically the interests of all GPs should be declared, since as members of the CCG they were all commissioners. The solicitor advised that executive GPs should endeavour to investigate what these were. The solicitor warned:

"You can't use the argument that you didn't know if you didn't take reasonable steps to find out....The trouble with anything to do with knowledge is it's very hard to prove."

Potential conflicts were wide-ranging including direct and indirect interests, pecuniary and non-pecuniary interests, and inducement. There were also potential conflicts arising from associations with

partner organisations. "What if the University Chairman is a GPs wife?" one of the doctors asked.

Executive GPs had put themselves forward to lead commissioning because they were willing to offer expertise and advice. The effect of the inherent conflicts of interest in the system was that they were under pressure not to use their expertise in any way that could be seen to benefit themselves or their colleagues. They were very concerned that the predicament of being "conflicted", which affected all GPs not just executives, would be especially problematic in clinical settings, and potentially unnerving for patients. The extract below referred to the situation where a GP when offering to take bloods from a patient under the AQP system, previously discussed, would be required to make the patient aware that a payment was involved and that there was a choice of providers.

Solicitor: "Patients will need to be told of the choice, and made aware if the Doctor has a financial angle."

Dr Cooper: "Our members will think we are potty."

Maggie: "Well...you just say, have your blood-test, these are your choices, I am conflicted."

Dr Cooper: "....and you think that's a normal GP consultation....The whole issue here is the Doctor Patient relationship."

During the ensuing discussion an exchange took place between Catrina and Dr Lovett. Dr Lovett talked about a workforce, pathways, and patient flow. Catrina talked about contracts, business, and enhanced services. The language was different. The agenda was different. The cues for sensemaking were derived from different priorities, serving to expose the differences between doctors and managers. It was clear, and I interjected to say so, they were trying to do two things at once: develop commercial competition, and develop professional integration within the context of the NHS Family. There was an inherent conflict; the question was whether both could exist side by side, not whether one or the other was right. My interjection had resonated with the doctors. Over the break a number of them came over to talk to me. Dr Lovett said "I

can't change who I am". The independent doctor from a neighbouring acute hospital said:

"There are many metaphorical and philosophical issues here that are more than the mechanics of dealing with interests....."

The second solicitor led the remainder of the afternoon. The content of his presentation was all about the possibility of investigation and the need for an audit trail of evidence of good governance. His language was peppered with words like "justification", "challenge", and "breach". He explained that Monitor, the regulator, had a role to prevent anti-competitive behaviour that was not in the interests of the patients. He seemed to reassure and alarm at the same time, advising people to "take solace in the fact that the word proportionate is used extensively", but then following up by emphasising the dangers:

"One piece of legislation might put you in breach of another one", The Public Sector, Social Values, Act, European legislation, Patient Choice..... if you are going gung-ho for the spirit of the public sector act like the minimum wage and a local workforce, it could put you in breach of Europe or Choice."

Towards the end of the meeting Dr Lovett decided to play dumb:

"I don't understand. I'm getting more confused. I don't think I'll ever grasp this.....If you put the patient, quality of care, at the centre, there's no problem."

Dr Lovett's statement, although couched in language of "confusion" was an important stage in the development of collective sensemaking regarding the impact of conflicts of interest. CCG managers and GPs wrestling with the ambiguities associated with as being "conflicted" was, I came to realise, a collective sensemaking process. This network was actively working out how to think together. Through various activities, including trying out competitive commissioning, identifying problems, reflecting in developmental sessions like this one, and taking different positions, like the managers and doctors, they had exposed, understood, and negotiated issues, a more nuanced plausible future was being

constructed where competition and collaboration could exist side by side.

Towards the end of my study, over a year after the development session had taken place, I followed up certain themes in interviews. Conflicts of Interests was one of these. The data from the interviews showed that both doctors and managers were still developing and negotiating how to think about this topic. Dr Lovett continued to be concerned that guarding against doctors serving their own interests could mitigate against the potential to serve the interests of patient. He found it offensive that managers could ascribe unscrupulous motives to the doctors. There was a danger of missing an opportunity by being too guarded about the risks:

Dr Lovett: Right, well I think the conflict of interest is a red herring and I think that... I think... the whole point about doing commissioning was to get people who are clinical in to the commissioning environment therefore they are conflicted. I think [there is] a lack of confidence in the ability to make an argument that's reasoned... it was the fear of being thought to be self-interested and I don't think the people who were making any decisions are remotely self-interested but I think they're aware of the drivers that get things done and we know that incentives change performance. We know that. It's not about sticking more money in to GPs pockets..... well I think there's something else as well, there is a conflict between managers and clinicians. There still is. There are some of the management I fear that are obsessed with the thought that their clinical colleagues might be pulling a fast one to get them a better deal than actually the patient... I still think that happens and I think it happens here and I think it's really disappointing. (LovettInterview)

In an interview with Lisa Diggle, the director of commissioning, I pushed her on the point about GPs acting in their own interests. Her view was the same as Dr Lovett's. GPs were concerned about the constraints of primary care, and concerns about payments were in this context:

Lisa: "I have very, very rarely seen anything where I've had the view that someone has expressed their opinion, which has been purely to gain a benefit, rather than they're expressing their

professional opinion. And I suppose the classic is where we're talking about services which could be provided by GPs, and I think GPs are always ... use that opportunity to identify the real constraints of primary care, which is real, and so I don't know, I wouldn't expect them to do anything different. They have to ... In order to say whether it's right for a service to be delivered in primary care or not, they have to start from this is the current position in primary care....."

Adele: "Have you ... you've seen mainly that it's not greed."

Lisa: "No, no it's not."

Adele: "I'm pushing you on that in case I'm wrong."

Lisa: "No, no, it's definitely not about greed. I've seen a couple of cases where ... You know the GPs who are far more business and money orientated..... I think GPs in general, absolutely aren't greedy. But what they are most concerned about is the capacity constraints within their particular sector, which means that there is absolutely no way they can do what they need to do without additional resource. That isn't greedy, that's just absolutely recognising the capacity issues within their bit, of which they are exposed to on a daily basis." (DiggleInterview)

Dr Strong, on the other hand, prior to one of the TM meetings, had once said to me "they're not all angels", and in an interview I asked him to expand his view:

Adele: "Does it matter, as long as that conflict's declared? Do you think, I suppose what I'm getting at is will GPs try and feather their own nests, or is that, the idea is that you shouldn't have these conflicts because GPs will act in their own interests, is that, can you comment on that?"

Dr Strong: "Yeah, I think it's inevitable."

Adele: "Do you? Or do you think sometimes they act against their own interests?"

Dr Strong: "Well, there's a spectrum and I think possibly I'm at the end of the spectrum where I might even act against my own interests.....So there are a few examples of that. But I think the risks of conflict are greater now than they were. I don't think that, even in conversations I heard this morning, sometimes GPs don't understand that they are, they're providers in the same sense that [Any NHS Trust] are. Why should they have special dispensations

around training, for example, rather than having to organise that for themselves, is something that some colleagues can't see.
(StrongInterview)

Here, he added context to his opinion that the risk that doctors would act in their own interests was a real one. He emphasised the fact that this was inherent in the model of primary care businesses. Doctors had to make enough money to cover their own training and operating costs so it was inevitable they would have an eye on how much they could be paid. Maggie also talked about the problem regarding fairness between primary and secondary care:

Maggie: "there's also different conflicts of interest and it's really focused on primary care in GPs, but there are bigger conflicts here. So, and this is where I find it a little bit frustrating, so for example, we have an [acute] Trust who's financially in deficit, we use non-recurrent monies to bolster it up, to keep it going.....well, that's a conflict of interest. What is the difference between giving [the Trust] money to keep that organisation going, than giving a local GP on the corner money to keep him going to provide health services for his population? So I think conflict of interest, I truly believe in the concept, but I think what we have to do is understand the grey and blur, the greying boundaries. We're a CCG, it's very easy to say to a GP, we're not putting money into primary care because that's a conflict of interest, but actually it's no more of a conflict than giving the Trust more money, because that's going to go over, where's the difference?" (SmithInterview)

The change in tone of the managers would indicate that as thinking had developed, a more nuanced understanding was emerging. The initial separation of managers and doctors into proponents and critics of competition initiatives appeared to be settling into a reconciled position following a process of trial and error. AQP had exposed tensions in operating a competitive process within a broadly co-operative system. In the end however, it appeared possible to reap the benefits of competition without a corollary loss of the benefits of co-operation. Both parties reframed their ideas to accept this based on a process of distributed sensemaking.

6.4 Discussion: Strategic Collaboration Level

6.4.1 Introduction

Below I discuss how and why GPs commissioned in the way that they did at SCL by identifying sensemaking processes within the context of networks and rules. The discussion is organised into three sections: wider context; temporality; and distributed sensemaking. Each of these sections draws on the thematic analysis using the codes: establishment of new organisations; legacies; changes to the profession; competition; and integration. In each section I first discuss the relevant findings to the heading and draw out the theoretical implications, focusing on sensemaking within the context of networks and rules. I conclude by presenting a summary in the form of a tabular matrix.

6.4.2 Wider context

The CCG network was nested within the wider network of the Castlefield NHS, which in turn was nested within the national NHS. This nested arrangement forms the wider industry context. As already discussed in the previous chapter, and earlier in this chapter, there were embedded expectations of prosocial behaviours between NHS actors who would respond by helping, regardless of organisational boundary.

National rules required the establishment of the CCG, and that decisions regarding how it was led were reserved to all members. Beyond this, rules were loosely specified. Similar to OPL, actors appeared to identify as NHS Family and use an embedded prosocial sensemaking type. Changes to the profession (see 2.2) were evident. At this level the GP network was hierarchically stratified into hybrid-leaders and rank-and-file. The call to professionalism was used by leaders to encourage compliance.

The added impetus given to commercial competition acted as a trigger for sensemaking. Inherent in the new rules was a potential role conflict for GPs who were both providers *and* commissioners. It

would be against the rules to give advantage to organisations in the NHS Family. The implication of the rule was that sensemaking should shift from a prosocial type to a market type. This resulted in ambiguity as actors did not have experience from which to derive cues as to how to be commercial. Actors were unprepared as to how to respond. Mistakes were made both on the commissioner and provider sides. NHS providers did not have market experience to produce bids of a sufficient quality to secure services, and commissioners failed to produce watertight specifications.

Another source of ambiguity was the commissioner-provider role conflict, which local actors described as a conflict of interest. Being “conflicted” entered the organisational lexicon. The legal implications of the field change were the subject of much discussion, and commissioning decisions made by the doctors were under added scrutiny. The CCG response included the development of principles by which to identify conflicts, and the concept of an “ethical wall” between GPs and certain decisions was used. It was an unexpected finding that doctors did not resist this conflict more than they did. After all, doctors were commissioners precisely because they had an expert contribution to make. This conflict was unavoidable, so the question was how to handle it. GPs appeared to respond by complying with the rule change, even sacrificing personal income to ensure patients continued to receive a service.

Integration could be interpreted in a number of ways. The NHS Family was the context for the integration of NHS services (for example between primary care and hospitals). This was the focus of integration rules at this level.

6.4.3 Temporality

In this section I explore the link between sensemaking, legacies and anticipated futures as new rules impacted on the SCL networks.

As far as the rules allowed, organisational architecture and associated ways of doing business were continued in the post April 2013 health and care economy. At the SCL, this meant that a GB

was formed which was similar to the PCT's outgoing Board, and an Executive Team that was made up of Executive GPs nominated by the GP-groups, and management directors. The Executive GPs also formed a PrC which was similar to the PCT's Professional Executive Committee. Rank and file GPs found it difficult to differentiate present arrangements from the past.

The differences in style that were apparent at OPL were subsumed into a single style as a way to unify sensemaking for collaborative purposes. The non-fundholder "NHS as system" sensemaking style was adopted by the network of leaders. The new rules were implemented within the context of the NHS, and could not alter the history of working together that the actors already had. Actors in the NHS Family shared a legacy as clinicians trained and experienced in working across organisational boundaries with a common aim of serving, often shared, patients. The NHS Family continued to solve problems together, even in a competitive model.

Because actors did not have experience of competition, there was a need to sensemake prospectively. This was the source of ambiguity, and the trigger for sensemaking which included taking distinct positions in networks (see 2.4.4). In the example of the split of managers and doctors, managers endorsed competitive principles by imagining a future where competition was the usual way of doing business. Doctors on the other hand were protective of existing professional and operational networks and wanted to retain co-operative non-market arrangements. During the process, actors from the same network were in a state of seemingly irreconcilable opposition, and did not realise that this was an inevitable stage in a longer timeframe in which a more nuanced understanding would emerge derived from a balance of retrospective and prospective thinking. In the end, competition principles were incorporated into the existing prosocial sensemaking type.

Sensemaking happened in a timeframe, and was paced. One key factor in this pacing was the role of sensegivers in a distributed

landscape. Sensegivers relied on personal legacies for legitimacy. The pacing of sensemaking, including its suspension, appeared to be an active process. For example, at the same time as the managers and doctors were making sense of the implications of competition, the rank-and-file GPs also needed to be kept informed and involved. OD processes were used, where a socially skilled individual appealed to the rank-and-file to refrain from reacting to the rule per se, but instead to act compliantly drawing on concepts related to “professionalism”. A theoretical implication of this is that action can commence before sensemaking is complete. Rather what is important is to diminish resistance by finding alternative ways to facilitate constructive engagement.

6.4.4 Distributed sensemaking

Technically the rule under which CCGs were established attributed shared decision making power to individual GP practices. It was not feasible for all GPs to be involved in every interaction or decision on a daily basis. Arrangements for decision-making were set out in a Constitution. These arrangements were tantamount to the distribution of actors in formal networks. The key formal networks were the GB, the PrC, and TM. The documents set out arrangements for the rank-and-file doctors of each GP-group to be represented by Executive GPs. These representatives operated as a collective of manager-doctor hybrids. They, alongside the management directors, comprised the PrC. The “NHS as System” sensemaking style seen in the PC GP-group at the OPL appeared to predominate across all members of the PrC. In addition TM, a collective network including GP representatives from each practice, was established. Through this mechanism, GPs were hierarchically stratified into hybrid-leaders and rank-and-file. The leaders recognised that it was important to engage with the rank-and-file since individual GPs retained ultimate decision-making power. It operated as the mechanism by which sensegivers could influence, listen to the ideas and opinions, and deal with resistance.

Sensemaking activities relating to new rules took place in these formal networks. A key observation during the study was that networks did not remain static at times of rule change, and that the distribution of networks was an active part of the sensemaking process. Active network distribution occurred in relation to the competition rule. Actors redistributed networks in order to consider rule change from different perspectives. One example was when practices were required to compete for business under the AQP rule. An active process of network separation took place. Rank-and-file GPs retreated into their uni-professional network to make sense of the rule by considering the implications for themselves and their patients. Within this uni-professional network the shared prosocial sensemaking type was in evidence. GPs indicated that they would enact the rule by working together to minimise any negative impacts on patients even if this meant a loss of income. Another example was when the ambiguity associated with the extension of competition triggered sensemaking amongst the CCG directors and the Executive GPs. In an active process of distribution the two occupational groups distributed into two sub-networks based on positions of proponent and critic. In this example the doctors displayed the prosocial sensemaking type and the managers displayed a market sensemaking type. By the end of the study, there was evidence to suggest that this had been a stage in a learning process whereby competition principles were incorporated into the existing prosocial sensemaking type.

As already discussed in 6.4.3 above, sensemaking existed in a timeframe, and was paced. One key factor in this pacing was the distribution of actors and the role of sensegivers. These sensegivers could hold sensemaking in suspension by diverting attention. This appeared to be an active process. For example, in parallel to doctors and managers taking different positions on competition, the rank-and-file GPs also needed to be continue to enact their own roles in commissioning arrangements. A socially skilled individual acted as sensegiver at TM' events. Rank-and-file doctors were encouraged to

put aside resistance, on the basis that to resist would be to act unprofessionally. This was an active process, designed to maintain stability until the leaders had themselves had time to give more consideration of the implications of the rule changes. The appeal to “professionalism” in this example was in the form of a request that doctors contribute ideas about how services for patients could be improved through active co-operation across the primary and secondary care boundary. A theoretical implication is that action can commence before sensemaking is complete. Rather what is important is to diminish resistance by finding alternative ways to facilitate constructive engagement.

For suspended sense to hold then the potential to improve services had to be a plausible reality. This plausibility was dependent on the existence of professional networks that were wider than primary care, and which were a further dimension to the distributed landscape. Another key role of sensegivers in distributed sensemaking was to maintain cross-organisational networks. GP leaders were positioned at the interface of the rank-and-file and medical leaders from other healthcare organisations. The emphasis was on the development of a cohesive network unified by the prosocial sensemaking type that existed in the NHS Family. OD processes, dependent on the legitimacy of critically placed individuals, were used to reinforce cross-organisational networks and prosocial sensemaking. FLEs were regular meetings where the topics concerned the interface between primary and secondary care, and where sensegivers from both demonstrated that the NHS was one system requiring joint work to develop pathways and referral mechanisms across organisational boundaries. In a similar way to TM meetings, OD facilitation techniques were used. Group work sessions allowed time for individuals to air their concerns and conceptualise the information that they were receiving. In this way, not only were rank-and-file GPs introduced to new ways of working, but also the inter-organisational medical networks to which Executive GPs belonged were displayed for all to see. In this

context, the detail of the technical aspects of contracting and specifications were absent. The focus was on shared diagnosis, treatment, and caring for patients when discharged.

6.4.5 Summary matrix of theoretical implications

The theoretical implications identified in 6.4.1-6.4.4 are presented in a summary matrix in table 23. The matrix structure is a map of the main thematic categories (side headings) and the SP co-ordinates (top headings). Contents of the matrix are articulated using concepts from BF and SP.

Table 24 Strategic Collaboration Level summary matrix

Strategic collaboration Level			
	Wider Contexts	Temporality	Distributed Sensemaking
Establishment of new organisation	National rules required the establishment of the CCG, and that decisions regarding how it was led were reserved to all members. Beyond this, rules were loosely specified.	As far as the rules allowed, arrangements from the pre-existing PCT were retained, along with associated networks Rank and file GPs found it difficult to differentiate present arrangements from the past.	The distribution of actors was set out formal documents designed to describe the arrangements for decision-making. Decisions about the leadership was reserved to rank and file GPs in a network called TM.
Legacy	Similar to OPL, actors appeared to identify as NHS Family and use an embedded prosocial sensemaking type.	The PC "NHS as system" sensemaking style was adopted by the network of leaders. The NHS Family legacy endured rule change and problems continued to be solved together. Sensegivers relied on personal legacies for legitimacy.	Executive GPs led rank-and-file acting as sensegivers within the context of the NHS Family.
Professional changes	Changes to the profession (as described SoP and medical sociology) were evident. At this level the GP network was hierarchically stratified into hybrid-leaders and rank-and-file. The call to professionalism was used by leaders to encourage compliance.	Sensegivers paced sensemaking, including suspending sensemaking processes amongst the rank and file whilst they themselves considered how to interpret new rules. This suspension was achieved by leaders linking being compliant with being professional.	The GP network was stratified into hybrid-leaders and rank-and-file GPs. GP leaders were the interface between rank-and-file GPs and secondary care. OD facilitation and group work was used for leaders to encourage compliance on the basis of "professionalism".
Competition	Competition rules implied a shift from prosocial to market sensemaking. They were mainly loosely specified. It was against the rules to give advantage to organisations in the NHS Family. Inherent was a role conflict for GPs as both providers and commissioners.	Competition created ambiguity. A combination of retrospective and prospective sensemaking resulted in the incorporation of competition principles into the existing prosocial sensemaking type.	Active network distribution occurred. In the leadership network, medical and management executive leaders formed a distribution into two sub-networks based on positions of proponent and critic. In the GP rank-and-file there was a retreat into uni-professional network.
Integration	Integration could be interpreted in a number of ways. The NHS Family was the context for the integration of NHS services (for example between primary care and hospitals). This was the focus of integration rules at this level.	NHS Family continued to solve problems together, even in a competitive model.	GP leaders were placed between the rank-and-file and other healthcare organisations. GP executives and doctor-leaders from those other organisations acted as sensegivers to the rank-and-file. OD facilitation techniques were used. The medical cross-organisational network was reinforced Group work sessions allowed time for individuals to conceptualise.

Chapter Seven: Sensemaking, networks and rules at the Interagency Strategic Partnership Level

7.1 Introduction

In the two preceding chapters the focus was GPs in the NHS. In this setting this shifts to the wider health and social care economy of Castlefield. Health services are only one part of a wider set of public services, including social care, community safety, education, and housing. GPs plan services with other agencies in two ways. They participate in partnerships that bring senior people together to set priorities and allocate resources. They also work with colleagues from other agencies to devise operational arrangements for service delivery. This chapter is an exploration of the dynamic of sensemaking, networks and rules in the inter-agency environment.

The opening section is an analysis of the implementation of two aspects of the new rules. The first is the statutory requirement to establish HWBs in each second tier LA area. The second is the associated statutory requirement to transfer the public health function out of the NHS and into LAs. Section 7.3 is an exploration of sensemaking processes between members of the HWB and the attempts that they made to develop shared understanding, and how they set priorities. In section 7.4, I focus on GPs, also drawing on findings from earlier chapters, in order to develop a more nuanced understanding of GPs sensemaking and networks at IPSL. I use the ICP as a case-study, to show that, similar to findings in earlier chapters, GPs relate most actively to rules in networks when they can focus on the operational implications, and take part in service design activities with other professional colleagues.

The observations took place in Bevin House, Castlefield Council's headquarters. The one exception to this was those that were

associated with integrated care; this was an interagency project, and its meetings took place in various locations.

7.2 The rules

There were two main rules in the HSCA 2012 that took effect at the level of the strategic partnership. First, LAs were required to establish a HWB, and second, public health duties were to transfer from the NHS into LAs.

The health of a population is not determined by its healthcare system; responsibilities for the health and wellbeing of a community fall within the remit of a number of organisations. Since the 1980s statutory cross-organisational partnerships have existed in an attempt to co-ordinate efforts (Sullivan and Skelcher, 2002). Just as Castlefield CCGs had been established based on the architecture of the pre-existing PCT, the HWB was based on its predecessor. Castlefield, like all English cities, had previously put in place a Local Strategic Partnership (LSP) which brought together public, private, and voluntary organisations with the policy intention to improve the economic, social, and environmental conditions of an area. The work of Castlefield's LSP had been organised into themes. One of these themes was public health, for which it had put in place an associated formal network called the Health and Wellbeing Partnership (HWP). This was a network of senior people who agreed an annual Health Needs Assessment and Health and Wellbeing Strategy. The last recorded meeting of the HWP took place in September 2010. A minute entitled "NHS and Public Health White Paper Updates" shows that the intention was to create the HWB by adding additional responsibilities to the HWP:

A Health and Wellbeing Board will be established as a statutory body. This board will have significant additional responsibilities to the HWP. It is likely that membership will be tweaked to include a much larger group than the HWP, however, it was recognised that there is a desire to maintain voluntary and community sector

representation. Structure and governance have not yet been developed. (HWB doc 1)

The process of adaption started immediately, and as a result the HWP did not meet again. The September minutes end with the statement "Please note the December meeting has been cancelled" (HWB doc 1).

HWBs are statutory partnerships. LAs were required to establish them as committees of full Council. A "task and finish group" including senior managers from the LA and the PCT was convened to make recommendations to be approved by the LA Executive Board. The Executive Board was made up of LA managers and senior councillors. The group's report was presented in July 2011, and proposals to "rationalise existing governance structures around Health and Wellbeing, namely the Health and Wellbeing Theme Partnership and the Health and Social Care Commissioning Board" (*HWB doc 2*) were agreed. The incorporation of the business of the Health and Social Care Commissioning Board (HSCCB) which had a focus on service design and resource allocation meant that the new HWB had a wider remit than either of the predecessors. An inclusive approach was adopted; the recommended membership of the new HWB included every organisation that had been part of the two pre-existing networks (*HWB doc 2*) and added in some others. The HWB in Castlefield had twenty-one members, compared to a statutory requirement of six. Castlefield HWB included representatives from the police, Jobcentre Plus, the housing provider, and the drug and alcohol partnership.

The HWB first met in October 2011, over a year after the final meeting of the HWP. It was in shadow form right up to April 2013 when the HSCA 2012 became a statute. On the website of the LSP the word *Partnership* was substituted by the word *Board*, and to the outside world the HWB appeared to be business as usual, an organic development of the HWP. The HWB was being packaged and presented as a replacement of the HWP, but the incorporation of the business of the HSCCB, and other changes impacted on how and

why business was enacted, and priorities were set. As will be described later, the interaction between members, and especially between doctors and councillors, had a major influence on why and how priorities were decided, and why and how spending decisions were made.

Designers of the HWB presented it as a partnership of inclusivity, optimism and consensus. Castlefield was a concentrated urban area. Rates of crime, drug and alcohol abuse, and unemployment were high. Everyone articulated a commitment to address urban problems, and a belief that co-ordinated interagency effort was the best way to do this.

The second rule change was the shift of the public health function from PCTs to LAs thus effectively redrawing the boundary between the NHS and local government. During the period of my observations the public health staff were “lifted and shifted”, in the words of one of the LA Directors when explaining the approach to the Peer Review Team (HWB fieldnote 3), from the outgoing PCT to Castlefield Council. In financial terms the transferred cost of the staff and the portfolio of service contracts that moved with them added up to circa 27 million pounds. Included were services that would have been considered mainstream healthcare by most people, for example: sexual health services including hospital services for genito-urinary medicine; drug and alcohol services such as needle exchanges and detoxification clinics; and all screening and immunisation programmes. Amongst these were a number of GP contracts for screening services, and other health promotion activities. These services would no longer be planned and paid for within the NHS; they would now be prioritised, or not as the case may be, within the context of the LA spending plan and budget constraints.

Some thirty staff, including nurses, doctors, managers, and administrators were moved from the NHS to the LA. This transfer disrupted long standing networks. One such disruption was in the

relationship of GPs and public health doctors. In the predecessor PCT public health staff had led interagency planning, with a direct consequence that GPs had not taken lead roles in this area. Not just in Castlefield, GPs and public health doctors had intertwining roles. There are many instances of public health doctors doing sessional work as GPs, and vice versa. As a result of the new rule public health staff left the NHS and moved to the LA. The people might not have changed, but their relative positions and pay masters had. Not only had money and staff transferred to the LA, but so had decision making power. Councillors, with their democratic mandate, were now the ultimate authority on the public health function and its resources.

The decision to build the new network as an extension of pre-existing networks gave a sense of familiarity and continuity but in fact there were significant changes in statutory duties. The previous HWP had been a network where the shared focus of members had been public health as a science focused on disease prevention and health promotion. The merger of the HWP with the HSCCB to form the new HWB with an extended remit, had changed the network, and therefore the social relationships for sensemaking.

The transfer of public health was a major structural field change with a redrawing of the boundary between the NHS and LAs. Public health services would now be prioritised, or not, in a LA context not a NHS one. This was a significant change to the GP role in inter-agency commissioning, as in the past GPs had relied heavily on public health colleagues to lead the health side in interagency relationships. What would be the impact of shifting public health outside of the NHS Family? How would GPs respond in this new and unfamiliar context? How would councillors enact the new health duties that they had, especially in terms of prioritisation and resource allocation? These were areas of ambiguity which triggered sensemaking. I focused my observations to gain insight into these questions.

7.3 Sensemaking in the Health and Wellbeing Board

7.3.1 Board members: differences and tensions

The rule-change requiring the transfer of public health functions from PCTs to CCGs affected some people more directly than others. The GPs and others that remained in CCGs had sat on the side-lines whilst public health colleagues struggled emotionally with the fact that they were to be moved to the LA. When any business changes owner, including when a public function is transferred between organisations, employees are protected under the Transfer of Undertakings (Protection of Employment) regulations which have the acronym TUPE. Because public sector staff are often moved under these arrangements, the acronym TUPE has been used as the basis of a new coinage. To be “tupe-ed” has become a colloquialism to describe when staff are to be moved from one organisation to another. Following the announcement of the changes the two most senior public health medical leaders left. The long serving highly respected Director of Public Health (DPH) left the public health speciality altogether and took up a medical management position in another organisation. The subsequent acting DPH took time off with poor health before retiring. Both of these doctors had parallel roles as GPs. James, the senior public health manager responsible for the transition also left after securing a job in another part of the country. Others stayed, possibly because they had no alternative, and began to work on interpreting and implementing the new rules. It was one thing moving desks and changing pay rolls; shifting emotionally based identities is quite another matter (Duncan and Barrett, 2007). The uncertainty and ambiguity associated with new rules triggered sensemaking more widely than the directly affected public health staff. Councillors and officers of the LA felt unsure what the acquisition of public health duties meant for them. Those who remained in the CCG were left to commission without familiar corridor-conversations to access the advice and skills of public health specialists. GPs were especially affected as they were left as

the only medical input into commissioning still working within the NHS.

The GP members of the HWB were Dr Poona from the Gurus; Dr Whitbread from NW, and Dr Strong from PC. Cat was also a member. Dr Strong held the executive lead for interagency matters, and tended to be the spokesman for the GPs at meetings. Dr Poona attended but rarely contributed, and often seemed disengaged – on one occasion he was observed to sleep through most of the meeting. Dr Whitbread would act as the figurehead for the CCG when required, presenting plans and strategies, but other than this tended to leave active contributions to Dr Strong.

The people who remained to form the new CCG and the transferring public health staff coped with this disruption by agreeing a formal “memorandum of understanding” (*HWB doc 3*) setting out arrangements for the continued technical public health advice to support GPs in their commissioning role. I first met Lizzie Gordon, a public health consultant who became my key contact, as she sat in a CCG open plan office that she and other public health staff had until recently occupied. She was drafting this memorandum surrounded by disconnected phones and computers and the things that had been left behind: personal notes; pictures on notice boards; and a battered Christmas chocolate tin labelled “tea money”. Lizzie, a nurse by background, was in a state of preoccupation with her move and felt that the future of public health in a LA was uncertain. There was a shared feeling in the public health team of being lost and adrift. The early days of the Board and its business reflected this preoccupation; an early analysis of papers showed that with the exception of one issue, priority families, the work of the board was concerned with its own establishment or with routine reporting (*HWB doc 4*).

It was shortly after the public health team had moved to Bevin House that I began to observe the HWB meetings. Following the departure of the DPH and his deputy, a temporary appointment had

been made, but when I arrived this too had finished. Eventually a new DPH was appointed. Dr Klein was well known to the people of Castlefield. He was already the DPH for the surrounding suburban and rural shire county and now he was to incorporate the city into his remit. I had known him since the late 1980s when he had been a public health trainee in Castlefield. He had lived through the development of GP commissioning since fundholding days. He understood the legacies and sensemaking styles of the key GP leaders in the area. His arrival appeared to have a settling effect in the network, being welcomed, by some at least, as a sensegiver. In Lizzie's words:

".....it was a turning point because it was substantive or it, it wasn't but it felt more permanent than anything that had happened before, we'd had somebody in on contract for one to two days a week for three months before that and she only stayed for three months until Dr Klein took up the post and it was, what it did it was just somebody's got an arm on the rudder and could steer the ship and it was just that sense of having somebody that was there and engaged and steering the ship." (GordonInterview)

After Dr Klein's arrival, there was an observable change in the shape of discussions as initial inertia gave way to puzzlement, and attempts to puzzle solve. Whilst Dr Klein was accepted as a sensegiver by the "health" people, this was not the case for other HWB members, as increasingly became apparent. Actors grappled with ambiguities arising from the complexity of interagency working. Members were representatives from a diverse set of organisations. This impacted on sensemaking especially when actors identified different cues in relation to a topic under discussion. Often a councillor would use examples from his or her own experiences to illustrate the failures of interagency coordination. The nature of the resulting fragmentation would be discussed. A plea to connect things would be made, often by the same councillor. For a while people would wrestle with how to make connections, before being beaten by the complexity.

In the extended extract below from an early HWB development session (*HWB fieldnote 2*), a councillor shows frustration at the inadequacies of approaches to address problems associated with harmful drinking.

Cllr Blunt animatedly posed a fundamental question: "How do you sort it? All my life alcohol has been around. How do you quantify it? How do you analyse it?"

"There are a lot of older people drinking at home – the saga louts" said Dr Strong.

The two doctors, Dr Klein and Dr Strong then tried to give definite answers rather than discuss the problem. Dr Klein said something technical which I, and probably others, didn't understand. His expert tone was intended to close down Cllr Blunt's question. Following Dr Klein's cue, no one asked Cllr Blunt to elaborate, but she did anyway.

"We've got hardly any provision. I've listened to so many of these [professional and managerial discussions], I've listened to them for years.....I went to a meeting.....they all stood up.....twelve groups. We've got all these groups doing the same things. There's no joined up writing."

Dr Klein answered: "This is what we're here to do today"

PC Warner, the enthusiastic policeman, interspersed to talk about an initiative called e-viper. "We need to get every plan. It's something I see as a priority across all organisations." He explained that the police were trying to restrict dangerous drinking through licensing, currently targeted at the city centre only. "We've shifted our tactics, to early evening, it's no point talking to someone at 2 in the morning, you just arrest them."

Dr Strong shifted the conversation back to one that used health service language. "We are absolutely right to speak about the wider determinants. Health interventions should also be there."

Cllr Blunt spoke up again: "I don't want to sound defeatist – how do we change people's lives so they don't need to be addicted to something. I live on an estate. A middle class lady stood on a podium and said the answer is education. These 14 year olds are Chemists! Are you going to give him a job? The old lady is lonely and gets the sherry out."

Cllr Blunt spoke from personal experience. She described repeated failures of professionals to solve a problem. From her perspective people drank because of a lack of opportunity to work and to belong. PC Warner had a different point of view; from the sensemaking perspective of a policeman the problem was street drinking and social disorder. Dr Strong, the GP, was concerned about individual patients. He saw the effect of alcohol on elderly people. Dr Klein and Dr Strong together attempted to come over as experts, and to give others the impression that the doctors had things under control. There were tensions between these approaches to sensemaking. For instance, there was a tension between the desire for an open discussion about the social problems for which Cllr Blunt was asking, and the authoritative closure by the doctors who, for good reasons, were used to giving reassurance and appearing certain that they knew what was best to do. Patients, after all, like to feel their doctors are experts in their craft; presenting with confidence is part of what doctors' feel is expected of them.

Differences in perspectives leading to ambiguity as a trigger for sensemaking were also evident in this next example (*HWB fieldnote 7*). This was a discussion about unequal life expectancies across Castlefield. A graphic was presented that visually represented Castlefield in the form of a bus map. It showed that those who lived in one affluent leafy suburb could expect to live to 77 years, whereas up the road, in a deprived area, the average life expectancy was 69. Overall Castlefield's average life expectancy was approximately five years less than the national average. Dr Klein attributed the cause of this to smoking rates. Dr Piaget, a psychiatrist, made the point that high levels of smoking amongst people with mental health problems meant that they were dying earlier than others. Cllr Blackstone asked "was something deeper going on with respect to poverty?" Cllr Lennon picked up this thread "Poverty is the main cause, so why don't we do something about poverty... a lot of male hostel accommodation". Anita, the Chief

Officer of Castlecare tried to think of another angle. "Are there research gaps?" she asked. At this point Dr Klein and Dr Strong returned to the issue of smoking and smoking cessation. Cllr Blackstone resisted, asking why the discussion had shifted back to health interventions.

"If we are a true partnership, then surely we need to do something that's wider than health.....All the interventions are health."

Dr Klein attempted to identify and address life style issues. This was being challenged by his new masters, the councillors, and also by the psychiatrist. Dr Piaget and Cllr Lennon saw their role as one of advocacy and representation. The people dying younger than others were poor, and also possibly mentally ill and vulnerable. They wanted to prioritise root causes. Others cast around for other explanations. Cllr Blackstone challenged the dominance of public health in the context of a network that brought together a wider range of perspectives. As a group they were trying to identify a plausible sensible reality, but this remained intangible; there was no mechanism by which to reconcile or align the ambiguities that arose from the different perspectives of the members.

The issue of smoking became the focus of differences on other occasions. At a later meeting (*HWB fieldnote 6*) Dr Klein gave a presentation on his DPH duty to reduce smoking rates. His overriding message was 'smoking is a bad thing'. He began with data from a 2011 government survey that showed a high level of public support for clamping down further on tobacco use. He talked about the economic costs of smoking, including time off work, and enforcement of the laws on illicit tobacco. Dr Piaget clearly felt uncomfortable with this single message approach, and she put up her hand to point out that forty percent of tobacco is smoked by people who were mentally ill. She didn't say it in so many words, but the implication of her contribution was that kindness and tolerance were required, and that she did not see much of that in the purist public health approach to the problem. This change in tone gave Cllr Lennon the trigger to express his view.

Cllr Lennon: "People in [my ward] think they keep their weight down by smoking"

Dr Klein: "The gains outweigh this one bad effect"

Cllr Lennon: "yes, but that's what they think"

Dr Klein "Some companies don't appoint smokers, we [Castlefield LA] could think about this"

The rules were unambiguous as far as Dr Klein was concerned. Smoking rates should be reduced. However to agree a strategy to achieve this would require members of the HWB to find a way to either align their currently opposed positions, or to make one dominant over others. There was the psychiatrist's view that being too draconian would affect mental wellbeing. The councillors believed they should represent the views of their constituents, including their opinions about smoking. It would certainly not be a quick win to agree that the Castlefield Council would stop employing smokers. Cllr Lennon himself was severely over-weight, and would usually remain silent, or talk in loud asides when life style issues such as obesity, alcohol, and smoking were discussed.

The social basis for sensemaking was not in place. Perspectives were different and were likely to continue to be different. If, as argued in Chapters six and seven, the NHS Family network had a shared prosocial sensemaking type, then in the HWB network this was only one type amongst several. The next section explores attempts to shed light on the nature of these differences when attempts are made to create the conditions for sensemaking to enable enactment.

7.3.2 Attempts to align sensemaking

There were OD interventions to respond to the differences in sensemaking types in the HWB network as it implemented the rules from the HSCA 2012. The first was an external "peer challenge" (Local Government Association, 2014). The second was a series of in-house development sessions. Both of these interventions were designed to allow members an opportunity to voice their individual

perspectives, which would serve to differentiate their approaches to sensemaking in the context of this statutory partnership network. Both were designed to bring to the surface underlying tensions, and to reinforce the rules.

The Local Government Association (LGA), on its website, is described as “the national voice” of LAs (2014). Its role is to represent rather than govern LAs which are independent. A national programme of support was put in place to implement the HSCA 2012, and as part of this the LGA organised optional “peer challenge” reviews, for which Castlefield LA volunteered. Even though the review was entered into voluntarily, it was organised and enacted with the same formality as an external audit or inspection visit, operating as a reinforcement mechanism for rule compliance. This type of outside intervention customarily accompanies public sector reforms and, however gently it is done, participants are aware that they are being assessed with regard to rule compliance. The intervention was designed to identify and address underlying resistance within the network. A team of peer reviewers, made up of a DPH, a LA director, and two LGA officials, visited Castlefield for two days and conducted a series of interviews with HWB “stakeholders”. The process was to be hosted and led by the Public Health team who were now in the employment of the LA.

The opening of the peer challenge took place in Bevin House, at nine o’clock on a grey Tuesday morning (*HWB fieldnote 3*). I arrived in reception at the same time as the Peer Review Team and we were shown upstairs together. The Team was taken into an office that was to be its base for the next two days. I was shown into the meeting room, which was little bigger than the twenty seated table that it housed. One side of the room was a huge window that looked out over the City-scape which somehow added context to the business that was enacted in there. People began to arrive. Cllr Lennon arrived first and we had a chat, I wrote in my notes:

I found myself waiting with Cllr Lennon. He told me he’d been poorly. He’d gone to the hospital at the weekend with chest pain.

The GP hadn't been informed. He'd been given a spray for angina, and told that nothing was really wrong. He thinks it might be his oesophagus. Cllr Lennon is a big man. I've known him years. He is a nice, gentle, straight talking person. He has always been big, and as a result absents himself from many social activities; he understands how isolation feels, and doesn't think being told what to do by doctors is helpful.

No one from the NHS had been invited to this opening meeting. James, the public health manager with responsibility for organising the "transition", opened the review with a presentation. One of the slides was a complicated diagram that attempted to illustrate the new system. The room we were in was what could be described as cosy which had the effect of magnifying the nonverbal behaviour. Cllr Lennon made his feelings clear using his face and his silence to let others know he felt a mixture of disgruntlement and cynicism. I did not know it at the time, but he intended to use this review process to express some strongly held views regarding the tension between the doctors and councillors. People from Castlefield were invited to describe any issues of which they were aware. When pressed, Cllr Lennon said ominously:

"There's something I want to talk to you about this afternoon."

Eventually the Chair drew the meeting to a close, at which point Cllr Lennon spoke one sentence with great feeling:

"Rather than a clinical solution, get a social one. Most of the problems are to do with loneliness."

The doctors might be present themselves as expert scientists, but, in the view of Cllr Lennon, the medical model did not necessarily make for happier people.

After this initial meeting the review process started. There was to be a series of interviews with groups over the rest of the day and the following morning. A meeting of the HWB was scheduled for the following afternoon, after which the team would present their advice. I observed the interviews with "key partners", and with "LA Members". These were interviews in confidence, and people were

asked to speak honestly .The interview with the councillors took place in a small windowless meeting room (*HWB fieldnote 4*). Cllrs Blackstone and Lennon described the NHS as protected from the harsh realities of austerity, with professionals that did not listen to or understand real people in the way that democratically elected councillors did.

Cllr Blackstone: "The danger with partnerships is you just spend a lot of time with the same people, just on different agendas.....health and the council are not the same.....health stands far away from politics on the side-lines waving..... [Integration] will be a bumpy ride.....We need to listen to the experts.....they need to listen to our ability to represent the constituency."

Cllr Lennon: "When people go to the doctor, doctors take a clinical view, "me arms 'urting." It may not be the best response to give them drugs..... I tend to look at the community good rather than the individual good. People come to us as individuals not communities. We then go to communities. There is no connection between the two."

The councillors were grappling with ambiguities associated with differences in political structures and funding regimes; between expert and representative functions. They were also balancing individual versus community perspectives, and medical versus social interventions. At one point during the interview Cllr Lennon remarked.

"That might be me just because I'm thick; the big issues are loneliness and poverty."

The review could never solve these conundrums, but it did serve to declare them, they would form part of the "feedback". In the "key partners" interview (*HWB fieldnote 5*) the view that the agenda was dominated by health was also expressed by a director of housing

Reviewer: "Does the Board really understand the role housing can play?"

Housing director: "Looking at the broader impact regarding welfare reform..... impact of indebtedness..... Castlefield on-call service, tele-care, alarms, tele-health, tenant sustainment services. There is

an underestimation of the role housing has. The Board is quite health professional focused.”

The peer challenge visit ended by feedback being given to HWB members following one of their meetings (*HWB fieldnote 6*). The issues that I had heard raised during the interviews formed the main substance of the feedback. The reviewers told HWB members to:

“Balance clinical evidence with the democratic mandate.”

This point was given emphasis. The review team advised that evidence should only be a starting point, there were other perspectives and elected members “understood the context very deeply”. This was a clear enhancement of legitimacy for the councillors’ democratic sensemaking type, and as a corollary a reduction in influence of the doctors’ expert approach.

The second OD intervention was a series of in-house development sessions. Following the peer challenge review, I was asked to facilitate two of these sessions to help members reach a better understanding of each other. Each of these sessions lasted for an afternoon.

Earlier in this chapter I analysed an extract of dialogue about a report on life expectancy where differences in sensemaking had been apparent. At the first development session (*HWB fieldnote 8*), I presented the Board members the same extract on a PowerPoint slide. The attendees appeared to become intensely thoughtful. When they began to talk, there was animated agreement regarding the fact that they had different “agendas”, in other words they recognised their differences in sensemaking type. They also recognised that they had no techniques to integrate these differences. They seemed to be relieved that this difficulty had been captured. Guards dropped and they decided to focus the next session on exploring their different points of view together, and the ambiguities that arose as a result. I entitled the second session (*HWB fieldnote 9*) “Understanding each Other”, and developed a

programme which allowed actors to describe their histories, feelings, and perceptions of the purpose of their current organisations. I divided people into groups based on the likelihood of them having similar perspectives and shared networks. Groups were: public health staff; LA councillors; representatives of service providers (including social care); GPs; Healthwatch; and commissioning managers. Each group was asked to develop a PowerPoint slide which described recent changes, their legacy, their feelings, and their perception of the *raison d'être* of their current organisation. By organising the distribution of the actors in this way, I drew differences to the attention of the group as a whole.

The GPs described their past in terms of changes to the infrastructure of the Health Service going back to the 1974 reorganisations, and the development of Family Practitioner Committees. Cycles of change were understood in terms of decades, rather than on the basis of the latest policy shift. They described the latest changes by developing a diagram that not only drew current structures, but anticipated future reorganisations such as the shift of further health responsibilities to LAs. For the GPs, their profession was affected by a process of continuous evolution. They expected current arrangements to change again. When asked to describe their emotions, they described feeling “neutral and resigned”, whilst expressing a worry for the future of the NHS.

Only one councillor was present, Cllr Peace was the new Chair of the HWB. He described feeling like an anchor point with a personal responsibility for success of the Board. He described himself as “fixed civic point”; there to give the HWB a “democratic mandate”. He recognised that established networks had been disrupted, and the new structures required nurturing. He also warned that nothing in the LA was sacred, given the unavoidable budget reductions that were required. He described the frustration fellow councillors felt with the health system. Councillors based their perceptions of health care on stories and experiences that they heard from the electorate. Some felt that medical power should be curtailed. He described

feeling a degree of personal compromise, saying “We come into public office to change things; but we have to deliver a balanced budget”.

Provider managers described their situation and feelings in terms of the gap between rhetoric and reality. Whilst the language described better provision, and more person centred care, in fact eligibility criteria were being tightened in order to save money and reduce staff which they described as “rationing”. The concept of early intervention was espoused in rhetoric, but in practice immediate or urgent requirements took priority. A further issue for providers was that contracting and competition rules had shifted their focus to tendering and reputation management. Income streams could not be taken for granted.

Commissioning managers were present from both the CCG and the LA. They separately described their situation and feelings, across a set of common points. The managers did not express their personal feelings. The LA manager described a legacy of stability in terms of political control by labour, the geographical boundary, and the organisational structure. The changes had been to the finances, with a massive reduction in budgets, and ring-fencing of grants being removed. There was also an increase in the level of demand. In the CCG boundaries had remained stable, and this in turn had limited the changes to staffing. Catrina, and other CCG colleagues had wanted to retain a strong focus on inequalities and public health, and clearly felt a sense of loss. A nervousness was expressed regarding the implications of national proposals to transfer further health monies to the LA budget regime. Catrina implied, but did not say directly, that she worried that health monies would disappear in the LA’s budget which was under severe pressure as a consequence of national austerity policies.

Public health professionals described a change in the nature of their role in health commissioning. Whereas previously they had directly commissioned health care, they were now part of a wider function.

They described the old health system as “fractured”. Their focus had shifted from epidemiology to the integration of health and local authority priorities. They emphasised the cultural differences that existed between them and the LA, but didn’t detail what these were. They described feelings of being “overwhelmed, frustrated and vulnerable”. Public health was an unknown quantity in the LA. Would their skills be recognised or valued? There was a fear that the portfolio of services that had been developed over years would be lost in LA budget cuts. Despite these fears, a feeling of optimism based on an increased scope of influence was described.

The Healthwatch representative was upbeat. His was a new organisation. He commented that partnerships were embraced in theory, but in reality players retained their individual organisational perspective. He expressed scepticism about whether budget sharing would ever really happen.

The overall picture was one of multiple perspectives meaning that the social basis for sensemaking including enactment was difficult to achieve. It was likely that perspectives would continue to be different, since each member had his or her own organisational legacy and priorities. The rules relating to the new HWB network were not bound to affect all member organisations beneficially, this was a time of post-recession austerity, and new competitive markets were being introduced. There was a tension between the medical sensemaking and its cue extraction based on a reliance on science, evidence, and expertise, and that of elected members who took their cues from the democratic process and the understanding that their legitimacy depended on the reflection of constituents’ ongoing concerns and values. A shift in the balance influence between sensemaking types away from doctors towards councillors was given further momentum by the LGA peer challenge team.

If the balance of influence was shifting in this network then how would this affect business? One way to explore this is to consider how the network made decisions about what its priorities would be,

and why it chose to prioritise certain aspects of shared interest. This is the focus of the next section.

7.3.3 Setting priorities and making decisions

Castlefield HWB was an inclusive network, and as a consequence its span of potential areas of work was broad and complex. Each member of the HWB was there to represent the priorities and interests of his or her organisation with its own substructures. One purpose of the HWB was to be a point of intersection; a place where relative organisational responsibilities and interests could be integrated and balanced, and work programmes initiated and monitored. In order to have a manageable work plan four priority areas were agreed. According to reports and minutes from before my fieldwork began, HWB members had agreed a list of criteria by brainstorming at a development session. The criteria were broad, allowing plenty of scope for interpretation. Priority areas must consist of interventions to improve quality of life, reduce inequalities, involve more than one partner agency, to potentially reduce costs, and to be aligned with targets.

There were four agreed priority areas. The first was *Troubled Families*. Castlefield had around 2,000 families that were receiving support from multiple agencies, and was a pilot site for the national Troubled Families Programme (Department for Communities and Local Government, 2012). To qualify, a family would need to meet certain criteria including school absenteeism, inter-generational unemployment, mental health diagnoses, and repeat offending. When targeted families achieved bespoke goals agreed in a multi-worker interagency plan then the LA would receive incentive payments. There was a strong impetus from the police to prioritise this area. Before my arrival, the Chief Superintendent had made a special presentation to the HWB to request that the work be adopted as a priority. There was already an active network in existence with responsibility to undertake this work. This programme chimed with HWB members' shared moral purpose of

addressing inner-city problems such deprivation and crime. Rules, networks, and sensemaking on this matter were complementary and aligned. The second priority area was *mental health*. The HWB adopted two aspects from the national strategy 'No Health without Mental Health' (Department of Health Centre for Mental Health 2012). One related to early intervention in the lives of those considered likely to develop conduct disorders, and one related to the improvement of employment opportunities for people with mental health issues. For both areas objectives were set, but they were aspirational due to the length of time between intervention and impact. There was general agreement on the importance of the goals, but there was no sub network charged with their delivery and no measurable actions. The objectives were not monitored, and the priority area seemed to be largely overlooked. *Harmful drinking* was the third priority. The misuse of alcohol had the widest cross partner relevance of all the priority areas. There were underlying differences of view about how this should be addressed. Health professionals had a treatment and prevention focus. Councillors and the police were responding to the public's concern about street drinking. Nonetheless, it had been possible to share agreement on a reduction target. A pre-existing network, the Crime and Drugs Partnership, was already working to a plan. Although there was no specific national rule, local objectives, networks, and sensemaking were aligned and as a consequence progress was being made. The final priority area was *integrated care* for the frail elderly. Prior to my arrival, and inherited by the HWB, the ICP had been initiated by the HSCCB in July 2012. A programme team had been put in place, so a sub network was already in existence. I joined this sub network as a participant observer during the middle phase of the study. There was no stated national rule requiring the integration of services. Nonetheless, a strong assertion from academia and NHS England regarding its desirability meant there was an expectation that integrated care would be developed across England. Whilst there was agreement on the non-specific desire to "integrate" there

was not a shared view about how this should be achieved across general practice, community health services, social care services, the hospitals, and to a lesser extent the housing and voluntary sector providers. Disagreements within the ICP, reflected the tensions between sensemaking types at the HWB. An important role of the project manager programme manager was to broker disagreements by acting as a boundary-spanner (Bartunek et al., 2006, Sullivan and Skelcher, 2002) as well as a sensegiver. The ICP is considered in more depth later in this chapter, since it gives insight into GP sensemaking in relation to interagency planning and operational delivery of services.

Looking across the four priorities, differences in the pattern of dynamics between rules, networks, and sensemaking can be extrapolated. These affected the way that business was conducted. In the case of priority families where all three forces were aligned, then work progressed well and achievements were easily won. In integrated care, networks existed, rules were in place, but there were sensemaking differences. In this case then a socially skilled boundary spanner brokered alignment at various stages in order for progress to continue to be made. In the case of mental health there was agreement that pursuit of this area was desirable but there was neither a network nor a set of rules; as a consequence this priority did not appear to be actively progressing. In the case of the alcohol strategy there was a pre-existing network and shared commitment; despite the fact that there were no specific external rules, progress continued to be made.

Choosing priorities is a process of selection. In all of the examples above this choice was influenced by what the partners thought about it. The evidence suggests that significant commitment from a number of members of the network was a prerequisite. In three of the four priority areas a sub network already existed. In the area (mental health) where a network did not exist, even though the area was prioritised, progress towards the goals was not in evidence. An explicit set of external rules existed in the area of Priority Families,

but for the other areas rules were locally determined. Progress was made on those priorities without associated external rules. It would appear that, for an area to be chosen as a priority, commitment needs to exist but beyond being chosen its progress will depend on the existence of an effective network, especially if no external rules are in existence. For business to progress, it seemed essential that a network is in place, and that there was an aligned social basis for sensemaking or a process to broker alignment. Formal rules were not essential, but some form of directive, even if locally devised, also appeared to be necessary.

If prioritisation is a selection process with a pre-requisite of commitment, then those areas that are not selected give an insight into relative levels of influence. Dr Klein attended the CCG GB (*GB fieldnote 5*). Back on NHS territory, he shared his opinion of the priority areas that the HWB had adopted. If he had been in post at the time they were set he would have pushed for the focus to be on smoking and obesity. He explained that problem drinking was selected to meet the agenda of the “politicians”. He explained that priority families were included because “the police have asked for this to be in”. The councillors had reasons to be seen to address concerns of the communities and voting public; they depended on being re-elected. It would seem that in Dr Klein’s opinion the political considerations had trumped public health concerns.

HWB priority setting was only part of the picture. The public health grant, NHS monies that had transferred to the LA, by the second year (2013-14) was worth 27 million pounds. Initially the public health function had been protected by the “lift and shift” principle. However Castlefield Council faced a budget reduction of 55 million pounds over two years, and was making cuts to balance the books. At the second development session (*HWB fieldnote 9*) one of the councillors provoked my curiosity. During the session, I had been touched by his sensitivity to the public health team and had made a point of telling him that his kindness was having an important soothing effect. He replied by saying “I hope they still think that

tomorrow when I tell them what is happening to their budgets” (*HWB fieldnote 9*). An exploration of the LA’s website eventually yielded the Council-wide proposals to achieve budget reductions. Public health was identified as a “Big Ticket Item” meaning that its “transformation” would make a significant contribution to the overall spending plans of the Council:

The responsibility for public health transferred to Local Authorities as part of the health and social care reforms initiated in April 2013. Government considered that councils have greater responsibility and power to shape the locality in a healthy direction, and public health would have the ability to shape services to meet local need, and better influence wider social determinants of health and tackle health inequalities. For Castlefield, a grant of £27m was provided to deliver this function, including commissioning a range of public health services to be used to meet the specific needs of citizens. Achieving greater efficiency and cost effectiveness across services will enable investment into the wider social determinants and public health responsibilities of the council. (HWB doc 5)

The detail of the plan included an intention to redirect spending of the public health grant by more than a third over a three year period. The Councillors and officers who made up the Executive Board of the Castlefield LA decided to shift the balance from health promotion and prevention activity to services that were traditionally provided by LAs such as parks and sports facilities, services that were otherwise in danger of being lost as a consequence of budget reductions associated with the Coalition Government’s programme of austerity. This plan was never brought to the HWB; instead it was agreed by the LA in its own Executive Board. This was part of a national pattern which received media coverage.

The difference in sensemaking type between LA councillors and doctors helps to understand how and why this happened in the way it did. Councillors now had ultimate control of public health and the HWB, and their sensemaking type with its orientation towards the democratic system was proving to be dominant in this context.

7.4 GPs and the interagency environment

7.4.1 The role of the GP in the Health and Wellbeing Board

The most striking observation of GPs at the HWB was that, compared to what I had seen in the CCG environment, they were distinctly quiet, deferring to public health colleagues to lead and shape the content of discussions. As already noted, Dr Strong, the lead GP for interagency matters, contributed most in HWB discussions, but even his contributions usually served to echo and reinforce those of Dr Klein, rather than provide a distinct GP perspective. Dr Whitbread's contributions tended to be confined to instances where a CCG figurehead was needed for the purposes of committee etiquette, for example the presentation of a CCG strategy document. Dr Poona tended not to contribute. The data in the previous two chapters, in contrast, showed the GPs as active leaders within CCG and wider-NHS networks. So why was their contribution in the HWB minimised, and sometimes absent?

In an interview with Dr Strong, I explored how he saw his role in relation to the LA. The following truncated extract from an interview (*StrongInterview*) includes his views:

Adele: "Can I ask around inter-agency working, more generally, and the Health and Wellbeing Board.....what's it like to be the lead GP with the Local Authority?"

Dr Strong: "I've really found it interesting.....my first introduction ever to the Local Authority was [c.2000]..... knew absolutely nothing about Castlefield Council, didn't even know where they were or what they did.....nothing.....nothing at all, so that was the beginning of my learning curve, which is still continuing. I still don't fully understand how they work, but it's been a really interesting dimension, I've been talking about influencing things at scale, I've done that at national level, but working within the local is different, very."

He continued to describe the impact of the *Better Care Fund*⁴ on LA officers and members, who for the first time were experiencing typical centralised management of NHS national initiatives with “templates that must be filled in and dictated timescales and exact prescriptive instructions about what you’ve got to do”. He described how this “shocked” councillors because “effectively they’ve done what they liked for years, never had to do this...” He also commented on the effect that the transfer of public health had on the CCG’s ability to perform its commissioning duties

Adele: “Do you want to comment at all on the implications of a public health transfer to the Local Authority, does that impact ...”

Dr Strong (interjecting): “**Disaster** [emphatic]. You can’t underestimate the value of public health and all, and some people just think of them as the drains doctors and people who chase us up about our vacs and imms, you actually need to have worked in a health commissioning environment to understand how important it is to have that technical expertise and what your needs are. What sort of service, you should be planning, the evidence base around what you’re trying to do rather than simply anecdotal evidence from practising and have that balance is crucial, and whilst we do theoretically have access to public health still, within this organisation, it has effectively vanished and commissioning is going to be much more poorer for that, in my view.”

This revealed an anxiety about the feasibility of CCG commissioning in the future. GPs were clinical practitioners and could advise based on clinical experience, but not on the basis of epidemiology that was at the core of the public health speciality. In the “Understanding each other development session” Dr Strong had expressed an opinion that further health functions would move to the LA, and later in the interview he commented that in his opinion primary care services should be “nationalised” and the independent contractor business model abandoned. Putting this together, the implication of

⁴ This was an arrangement to transfer funds from the NHS to the LA. It was a new name for an arrangement that had previously been known as the Integration Transformation Fund.

Dr Strong's analysis was that this shift of public health to the LA signalled the end of an era, if not the end altogether, for GP commissioning. This was coupled with an anxiety regarding the process of healthcare prioritisation and spending in a LA context. He commented on the re-allocation of the public health grant to traditional LA areas, like parks and gardens:

".....and we have determined that this year these are our priorities within the public health, it's going to be different to last year's priorities, but that's not taking the money out, is what they'll say to you."

In his view, regardless of the reasons people gave, the unavoidable reality was that there had been a net reduction in the budget available to spend on health priorities. It is likely that this insecurity about the direction for the NHS and GP commissioning was part of the reason that the doctors were relatively quiet at the HWB.

Clinical practice, and the CCG, for GPs were separate from civic planning and LA business. These were unfamiliar networks, without access to the important embedded shared sensemaking legacies of the NHS Family, and the medical profession. Doctors did not have a feeling of belonging in this environment. The GPs were not the only quiet people at the HWB table. In fact, there were only two consistently prominent voices – public health and the councillors. Even though GPs were now the medical representatives from the NHS side, they continued to abdicate commissioning medical-lead responsibility to public health doctors continuing the historically-derived distribution of responsibilities established when all the doctors worked in the NHS. One way of understanding this is that the integrated nature of the medical network is so embedded that organisational boundaries are not relevant.

Another possible explanation for the relative absence of the GP voice is that they were simply showing a graceful sensitivity to the position of their "tupe-ed" public health colleagues. The doctors at the HWB have known each other for many years and are friends as well as colleagues. Two senior public health leaders had, after all,

left in less than happy circumstances. The move to the NHS had disrupted very long-term working relationships, the longest of which was the GPs' professionally based network with public health physicians. There had been distinct emotional responses to this change. Public health specialists were attempting to transpose epidemiologically evidence-based sensemaking into the LA environment with its democratically-based sensemaking type. It could be that Dr Strong, Dr Poona, and Dr Whitbread, were standing back in order to allow their friends and colleagues to establish their new position in the field's networks.

It could be that GPs felt vulnerable as service providers.. Public health services would now be prioritised, or not, in a LA context, including a number of GP provided contracts for screening and vaccinations and immunisations. It could be that GPs were conscious that not only were they commissioners, but also they were providers of services for which the LA was the paymaster.

Perhaps it was just that GPs didn't expect this partnership to last. At the "Understanding Each Other" (*fieldnote 9*) development session, the GPs had understood cycles of change in terms of decades, rather than the last policy directive. They had described a still shifting health landscape. More than any other group, the GPs described the recent rule changes as just one more in a process of continuous evolution of their profession, and were not expecting the current arrangements to be enduring. Their description of their feelings as "neutral and resigned" was perhaps a way of expressing that they would side step the political world, whilst continuing to develop clinical services.

New rules had created a change in role for GPs, and a shift in organisational boundaries had disrupted a key commissioning network putting some actors outside the NHS Family. There was also a need to incorporate the implication of a change in the degree of influence for the democratic sensemaking style. There were significant ambiguities and uncertainties associated with this

complex set of changes. GPs appeared to leave active sensemaking to the councillors and public health staff, becoming apparently passive as a consequence.

Having noted the passive role of the GP in the strategic interagency environment of the HWB, in the following section I consider the position of GPs in the more operationally focused ICP, where by contrast they took a more active part.

7.4.2 GPs and the Integrated Care Partnership

This next section is a discussion of disparate sensemaking approaches within the ICP, with a particular focus on the GPs within the network. As already outlined earlier, integrated care was one of the four priorities agreed by Castlefield HWB. All partners had agreed that the pattern of Castlefield's older people's services was complicated, fragmented, and led to confusion and inappropriate use of services including avoidable hospital admissions. The interagency ICP had been initiated by the HSCCB in July 2012, and subsequently adopted by the HWB. A well-established interagency network was in place including GPs, Castlecare clinical managers, and social services managers, amongst others. It was coordinated by a CCG employed project manager. During the study, I was attached to this programme as a participant observer, assisting Sarah Tompkins, the ICP project manager, in areas where she needed help, usually by facilitating groups when inter-agency dynamics were proving to be difficult. She used me as a sounding board, and a source of emotional support.

The case to integrate care was accepted by all. Dr Conary (*ConaryInterview*), in an interview, used the example of a patient of hers to explain the reasons why integration across the network of services was important:

"..... I'll go and check the medicines and the next day somebody goes and checks her feet, another day somebody checks her bowels, another day somebody does something else and she has lots of people going in and none of us talk to each other and none

of us know what each other are doing and we say you ought to walk a bit more and the next one goes you ought to walk a bit less and you ought to eat a bit of this, oh no you ought to eat a bit of that and the poor patient in the middle of it all sees all these professionals coming together to try to help them but they kind of like say it's too much. I've got one in particular I can think of who her neighbour had to open the door for her every time and he said he had twelve different people come every day and he couldn't go out because he had to open the door for all these people to come into see her and she was just, you know nobody was pulling it together and I was trying to pull it together to say she needs these four things doing and everybody who goes in should ask her about these four things but there wasn't a system to be able to pull it together to do that they were all doing differently, she got over it in the end this illness she had but really it was longer than it could have been and she went into hospital once and she need not have done. So that's the integration that we're trying to work towards is trying to work together so there's not only lots of services out there that we could refer one patient to but we've also got all these people going into the one patient and not talking to each other."

In this extract she is describing her own perception of fragmentation seen through a patients' eyes. The King's Fund⁵ had published a fictitious case study used in Torbay to illustrate the effect of fragmented services on the life of "Mrs Smith", a vulnerable elderly person. The ICP, along with many other CCGs, had adopted this idea. An animated video had been produced in Castlefield called Elsie's Journey which told the story of a white, elderly lady, navigating the complexities of the health and social care system. The video was in two parts, first how things were now, and second, how it was hoped they would be when services were integrated. It was based on the real life experiences of Sarah's grandmother.

Project management is a widely used approach to the implementation of change in NHS organisations. It is a way of proactively managing a network, the members of which will have

⁵ The King's Fund is a high profile independent research focused charity whose publications are aimed at improving health and social care.

different perspectives. It is often used when a disparate network needs to be co-ordinated. Individuals are made accountable for the delivery of the programme overall, as well as sub tasks within it. The project management model requires the identification of senior sponsors who ensure the project maintains momentum. Castlefield's ICP had two project sponsors – Maggie Smith, the Director of Primary Care from the CCG, and Vicky Brown, a LA senior manager responsible for social care. These two shared the leadership of an interagency project board. Below this was a project team made up of people responsible for contributing to the overall delivery of the programme. The project team included people from different organisations represented at the HWB. Castlecure community services, General Practice, and the LA's social services duties were the three main elements of services to be integrated.

Sarah was an occupational therapist by background. She was a quietly spoken, logical person. These personal qualities along with her own professional background appeared to be the basis of her legitimacy. She gathered a supportive inner circle around her. She was prominently supported in her task by two lead managers from Castlecure, Simon (a social worker by profession who had moved into the NHS) and Jayne (a physiotherapist). These three together, formed the inner core of the project, and acted as sensegivers, never wavering from the challenge to keep things moving forward. Sarah's role depended on maintaining alignment as people made sense of the future distributed across multiple organisations. This depended on brokering agreements on a continuous basis. The alignment of this distributed group of sensemakers was a slippery thing which needed constant attention and repeated intervention to maintain.

When I arrived on the scene, the plan for integrated care was in place. Locality based operational teams were to be established called Care Provision Groups (CPGs). Each CPG would have co-located health and social care staff and would serve a number of general practices, grouped in localities. Each CPG would have its

own care co-ordinator, nurses, occupational therapists, physiotherapists, and social work input. The project team's job was to put these arrangements in place. The work was organised into subcategories called workstreams.

Dr Kerala, an executive GP from Chamber network, was the lead doctor in the project team. Other GP members were Dr Poona (the Gurus Chair) and Dr Milligan (a member of the PC GP network and a partner at Dr Strong's practice). Dr Kerala described how he conceptualised his own role in an interview (*KeralaInterview*):

"I think there are two roles which I have; one is there in a professional capacity as a GP, there are two roles I have, what is it as a GP, what do I think, and how am I helping a person navigate the system. Secondly, as the exec lead, which is trying to link various fragments of the system and if anything, clinically where there are duplications and to remove those duplications, because I hate a person being fobbed off from one part of the system to another and another, going around in circles. But sometimes, reminding people to put the patient back into the pathway, because quite often the pathway is very much convenient and we all look through our own views and mind-sets, so we design it based on our own experiences, and trying to bring a patient back into that, how would a patient navigate, can you describe, and I think that's what my role is."

In this extract he is describing a situation where his clinical experience as a GP is informing the commissioning task that he is undertaking. He is clearly aware of the interrelationship, going so far as to describe them as different roles. As was seen in the Chapter 6: *Sensemaking, networks and rules at Strategic Collaboration Level*, Executive GPs interpreted commissioning to mean the design of clinical services, pathways, and referral mechanisms within wider systems. In the context of the ICP the system was wider than healthcare, but the same systems based approach needed to be taken, and Dr Kerala understood his role to be about designing clinical processes, and to bring an understanding of the operational implications for GPs.

As a participant observer, I was asked to facilitate sessions for the “processes and protocols” workstream. Our aim was to produce a set of operational policies for use in the new multi-disciplinary teams. The meetings were attended by Dr Kerala, Dr Poona, and Dr Milligan, as well as Jayne, from Castlecure, and a LA social work manager. In contrast to the reserved approach of the GPs at the HWB, these doctors led discussions and were the main creators of the new operational system that was ultimately adopted. It would be based on an electronic “risk stratification” tool already in use in Castlefield practices. This was a locally designed interactive database that was shared between hospitals, community services, and GP practices. It included visual alerts to changes in the health or social circumstances of patients who were near to death, or had significant and/or complex needs. This was especially useful for patients who were unstable because those accessing the database could see a simple up or down arrow that would act as an alert if someone was deteriorating (↓) or improving (↑). All staff in the CPGs would have access to this database. Those patients that the system flagged would be reviewed in regular meetings. There were reservations and scepticism. The doctors had serious doubts about whether GPs would be able to attend multi-disciplinary meetings in practice, and the social work manager was certain that social work cover would be limited given extent of austerity measures. Nevertheless, everyone did remain committed. Dr Kerala agreed to pilot this approach in his practice. There were high hopes for the positive impact that the care co-ordinators would have, of which there would be eight. GPs would be formed into eight new networks called locality groups. Those practices that were close to a boundary would have a choice of locality, but by and large these would be imposed groupings, based on geographical location. Eight lists were drawn up, allocating practices to groups. Evening meetings were held in order for GPs to ask questions.

At the same time as the ICP was dividing practices into geographical groups, there was a swell of national interest in the idea of GP

“federations”. The idea was that networks of practices would share functions in order to be of an appropriate scale for 21st century medicine. I discussed this with Jim Wood from the LMC in an interview (*WoodInterview*):

The difference, the real challenge is what is entirely new is the idea of GP practices working in groups

Whilst GP practices had been organised into groups for various bureaucratic reasons in the past, this had not involved any real pooling of resources or patients. Changes in medical practice, and initiatives such as integrated care, were now driving the need for GPs to develop new inter-practice networks which were given the name “federations”, although there was no exact blueprint as to what this meant. The new leader of the General Medical Council⁶ was leading the profession towards an acceptance of forming federations in response to the changing environment of medicine. Again, in Jim’s words:

“.....he’s an influencer, he’s far sighted, he’s been involved with the college, he’s been involved with the NHS alliance and organisations like that so he’s got a lot of broad interests..... he’s brought a change of attitude and he’s brought in an attitude which is that you know whether we like it or not general practice is going to change.....and they do buy into this concept of federation.”

Sensegivers within the profession were future-orientated, suggesting that the model of general practice would need to change and a vehicle for this was the development of federations. Jim described this as follows:

“So having analysed that the Government appears to favour the idea of practices working at collaborations as being you know, I mean that’s making a virtue of necessity. And I think within the profession itself, ourselves included we also believe that that’s the

⁶ The General Medical Council is the body with responsibility for setting standards of performance and conduct for doctors, and for maintaining the register of doctors deemed fit to practice. Its statutory duties are enshrined in the 1983 Medical Act.

way forward. Even if things weren't in crisis we would say it seems intuitively to be the way forward because the traditional model of General Practice as the kind of corner shop small practice model and particularly the single-handed practice model is past its sell by, there's no question.....So change is inevitable."

Whilst there was emerging consensus that GPs would by necessity form new interdependent networks, what was not clear is what form these networks would take. If a new more networked model of general practice was an inevitable and seemingly desirable development then how would this shift to a more future-orientated sensemaking happen? Managers would prefer new networks to form in tidy alignment to bureaucratic delineations. In an extract from an interview (*SmithInterview*) below, Maggie explains why GPs should, in her view, form geographically based networks:

"We're trying to create federations and I know I'm still looking at federations about like-minded GPs working together, that's not going to work. They've got to geographically work together, they see the same patients and the same area, if you're a single-handed GP and you go off ill, you need to know that your patients could walk up the road to the next practice, or somebody could walk down to you, or, you're seeing those geographical patients. They've got to put aside their personal preference for professionally what works and for the patient what works. And they're starting to see that, reluctantly."

A principal driver for this was the formation of CPGs, and, to a manager, it seems to make obvious sense that GPs are grouped in the easiest way to provide cross cover. The Executive GPs however were not of this mind. A geographical arrangement could work, but only in situations where good relationships existed between practices. Dr Kerala described this in an interview (*KeralaInterview*)

"...So the CPGs, although they have become a reality from the point of view of the contract, I can see that the teams, the community teams are not becoming the neighbourhood teams, in effect that they're not working together. And GPs are looking at them, that this is the work being done around them, rather than being a part of it. So for the next year, it is a priority in itself that no, how do we make this into a networking or neighbourhood..... I think it will

happen in a fair few, but for it to happen in all units, it will have to, there will have to be significant gains and we will need far more medical leadership for that to happen.....”

When I exited the study site, where good relationships existed between GPs then CPGs were working well, but where relationships were strained then CPGs were succeeding in name only. In these cases the GPs were simply letting the CPGs happen around them - not resistant, but neither were they actively engaged. This prompts a further question. Why did some practices have such reluctance to work with their neighbours? Dr Lovett described in more depth the reason why practices would not cooperate with one another.

Dr Lovett: “Well it’s exactly the same argument. I think federations will work if they’re like minded people.....federations work if the practices themselves think it’s in their interest to be federated with it and they like the people, they respect the people or they think they can work with those people, I think that works.”

Adele: “It’s trust then?”

Dr Lovett: “Yeah, it is. But don’t for God’s sake make them go to somebody that they really don’t like and they don’t trust them because they... and that’s the problem with CPG group.”

Adele: “That’s in the abstract, you’ve talked about in the abstract, in reality how many practices couldn’t get on and how often does it really happen? I know there’s the odd one.”

Dr Lovett: “Well I can give you an example because of course... a family example for you because my dad worked with a guy called Dr X for years and he... my brother was joining the practice and Dr X then up and left with half the patients so that... and the X practice are still next door to my practice... I mean I don’t have a problem with them but they were two brothers, we were two brothers in ours, a father and two brothers and my dad would have had war with them at any time he possibly could. It’s not my style.”

Adele: “So it’s about all those businesses poaching and in competition.”

Dr Lovett: “It is. It is. You see in small business... well it’s two things, one is that... yeah, and again it’s a bit about the... do you have the same principles and most people have the same principles but not completely so... I know that in Castlefield there’s some

people that I could work with very easily and some people that I would probably need more time.....So if you have a group practice, you go to any group practice there are tensions between the partners within a practice, you multiply that by distance and a different set of rules and it gets worse and worse and worse so it's difficult."

In Dr Lovett's analysis, based on his own personal experience of being a clinician, a CCG leader, and a leader in the regionally based Local Education and Training Board, GPs would only work in groups if they had commercial, professional, and personal trust. It was possible to organise GP practices into groupings for various purposes, but any more sophisticated network that required sharing of resources or staff would only be feasible where personal and financial trust existed.

7.5 Discussion: Interagency Strategic Partnership Level

7.5.1 Introduction

In the sections below I draw on the findings presented in the preceding parts of this chapter in order to discuss how and why GPs commissioned in the way that they did at the ISPL. The discussion is organised into three sections: wider context; temporality; and distributed sensemaking. Each of these sections draws on the thematic analysis using the codes: establishment of new organisations; legacies; changes to the profession; competition; and integration. In each section I first discuss the relevant findings to the heading and draw out the theoretical implications, focusing on sensemaking within the context of networks and rules. I conclude by presenting a summary in the form of a tabular matrix.

7.5.2 Wider context

Whereas at OPL and SCL the wider sensemaking context appeared to be the vertical relationships within the NHS, at the IPSL the wide context was a horizontal relationship between the partner

organisations. The HWB was an exercise in the management of a wide context. The ostensible national policy ambition was to align otherwise largely unconnected organisations. I observed multiple attempts by representatives to find connections and to identify common ground. These attempts appeared to comprise of broad statements. The one thing that all held in common was that they had responsibilities in Castlefield. They agreed that issues relating to urban deprivation were best achieved through co-ordinated efforts of Castlefield agencies. This broad agreement meant that the membership was extended even more widely further expanding the context and increasing the difficulty of achieving alignment.

In order to manage this complexity, two main business mechanisms were created. Firstly specific inter-sector priorities were identified which were pursued and monitored, some more successfully than others. Secondly, a significant degree of attention was paid to routine uni-agency reporting.

HWBs were inter-organisational public partnerships put into place for two main policy purposes. The first was to increase the democratic accountability of healthcare commissioning by giving the lead responsibility for HWBs to elected local authorities. The second was to integrate the operational delivery of services. Interpretation of these national expectations was left to local areas. As part of the intention to increase democratic influence on healthcare, public health duties were transferred from the NHS to the LA, resulting in a redistribution of actors at national and local levels. Another impact was that the balance of influence shifted towards the democratic sensemaking of the elected representatives, and away from the bio-medical expert approach of the doctors.

There was a national programme to support implementation of HWBs, including a series of external peer reviews.

7.5.3 Temporality

Two pre-existing groups, the HWP and the HSCCB, were merged to form the new HWB. Outwardly, this gave the impression of a

process of natural evolution. This seeming continuity detracted from the scale of change and disruption of legacies introduced by the new rules.

The transfer of the public health duty from the NHS to the LA and to establish HWBs as committees of the LA was a structural change that put an organisational divide through the previous commissioning network and its legacy. Retrospective sensemaking was difficult as a consequence. Prospective sensemaking also appeared difficult. Public health staff were no longer part of the NHS Family. As a consequence they felt vulnerable and their close colleagues in the CCG felt bereft. There was a sense of fragmentation and confusion and sensemaking appeared stalled, commencing only on the arrival of an established public health leader as the new DPH. He made a working assumption that business should carry on as usual, acting as if the DPH position had equivalent status and role to that which had existed prior to the rule change. This signalled to others to extract cues from what they had known in the past. It seems likely that this continuation exacerbated the apparent tension that existed between the doctors and the councillors, although this was never voiced so cannot be directly evidenced.

One impact of this business-as-usual approach was to stymie the creation of potential new roles that could have resulting from the redistribution of responsibilities. It is likely that the GPs felt sensitive to the position of public health colleagues, and did not want to step into the established roles of their displaced friends and colleagues. GPs followed the lead of the DPH who continued as the main medical input to the HWB. GPs were relatively subdued in HWB meetings, in contrast to the roles they enacted in the CCG. Their chief concerns were elsewhere. They were otherwise occupied in establishing CCG networks. GPs appeared to have a longer time horizon than other members of the HWB. This was evidenced at a development session. The GPs described this latest change as just one further stage in a continuum of change to the profession which

they traced back to fundholding and non-fundholding. They anticipated further change in inter-agency arrangements with more transfers from the NHS to the LA.

7.5.4 Distributed sensemaking

This type of inter-sector public partnership is put into place in an attempt to co-ordinate activities in areas where more than one organisation has a responsibility. The *raison d'être* of the partnership was to solve a sensemaking distribution problem. It should not therefore be a surprise to find unaligned perspectives in public partnerships. The partner organisations had different rules, and core duties, and by extension their respective actors had different perspectives when it came to sensemaking. During the HWB meetings members often talked at cross-purposes reflecting their different perspectives which I conceptualise as different sensemaking types. Some differences had a more significant impact on business than others.

The transfer of public health duties from the NHS to the LA was a redistribution of responsibilities at national level. Councillors now had ultimate responsibility for public health and the HWB. This redistribution of responsibilities was evident in the decisions that were made, including those regarding the allocation of the public health grant. The relative influence of expert doctors versus democratically accountable councillors became a matter of regular contention.

As at the SCL, OD was a mechanism used to facilitate sensemaking at a time of rule change. The OD interventions at the partnership level were distinct from those discussed in the previous two chapters. OD in the healthcare sector emphasised the alignment of sensemaking especially of rank-and-file GPs. In this context of multiple organisations with multiple sensemaking types, OD processes were used to explore and expose tensions.

The peer review was an example of an external intervention. During the review, councillors and other partners expressed a view that

doctors were dominant in the HWB. In response, the review team recommended that greater weight be given to the “democratic mandate”. HWB members’ followed up the review with in-house OD activity designed to better understand their different perspectives. OD at this level served to help actors articulate and understand differences. The impact was to give added legitimacy and influence to the democratic sensemaking type of the councillors (external peer review), and to aid greater awareness of the differences in sensemaking types (internal development sessions). Because the actors were not ready, or simply it was not possible, to align sensemaking types, this left a gap for the councillors, and their democratic sensemaking type, to become dominant, and as a corollary others became passive, including the GPs.

In this context the focus was on understanding differences and tensions. The overall picture was one of multiple sensemaking types that would continue to be different. It is not always possible to align sensemaking processes, or resolve tensions. In these circumstances it is more difficult to identify critical individuals from within the ranks who have legitimacy to influence across the network. External interventions were used to align work with the rules. Internal processes were externally facilitated, and were focused on understanding differences.

At the ISPL, the focus was on integration, not competition. The term integration was used in two distinct ways. First was the creation of a HWB strategy, involving the integration of partners’ strategies. Because the partnership was a collectivity involving different sensemaking types this integration was elusive. Instead of comprehensive integrated strategies, priority areas were identified. Second was the integration of community health, GP, and social services. This became one of the agreed priority areas identified. Work on priority areas was executed in sub-networks. Like the HWB, sub-networks comprised of actors that were usually distributed throughout a number of separate organisations. By bringing those together in one network it was intended that widely

distributed responsibilities could be brought into alignment. The ICP was organised using a mechanism known as Project Management. A related set of networks was created to co-ordinate distributed sensemaking. Workstreams were accountable to a project team, and the project team to a project board. The ICP was co-ordinated by a project manager whose ostensible role was to monitor timescales and tasks, but who also appeared to invest significant time in brokering disagreements between actors distributed in member organisations.

GPs took an active role in the ICP, in contrast to their relative disengagement in strategy discussions at the HWB. At the SCL GPs preferred interpretation of their commissioning role was to design and improve clinical services and processes. Their role in the ICP was to contribute to clinical service design, thus extending their work at the SCL into social care. The integration of health and social care involved the creation of a new infrastructure for referrals, discharges and case management of older people. The building block was to be locality based teams, each with its own care co-ordinator. Each Practice would be allocated to a locality based team that did not correlate to existing GP-groupings. CCG managers strongly supported the concept of bureaucratically determined geographical groups; this would fit tidily with other agencies' bureaucratic boundaries. The GPs however, were hesitant about how far this geographical approach could be imposed. At the same time as the ICP groupings were put into place, GP federations were increasingly talked about at national levels. GP practices were businesses. Commercial, professional and personal trust would need to be in place before GPs would federate in anything other than a loose arrangement. GPs somewhat reluctantly complied with this allocation, whilst also retaining the four existing groups for commissioning purposes.

7.5.5 Summary matrix of theoretical implications

The theoretical implications identified in 7.5.1-7.5.4 are presented in a summary matrix in table 24. The matrix structure is a map of the main thematic categories (side headings) and the SP co-ordinates (top headings). Contents of the matrix are articulated using concepts from BF and SP.

Table 25 Interagency Strategic Partnership Level summary matrix

	Wider Contexts	Temporality	Distributed Sensemaking
Establishment of new organisation	HWBs were inter-organisational public partnerships put into place in an attempt to coordinate service delivery. The transfer of public health duties from the NHS to the LA was a redistribution of responsibilities at national level, intended to increase democratic influence in the NHS. There was a national programme to support implementation including external peer reviews.	Two pre-existing groups were merged to form one new organisation. Outwardly, this gave the impression of a process of natural evolution. This seeming continuity detracted from the scale of change and disruption of legacies introduced by the new rules.	The HWB was a network of representatives with The different sensemaking types. OD processes were used to support establishment of the HWB. The effect was to give added legitimacy and influence to the democratic sensemaking type of the councillors (external peer review), and to aid greater awareness of the differences in sensemaking types (internal development sessions).
Legacy	The shift of Public Health from to the LA was a significant change in field rules. Public Health was a distinct speciality within medicine (as well as other professions such as nursing). A corollary impact was that GPs became the NHS medical representatives in the inter-agency partnerships.	The rule change disrupted the shared legacy of Public Health and NHS commissioners. Actors were confused, and sensemaking was stalled. Sensemaking recommenced when a past leader was appointed, extracting cues from the old shared legacy taking a "business as usual" stance. Thus, potential new roles resulting from the repositioning were not created. GPs followed the lead of the DPH who continued as the main medical input to the HWB.	Each HWB represented a partner organisation that had its own rules, duties, and legacies. This meant that different sensemaking types were attempting to sensemake together. The difference between doctor (expertise and evidence) and councillors (democratic mandate) became a matter of regular contention.
Changes to Profession	The rule change was intended to add democratic legitimacy to the NHS. This had the effect of rebalancing the relative influence of expert doctor and democratic councillor. .	GPs saw the rule change as the latest stage in a continuum, anticipating further transfers from the NHS to the LA. GPs were relatively subdued in HWB meetings, in contrast to the roles they enacted in the CCG. Their chief concerns were elsewhere. They were otherwise occupied in establishing CCG networks.	The ICP included new geographically based arrangements to deliver integrated health and social care services. As a result GP practices would be allocated to new networks that did not correlate to existing GP-groupings. GPs complied with this allocation, but also retained the four existing groups. This was a source of tension between managers and doctors
Competition	Not apparent in the data	Not apparent in the data	Not apparent in the data

	Wider Contexts	Temporality	Distributed Sensemaking
Integration	Integration of health and social care services was a national expectation, although this was not stated in formal rules or policies. Interpretation of the national expectation was left to local areas.	No implications	Integration appeared to mean two things. First was the integration of partners' strategies. Because the partnership was a collectivity with different sensemaking types this integration was elusive. Instead of comprehensive integrated strategies, priority areas were agreed. One of these priority areas was the integration of community services. This was the second meaning of integration. A project called the ICP was established, delivered through a sub-network with workstreams.

Chapter Eight: Discussion and theoretical implications

8.1 Revisiting the research questions

In section 1.1, I set out my aims in relation to this thesis, along with two related research questions:

- Why and how did GPs enact their commissioning duties in the ways that they did?
- How does sensemaking influence field change within the context of networks and rules?

The first of these questions relates to my aim to add depth and nuance to our understanding of *why* and *how* General Medical Practitioners (GPs) commission services in the way that they do. The second relates to my aim to contribute definitional clarity to the term cognitive frame in BF by using SP concepts. In addition I aim to contribute to SP in the areas of wider contexts, temporality and distributed networks. Whilst my empirical findings are drawn from a study of a health and care economy, the theoretical contributions are intended to be equally useful in other organisations and industries.

In the three preceding empirical chapters I have presented data, in the form of stories. In order to clearly link the contents of those stories back to the data-analysis process (see *Chapter 3: Methodology and Methods*) each chapter concluded with a summary matrix of the main empirical thematic categories (establishment of new organisations; history and legacy; changes to the profession; integration; and competition) and SP analytic co-ordinates (wider context, temporality, and distributed sensemaking). Each matrix contained an analysis of the relationship between sensemaking (cognitive frame), networks and rules.

In this chapter I discuss the implications for the field as a whole, by aggregating the findings associated with each of the separate levels.

The chapter is organised as three discussions: wider context; temporality, and distributed sensemaking. Whilst these analytic co-ordinates are useful as headings, the content of each section is not distinct and discrete. The impact of distributed sensemaking, temporality, and wider context is interwoven, each embedded within the others. Next I present a distillation of the theoretical implications for BF and SP, and finally conclude with a statement of my theoretical contributions.

8.2 Wider context

8.2.1 Introduction

As outlined in 2.5.2, scholars agreed that the focus of the extant SP literature was limited to micro-level enactment, and one-off events. Maitlis and Christianson (2014) identified macro social structures, and collective enactment in these, as an area for further development. Brown, Colville, and Pye (2014) noted a lack of attention to culture and institutional contexts. Sandberg and Tsoukas (2015) similarly noted that sensemaking in wider contexts was overlooked. This three-levelled case study over an 18 month period provided an opportunity to consider organisational processes in an established industry. Castlefield's health system was part of a national industry with cultural and institutional dimensions. Additionally, the multi-levelled nature of the field provided the opportunity to make observations within and between those levels. In the following paragraphs I discuss the implications for sensemaking in a wider context, introduce the concept of a *sensemaking type* associated with an industry, and consider the implications of rules that imply changes in sensemaking types, and contexts of multiple sensemaking types.

8.2.2 NHS Family network

The historically-rooted NHS was the context for actors at both the OPL and the SCL (Coleman et al., 2010, Davies and Harrison, 2003, Harrison and Ahmad, 2000). An associated shared NHS identity

(Segar et al., 2014) was in evidence, for which I have used the term NHS Family. Belonging to the NHS Family appeared to have emotional resonance for many inner city doctors. The NHS Family operated as a tightly-coupled network, with shared problem solving and mutually supportive working practices. I conceptualise this as a *prosocial sensemaking type* (Grant et al., 2008). The empirical chapters contain a number of examples to evidence this. In PC GP-group the attempt of GP practice staff to relate to Castlecare nurses as commissioners was abandoned in favour of collegueship. Another example was that Castlecare staff agreed to provide a phlebotomy service when the AQP exercise resulted in a loss of provision. The interface between doctors from primary and secondary care at the FLEs was a further example of a cross-NHS network co-operating to provide shared services to patients.

8.2.3 Professional context

The wider professional context, and developments in the GP profession, was also a prominent influence on sensemaking in the field. National developments in medicine included restratification (McDonald et al., 2009b, Sheaff et al., 2002), hybridisation (Kirkpatrick et al., 2009, McGivern et al., 2015, Noordegraaf, 2007, Waring and Currie, 2009), and limitations to medical autonomy (Harrison and Ahmad, 2000, Numerato et al., 2012). These were in evidence in the GP-groups at OPL, and between leaders and the wider GP community at SCL. Each GP-group had its own pattern of adoption of changes to the profession, which reflected its history and legacy, and future orientation (see 8.3). These variations resulted in different communication and leadership styles with corresponding differences in the distribution of actors (see 8.4). I conceptualise these variations as distinct *sensemaking styles* within the overall sensemaking type.

8.2.4 GP dual role as commissioner and provider

The HSCA 2012 introduced an increased emphasis on competition at national level, with the implication that commissioning and provision

roles should be distinct. National competition rules were enacted at the SCL. The new rule extending the use of commercial competition had inherent ambiguities which triggered sensemaking. NHS and commercial organisations have different approaches to sensemaking; there is evidence to support this in a study of a public-private partnership where issues of difference and incompatibility regarding strategic orientation, management approach, and workforce practice were identified by NHS staff (Bishop and Waring, 2011, Waring and Bishop, 2012, Waring et al., 2013).

The interface between commissioners and providers was not a simple contractual relationship. Commissioners and providers were both part of NHS Family network. Actors working in different organisations had often trained together and were friends. Sometimes the commissioner and provider could be the same person in the case of GPs commissioning services provided by GPs. The competition rule implied *a change of sensemaking type* from the embedded and established prosocial sensemaking type (Grant et al., 2008) to a market sensemaking type (Kennedy, 2008). This rule was loosely specified. In the end, whilst competitive activities were incorporated into business practices, there was no evidence that a change in sensemaking type took place. The mechanism by which CCG leaders, from their NHS Family network perspective, attempted to make sense of the competition rule is discussed in more detail in *8.4 Distributed Sensemaking* below.

8.2.5 Interagency partnerships with multiple sensemaking types

Of the three levels, the widest context was the ISPL. The HWB, introduced by the HSCA 2012, was formed on the policy assumption that the existence of a social network comprised of members from separate organisations would result in coordinated strategies across those organisations. This was not easy to operationalise. Not only where there multiple rules, but multiple organisations, networks,

professions, and budgets. Associated with this were differences in priorities and sensemaking types. Whilst my data did not allow for a full analysis of the sensemaking types in this arena, it was clear that the NHS prosocial type (Grant et al., 2008) was differentiated from, for example, the LA Councillors' political democratic sensemaking type. Consequently there was no easily identifiable starting point for a collective sensemaking process through which to agree collective action. Sensemaking continued to be separated along organisational lines, and in this politically charged context, a combative relationship between sensemakers appeared to be the *modus operandi*. Tensions rose to the surface, and certain actors asserted their perspective more forcibly than others. Other actors appeared to be passive, even docile, in response.

8.2.6 Theoretical implications

The theoretical implications of the above discussions include the following points. A multi-levelled field consists of different contexts. In a single industry such as the NHS a unifying *sensemaking type* may exist. Within this, internal networks may have differentiated *sensemaking styles* reflecting differences in legacy, future-orientation, and the distribution of actors. When the context of a field level is industry specific and that industry has a *single sensemaking type* then aligned sensemaking is easier to achieve when new rules are introduced. This is not the same as saying that the rule will be implemented as the rule-writers intended. Rather, interpretation of that rule will be through the lens of the industry sensemaking type, making interpretation more aligned. When a new rule implies a change in sensemaking type, then embedded sensemaking types that derive from an industry's history are not easily displaced, even if the implication of rules is that this should be the case. Where *multiple sensemaking types* exist within a field level then aligned sensemaking is more difficult to achieve and rules more difficult to operationalise. In this situation, a dominant

sensemaking type may be established, with an associated docility of actors with other sensemaking types.

8.3 Temporality

8.3.1 Introduction

As outlined in 2.5.2, in two recent reviews of SP scholars have identified the limitations of the extant SP literature in relation to the impact of time, especially prospective sensemaking (Sandberg and Tsoukas, 2015), and temporal work in multi-levelled contexts (Maitlis and Christianson, 2014). Maitlis and Christianson linked this observation with the potential to extend SP into wider and routine contexts where the time dimensions of sensemaking are different from those in micro-level and/or one-off events. In this next section I consider the relationship between sensemaking and time in a wider context with actors distributed in networks at the time of rule change. I discuss the preservation of historical arrangements; the impact of history and legacy; and the existence of different time horizons, sense pacing and sense suspension.

8.3.1 The preservation of historical arrangements

One very obvious way in which time had an impact was the preservation of historical arrangements through rule change. At all three levels, pre-existing formal organisational structures were preserved through rule changes wherever possible. This happened to a greater or lesser extent depending on the degree of flexibility in the rules. Thus, by default, pre-existing networks of actors were retained. At the OPL GP-group structures from the predecessor PCT were retained in the new CCG. The retention of PCT arrangements was such that, at the SCL, rank and file GPs found it difficult to differentiate present arrangements from the past. At the ISPL two pre-existing groups were merged to form one new organisation, giving an impression that the implementation of new rules was a process of natural evolution. This seeming continuity detracted from

the scale of change and disruption of legacies introduced by the new rules.

8.3.2 The impact of history and legacy

History and associated legacies (Coleman et al., 2010) were important influences on sensemaking in a wider distributed field. A consequence of the preservation of organisational arrangements through rule change was the retention of networks, with their established working arrangements and relationships, which can be said to constitute a legacy. Because this was a wider context in which sensemaking was a process involving interrelated networks, retrospective and prospective sensemaking mechanisms operated at network level, rather than individual level. At all levels, actors in networks had a perspective on the future that depended on its shared past experiences. In other words, the plausibility and nature of an anticipated future was shaped by the nature of shared past experience.

The historical nature of the NHS as an industry had resulted in a shared prosocial sensemaking type, discussed in section 8.2.2 above. This was evident at both OPL and SCL. The NHS Family legacy endured rule change and problems continued to be solved together. One effect of the existence of a shared sensemaking type was to enable prospective sensemaking. Because the shared NHS identity was embedded it acted as a secure foundation for sensemaking. When the introduction of a new rule to increase competition created ambiguity, managers and doctors divided along occupational lines in order to explore the tensions between an integrated and a competitive commissioning system. A combination of retrospective and prospective sensemaking resulted in the incorporation of competition principles into the existing prosocial sensemaking type.

Within this legacy-derived NHS sensemaking type, there were also other legacy-derived sensemaking styles. The origin of these styles appeared to lie in the existence of a shared network history even if

that history was short. These were in evidence at the OPL. The four GP-groups had individual histories of working together. Three groups had histories of more than a decade. Two of these three had legacies that were directly related to the commissioning rule and experience of fundholding and non-fundholding (Coleman et al., 2010). The fundholding style was derived from a legacy of all practices adopting management strategies in order to contain demand and control costs. The non-fundholding group's style was highly stratified with its leaders interpreting commissioning to mean that they should act as stewards for the NHS system. This style appeared to be adopted at the next tier; at the SCL; commissioning was interpreted as responsibility for maintaining the NHS system in the context of the Castlefield health and care economy. The third GP group had a multi-faceted legacy. They had in common the experience of migrating from India to work in the NHS, and then running small practices in deprived areas. The remaining network had only recently formed. The difference in legacies resulted in variations in the distribution of actors, and in how the enactment of commissioning business was focused.

At OPL, retrospective and prospective sensemaking was linked to the nature of the GP-group legacies. Two groups in particular were future-focused for different reasons. The older group of small practice doctors in the Gurus, looking for cues about the future, found reason to be anxious, which in turn affected their ability to think optimistically. By contrast, the innovation and improvement focus in NW, was a source of optimism, and members of the network considered it plausible that the future would be one of improving and developing primary care.

At the ISPL, rule changes altered the field structurally, and public health staff moved from the NHS to the LA, disrupting the NHS Family legacy and network. This appeared to impede both retrospective and prospective sensemaking. There was a sense of fragmentation and confusion. Sensemaking recommenced following the arrival of an established public health leader as the new DPH

who enacted a “business as usual” approach, accessing the old legacy sensemaking network, even though structural relationships had changed. He did this as a sensegiver, thus signalling to others to extract similar sensemaking cues to those that they had before the implementation of HSCA 2012. GPs followed the lead of the DPH, allowing him to continue as the main medical voice in HWB discussions.

8.3.3 Time horizons, sense-pacing, and sense suspension

In a wider context with distributed networks of actors multiple sensemaking processes contribute to an overall field level interpretation of new rules. The role of sensegivers in this situation involves the co-ordination of paced sensemaking in a timeframe. Not all actors have the same time horizons, and not all make sense at the same time.

At the SCL, hybrid-leaders were actively engaged in temporal work. These hybrid leaders faced in two directions. When facing the wider CCG GP-membership, socially skilled sensegivers paced sensemaking, including suspending sensemaking processes amongst the rank and file whilst they themselves considered how to interpret new rules. One way this suspension was achieved was by hybrid sensegivers indicated that to be professional was to comply with the rules.

When facing CCG managers, there were differences in respective time horizons. Managers appeared to have a shorter time horizon, responding to external national deadlines. Executive GPs did support the managers in this, but took a more critical approach to the Centre and its rules. Their focus was on the impact rule changes would have on patients, GPs, and secondary care providers in the longer term.

At the ISPL, GPs saw the rule change as the latest stage in a continuum of change in the profession which they traced back to fundholding and non-fundholding, anticipating further transfers from the NHS to the LA. GPs were relatively subdued in HWB meetings, in

contrast to the roles they enacted in the CCG. Their chief concerns were elsewhere. They were otherwise occupied in establishing CCG networks. GPs did not see a clear role for themselves in this environment now or in the future, and as a result were emotionally disengaged.

8.3.6 Theoretical implications

The theoretical implications of the above discussions include the following points.

In any one context with multiple networks there will be different histories and anticipated futures which contribute to the differences in *sensemaking styles* within the overarching *sensemaking type*.

Networks with shared legacies can endure rule change. These shared legacies impact on the interpretation of rules by networks. This is especially so when rules are loosely specified. Sometimes, but not always, legacies are directly relevant to the new rules. Very often a shared legacy will be based on factors that are unrelated to the rule that is affecting the network. Even where legacies are directly relevant to the rule, there will be differences between networks as a result of different interpretations of predecessor rules.

The extent to which networks are retrospective or prospective in their sensemaking style reflects the extent to which a shared legacy is embedded, whether or not this legacy relates directly to the new rule, and also what emotions they feel about the future (for example, are they fearful or optimistic?).

There are also differences in future time horizons. For example in the study managers were focused on deadlines associated with tasks directed from the center, whereas doctors were mindful of a longer timeframe associated with the development of the primary care.

8.4 Distributed sensemaking

8.4.1 Introduction

In the extant SP literature distributed sensemaking has been used to describe those situations where people with different parts of the “jigsaw” come together in order to respond to a crisis, or implement a project (Fisher et al., 2012, Kendra and Wachtendorf, 2006, Stigliani and Ravasi, 2012). As outlined in 2.5.2, Maitlis and Christianson (2014) and Brown et al. (2014) identified distributed sensemaking as an underdeveloped area in SP. A feature of wider contexts is that interconnected groups of individuals need to be included in sensemaking, and that therefore patterns of distribution need to be established. The analytic category of networks in BF is one way to understand the distribution of sensemakers in a wider context. I have already proposed that the concepts of *sensemaking types* and *sensemaking styles* are useful to understand sensemaking in a wider context and the impact of time on sensemaking. In this section I develop these ideas further by considering the relationships between styles and types in a distributed system.

A description of the distribution across field levels is a useful place to start. To all intents and purposes, at the OPL business continued as usual throughout the implementation of HSCA 2012. The four groups were in existence prior to the rule-change and they continued to do business using their established sensemaking styles. This set of differences was in the background on a day to day basis, in so far as each group was left alone to its own methods of commissioning. The differences between the groups only came to the fore at times of inter-group negotiation such as the inter-group budget setting exercise. A shared style existed between PC and the SCL leadership. At the SCL a hierarchically distributed model was put in place. The wider body of GPs was treated as one network under the direction of the Executive Team. It would be impractical for all GPs to “front” commissioning so the CCG Executive GPs

operated as an elite leaders acting on their behalf. The Executive GPs faced outwards from the CCG to interact with professional leaders in other healthcare organisations, as well as leading and guiding rank-and-file GPs. SCL represented the CCG at the ISPL. The ISPL was a partnership of public organisations with differences in sense-making type. Priorities set at this level took effect at SCL and OPL.

This distribution is summarised in the table 25 below.

Table 26 Summary of network distribution

OPL	<ul style="list-style-type: none"> • GP-Groups with individual styles • Inter-group negotiation under direction of SCL leadership
SCL	<ul style="list-style-type: none"> • Single rank and file network is created, and is hierarchically influenced by GP Executives • GP Executives boundary span provider and commissioner organisations in a professional network • Executive Leaders divide on occupational grounds to debate competition/co-operation implications. • Rank and file group retreat to consider.
ISPL	<ul style="list-style-type: none"> • Multiple sectors at HWB with multiple sense-making types. • SCL leaders act as representatives in HWB. • HWB joint priorities have impact on SCL and OPL • Sub-networks comprised of multiple sectors take forward HWB priorities

This pattern of distribution is analysed further below. Firstly, I consider the unifying effect of a sensemaking type. Secondly, I consider how ambiguity can cause tensions between sensemaking types. Thirdly, I consider how OD approaches are used to manage and manipulate sensemaking in a distributed field. I conclude by identifying theoretical implications.

8.4.2 Distributed sensemaking: the unifying effect of a sensemaking type

The NHS Family sensemaking type was a unifying factor across OPL and SCL. The impact of this sensemaking type on distributed sensemaking was various.

Firstly the NHS sensemaking type was an enabler for aligned sensemaking across the distributed general practice businesses. When new rules were introduced, the implications were unclear. If the co-operation of rank-and- file GPs was to be maintained in order

for the system to remain stable, then a way to conceptualise the new rules was needed. The potential for the new rules to enable improvements in patient care by working at the interface of primary and secondary care was emphasised. The context for this would be the NHS Family network with its shared identity and sensemaking type.

Secondly the NHS sensemaking type enabled prospective sensemaking (see 8.3.2). Because the shared NHS identity was embedded it acted as a secure foundation when managers and doctors divided along occupational lines in order to explore the tensions between an integrated and a competitive commissioning system. Managers adopted a pro-competition schema. This was challenged by doctors who adopted a pro co-operation schema taking the role of critic and patient advocate. Doctors highlighted errors, problems, and inconsistencies associated with attempts at competition. Through this dialogic interaction, a more nuanced approach was developed that incorporated competition whilst at the same time preserving the integrated NHS network and its sensemaking type.

Thirdly, GP Executives acted as individual boundary spanners (Bartunek et al., 2006, Sullivan and Skelcher, 2002) across healthcare sectors that shared the NHS sensemaking type, forming networks with doctors in healthcare provider organisations such as hospitals.

8.4.3 Ambiguity and tension in a distributed field

Differences in sensemaking styles or types can be useful in understanding sensemaking tensions.

At the OPL, the different sensemaking styles in the GP networks could result in ambiguity which caused tensions inter-network tensions, as was seen in the budget setting exercise where the over-spending behaviour of PC practices was rewarded rather than sanctioned. Whilst this caused a period of inter-network tension, it

did not result in changes in the approach to sensemaking. GP-group sensemaking styles were embedded and stable.

There was interdependency, including a shared sensemaking style, between PC and the CCG leadership. One reason why the behaviour of GPs in the PC network was sanctioned was because its GP executives were the most active and influential at the SCL. The hierarchical systems-orientated sensemaking style shared by PC and the wider CCG at SCL was predicated on the importance of cross-organisational relationships between NHS organisations. This was an anchor for sensemaking when ambiguities and associated tensions arose. I have discussed above the divergence of doctors and managers in order to make sense of the coexistence of competition rule and the co-operative principle. It was the shared NHS Family sensemaking type across the CCG leadership network that enabled this divergence without network fragmentation. Co-operative commissioning arrangements were retained, alongside the incorporation of competition principles as a set of restraints to ensure actors remained alert to actual, potential, or perceived conflicts of interest, and avoided conferring competitive advantage on NHS organisations – including GP surgeries.

By contrast, at the ISPL, the HWB was a public policy partnership wherein there were incompatibilities (Klijn and Skelcher, 2007) between world views of the actors resulting in ambiguities. The rule change that introduced HWBs required a structural reorganisation where actors with different sensemaking types were redistributed, and decision making powers were reallocated. This created ambiguity and the sensemaking processes that were subsequently triggered were unaligned and fraught with tensions. The public health sensemaking type, and the Councillors' democratic sensemaking type were often in overt tension. Tensions rose to the surface, and meetings of the network became an arena for certain actors to dispute the value base of others' sensemaking types. Over time, underpinned by structural statutory decision making power, and further reinforced by the intervention of the external Peer

Review team, the Councillors moved to achieve a dominant position in the ISPL.

In the three-levelled distributed field, tensions could manifest between, as well as within, levels. At the ISPL, the HWB was not an end in itself, it was there to align the strategies and operations of the organisations represented in the network, with consequent impacts on other levels. Broad agreements regarding the priority of strategies were made at the ISPL. Plans to operationalise these were made at the SCL, and the operational delivery of the plans was affected at the OPL. Whilst the DPH was the lead doctor in the HWB, it was GPs that took a more active role in its subnetworks such as the ICP. The work of the ICP was to design new ways of working across professional disciplines including the combination of assessment, referral, and information systems. This planning and design focus corresponded closely to the role of Executive GPs' at the SCL, and they engaged actively in the familiar task of creating new services and pathways. Despite these similarities the ICP specific networks were accountable to the HWB where LA rules were statutorily paramount despite the diversity of sensemaking types. A key difference between LAs and the NHS related to the definition of the populations that each served. LAs serve a resident population and they organise their services on a geographical basis. GPs serve a registered population and are not bound by geography. Moreover the CCG was established as an alliance of GP practices which were independent businesses. There were historical tensions and competitive rivalries between these businesses, and the existence of these contributed to the pattern of self-selecting membership of the GP networks at Practice Level. When it came to the ICP, community-based services, including general practice, were to be organised into geographically-based teams. This was a potential disruption to the existing pattern of GP-groups with their embedded shared legacy cognitive frames. At the time I completed my field work these teams were being established. In those instances where there was a high degree of mismatch between the existing GP

networks and the proposed community teams then tensions with the potential to undermine the new bureaucratically-driven geographical structures were beginning to show. These imposed arrangements were exposing tensions between sensemaking at OPL, SCL and ISPL.

Tension could exist between networks, within networks, and even within individual people in those instances where a dualistic tension was part of the response to a rule. Networks were the arena where separate parties took different approaches to sensemaking as a precursor to reaching a more nuanced shared cognitive frame. If a network has multiple sensemaking types amongst its members then tension may be an ongoing feature. Differences between sensemaking types may account for varying degrees of assertiveness and passivity amongst the actors in the network. In a multi-levelled field the interpretation of a rule at one level may not resonate with sensemaking at the level at which the rule is operationalised. Where this is the case, ambiguity will arise, resulting in tensions with the potential to undermine or limit the implementation of the rule.

8.4.4 Organisational Development in distributed sensemaking

An important aspect of sensemaking in a distributed field was the use of OD. In the next sections I consider a range of interventions and the relationship these had to sensemaking.

8.4.4.1 External intervention

Across the three levels, there was only one example of an external OD intervention, and this was at the ISPL. The fact that an external intervention took place was indicative of the nature of the field change which shifted the boundary between the NHS and the LA.

The national policy implementation process was coordinated by the LGA who had an “offer” to help LAs implement the HSCA in the form of a Peer Review. In Castlefield, the reviewers identified tension

between doctors and councillors. Councillors prioritised the democratic representation of public opinion, and the doctors prioritised “evidence” and the bio medical model. The peer review team gave a clear message that the sensemaking type of the councillors needed to be given more weight in the partnership. In this way, the national policy intention to make the NHS more democratically accountable was reinforced. This is an example of an external intervention affecting and delimiting local processes of implementation by enforcing national rules. This intervention served to identify tensions in sensemaking and recalibrate the dynamics in order that rules were implemented according to national intentions. Follow up development sessions, focused on developing understanding of different sensemaking types, were also externally facilitated.

8.4.4.2 Time out to reconceptualise

When rules change “time out” is a mechanism for members of a network to discuss the implications of rules in a process of interpretation. McDonald et al. (2015) identified the importance of protected time to learn about and reconceptualise change.

Examples of protected time to reconceptualise were seen at both the SCL and ISPL. The Conflicts of Interest session and the HWB development afternoons both provided protected time for actors to conceptualise the implications of the rules that they were charged with implementing. Another example of protected time was the LMC event for rank and file GPs to reflect on the implications of competition on their own businesses.

The Conflicts of Interest session was designed for members of the GB network to consider the ambiguities that arose as a result of GPs commissioning within a system in which they were also providers. This network comprised of actors that worked together often. The time out was held after a time of trial and error (Rerup and Feldman, 2011) and marked the point at which the distribution into doctors and managers ended. This protected time was an

opportunity to share perspectives about how to balance the competition rule into the co-operative NHS system in a nuanced way, and to ensure that GPs did not further their own interests in the process.

By contrast, the HWB Development Session was designed to enhance mutual understanding of ongoing difference in what was a widely distributed network. Members of the HWB belonged to separate organisations and would continue to have different sensemaking types. The focus was on unpacking the reasons why actors had different perspectives and feelings in order to enhance tolerance between members when tensions arose. The outcome was a more sophisticated recognition of these differences.

Different again was the time out organised for the GPs by the LMC. In this case, the rule requiring GPs to compete to continue to provide certain services had caused a disruption in the embedded NHS Family network. GPs were a widely distributed group but were nonetheless connected by the NHS Family sensemaking type. When AQP was applied to their services they appeared to be shocked to find themselves on a “level playing field” with non-NHS providers in a competitive environment. This time out was designed to allow GPs to retreat and regroup, in a uni-professional network, in order to reflect upon the implications for how to make sense of what they were being required to do. They decided to co-operate, prioritising the quality of patient experience above their own financial interests. This had more significance and impact than had been intended originally, since the co-operative, even docile, reaction allayed fears of leaders regarding the risk of personal interests being pursued by rank-and-file doctors.

8.4.4.3 The role of socially-skilled individuals

At SCL, both All Members meetings and FLEs were organised using OD methods. Group development techniques such as breaking into small groups to consider issues were used to ensure active engagement of those in attendance. Trusted individuals with

established credentials (Fligstein, 2001, Fligstein and McAdam, 2012, Lockett et al., 2014) were “placed” as facilitators in order to set the tone, and convey messages. In SP literature roles similar to these have been described variously as sensegiving (Gioia and Chittipeddi, 1991), or sense-demanding (Vlaar et al., 2008, Weick, 1969:p40), and have tended to be attributed to middle managers (Balogun and Johnson, 2004, Balogun and Johnson, 2005, Huy, 2002) or senior leaders (Gioia and Mehra, 1996, Gioia et al., 1994). In this wider context, large groups of professional staff needed to be influenced, and this required a different approach from those previously identified in the literature. The facilitator role varied between sensegiving, and pacing sensemaking including holding sense in suspension. The pacing and suspension of sense is a new sensemaking concept in addition to those identified by Maitlis and Christianson (2014:p69). The time-related aspects have been discussed in 8.3.3 above. Pacing and suspension of sense were also dependent on the distribution of actors and networks.

Sense suspension was an active process. TM meetings took place before the leaders had chance to form their own thoughts regarding the new rules, meaning it was not possible to give sense to others about the implications, especially those aspects of the rules that related to extended competition. In the absence of sense, rank-and-file GPs were encouraged to trust in their leaders, and not to reach conclusions about the rules per se. A doctor with an established reputation for encouraging and developing other members of his profession acted as a facilitator, giving clear messages that an attitude of positive engagement would best serve the interests of everyone – GPs and patients alike. Space was created for worries and resistance to be expressed. This appeared to be part of a process whereby resistance was absorbed. The message given by the facilitator was that General Practice was ever-evolving; and to be professional (Evetts, 2003, 2006) was to rise to the personal challenge of contributing to improvements in clinical care. He appealed to an enduring sense of professional motivation,

encouraging actors to refer to their vocation as doctors. He also steered actors to accept that being a doctor was ever-changing, and never-changing both at the same time. An important implication of this is that not all actors make sense at the same time, and that it is not necessary that they do so before actions commence. What was important, though, was to diminish resistance and to replace reluctance with an alternative reason for moving forward.

If suspension of sense was to be sustained, and resistance to continue to be controlled, then constant reinforcement seemed to be required. FLEs was one mechanisms for enacting this reinforcement. In a similar way to TM, this approach depended on the legitimacy of critically placed individuals. This time, respected hospital consultants guided GPs to think about their role in shared pathways of care to look after shared patients. Here the focus was on demonstrating the success of GP leaders as agents for service improvement within the NHS Family network. This in turn established plausibility for the leaders' argument that rank and file GPs should engage optimistically as commissioners (Coleman et al., 2009:p18). In these FLEs, no attention was given to the requirement to extend competition into the NHS network.

8.4.5 Theoretical implications

Across an industry a shared sensemaking type can exist in networks that span organisational boundaries, and operational and strategic levels of action. Sometimes tensions can appear to exist when a more sensemaking type is becoming more nuanced. This is a different form of sensemaking tension to that which exists when different, possibly opposing, sensemaking types or styles exist in the same network. Tensions between sensemaking types may be a feature of formal structural redistribution of actors and decision making power. If a network has multiple sensemaking types then actors of one type may be more assertive than actors of another depending on the nature of the rules that are being enacted. Tensions can also exist between levels, in a multi-levelled field.

In a wider context, networks change, and actors are redistributed in as part of an active sensemaking process. The nature of the distribution changes according to the sensemaking that is happening. In this respect OD is important. This can take various forms. When a national field change shifted the boundary between the NHS and the LA, an external OD intervention served to identify tensions in sensemaking and recalibrate the dynamics in order that rules were implemented according to national intentions. On other occasions “time out” sessions were organised in order that members of networks could discuss the implications of rules in a process of interpretation. These were used to support distributed sensemaking processes, which included a retreat into a uni-professional group; a reconciliation of distanced positions into a more nuanced understanding across a network; and an enhancement of tolerance and understanding in a diverse network.

OD in distributed sensemaking includes input from trusted socially – skilled individuals with established credentials. These were “placed” as facilitators. Their role varied between sensegiving, and pacing sense including holding sense in suspension. These were active processes. In the absence of sense it was important that the body of rank-and-file workers continued to follow their leaders if the system were to continue to function. The potential for resistance was absorbed, by suspending sensemaking about the rule change per se, instead replacing it by a focus on the enduring nature of professional motivation emphasising the ever-changing, and never-changing condition of being a doctor. All actors were not in a position to sense at the same time, so it was important that sensemaking was paced and that resistance was diminished in order that action could commence.

8.5 Summary of theoretical implications

BF was developed for application at the macro level. SP has been limited to the micro level. By considering sensemaking as the active

dimension of cognitive frame in BF, a research gap has been addressed in that this is has also been an exploration of sensemaking in wider contexts. Throughout the thesis, I have used the overlapping and inter-dependent analytic co-ordinates of wider context, temporality, and distributed sensemaking to do this. In the following paragraphs, I present the implications that my findings have for SP, before presenting a proposed definition for cognitive frame within BF.

8.6 Contributions to sensemaking perspective

8.6.1 Wider contexts: sensemaking types and sensemaking styles

Within a wider context, in this case a multi-levelled field, then actors within an established industry are likely to share a *sensemaking type*. The concept of sensemaking type that I propose here is a shared idea about the nature of cues that workers in a particular organisational context will seek to identify when making sense of new rules or contexts. In the case of the NHS this was prosocial type linked to long-standing organisational and professional identities. Changes in the industry, and wider workforce changes were important outside influences. When a rule is introduced that implies a change in sensemaking type, in this case a change from prosocial to market sensemaking, it will not be simply adopted, but first it will be interpreted through the lens of the existing type.

A shared type can act as a unifying force both within and between field levels. In any one industry or context where a sensemaking type is shared but where there are multiple networks each network will reflect its actors' past experiences. The result will be different approaches to sensemaking within the overarching sensemaking type. I have used the term *sensemaking styles* to describe this. A style reflects the combination of a network's shared legacy, shared

ideas about an anticipated future, and the associated distributed relationships that it has put in place.

Where *multiple sensemaking types* exist within a field level then aligned sensemaking is more difficult to achieve and rules more difficult to operationalise. In these circumstances there is the potential for a dominant sensemaking type to be established, with an associated docility of actors with other sensemaking types. In a multi-levelled field the interpretation of a rule at one field level may not resonate with sensemaking at other field levels even though it will take effect at these levels. Where this is the case, there is further scope for the rule to be reinterpreted, including being bent or broken.

8.6.2 Distributed sensemaking and distribution as an active process

In order for sensemaking to take place in a wider context it needs to be orchestrated. In this respect OD appeared to be an important mechanism. This can take various forms depending on the distribution of actors and networks and the nature of sensemaking relationships. For example, in an industry with a shared sensemaking type actors can divide and regroup existing networks to consider the implications of rules without destabilising the overall sensemaking type. In this way the adoption of separate positions can be a prelude to a more nuanced shared position. Specific groups can separate or retreat in “timeout” sessions in order to conceptualise the implications of a rule for them. There were also examples of hierarchically managed events where leaders suspended sense amongst the wider group whilst they continued to consider the implications of a rule change that implied a change in that type. In an inter-agency environment with sensemaking types then the emphasis of OD interventions can be to promote a lead sensemaking type, or to promote understanding of differences between types. Where there is no shared type OD interventions may be externally facilitated. This may include interventions by rule-

enforcement agencies in order to identify tensions in sensemaking and recalibrate the dynamics in order that rules are implemented.

8.6.3 Role of critically placed socially-skilled individuals: sensegiving, sense-pacing, and the suspension of sense

The role of trusted individuals with established credentials was important. Socially skilled leaders were “placed” as facilitators in order to set the tone, and convey messages. Their role varied between sensegiving, and pacing sense including holding sense in suspension. These were both active processes. Where leaders had not yet undergone their own process of sensemaking in relation to a rule change, they could not act as sensegiver to the wider professional community. Through the suggestion of an alternative focus, in this case the enduring motivation to work constructively as a doctor to improve services in a professional medical network that spanned boundaries, sense was suspended and resistance to change absorbed. An important implication of this is that not all actors make sense at the same time, and that it is not necessary that they do so before actions commence. What was important, though, was to diminish resistance and to replace reluctance with an alternative reason for moving forward. This needed continual reinforcement, which was again facilitated by critically placed individuals with social and professional legitimacy.

8.7 Contribution to Beckert’s Framework

The existing definition of cognitive frame is without sensitivity to the nature of human interaction whilst SP is too individualised and related to one-off events. Having considered sensemaking as an active process in a wider and more routine context I use this to develop a definition of cognitive frame within the dynamic relationship with rules and networks.

Beckert originally devised his framework in order to examine the social dynamics of markets. This was at the macro level, concerned with identifying a new way of explaining market dynamics that was

not predicated on the pursuit of individual interest. As discussed in section 2.3, BF is vulnerable to analytic drift if the categories remain under theorised, and based on untested assumptions. These assumptions include that actors have “how-to” rules upon which to draw when implementing new rules, and that they will adopt these in an uncomplicated manner. Cognitive frames for Beckert were the “taken for granted scripts” (citing Freidson, 1983, Meyer and Rowan, 1977) that correspond to prevailing scripts in the industry. He assumed that there would be a high degree of consensus regarding the direction of field change. Finally he assumed that by and large actors would pursue their own interests. These assumptions all relate to the analytic category cognitive frame. In this next section I address these assumptions before going further to extrapolate a description of cognitive frame within BF.

The first assumption is that “how-to” rules would be available to actors. Based on the empirical finding from my study this does not always appear to be the case. When a rule was introduced that implied a field change from a prosocial to a market cognitive frame, it was first considered through the lens of the existing cognitive frame. The rule was followed, but the implied field change did not take place. Rules can be adapted, or even broken depending on the fit between the sensemaking type implied by the new rule, and the pre-existing type. The extent to which how-to behaviours were available to actors depended on the relevance of the new rule to the legacy of the network. Very often a shared legacy will be based on factors that bear no relation to the rule that is affecting the network. Legacies can stabilise, but can also constrain. This could delimit the interpretation of rule change especially when the rule is loosely specified, as cues extracted are derived from the legacy. The second assumption is that there would be consensus regarding the direction of a new field rules. The findings from my study suggest that this is only true when the pre-existing sensemaking type is in line with the direction of the new rule, such as in the example Beckert’s uses where capitalist markets supported a field change to

diversify which would result in increased profits. In my example where a prosocial non-profit sector is asked to adopt market behaviours this consensus was not achieved. Certain groups of actors made more attempts than others to adopt new rules, but in the end existing prosocial business behaviours were adjusted to accommodate the new principles of competition to a limited extent. Similarly at the level of a strategic partnership where groups with various sensemaking types were required by rules to co-ordinate strategies, this was difficult to operationalise. In such a situation, discrete areas for joint action were agreed, but these were limited in both scope and effective enactment. The third assumption that all actors will pursue their own interests was also found not to stand. In the complex healthcare industry, doctors had a legacy of interpreting new rules in terms of compliance. They continued to do this even when this resulted in financial cost to them, and disrupted services for their patients. This was evidenced at both the OPL and the SCL. By identifying every possible conflict of interest they on occasions acted against their own interests. This was the impact of a competitive model in a prosocial environment.

So what are the implications of these challenges to assumptions and other findings for the definition of cognitive frame in BF?

Firstly, it is not a static state of itself, within the interdependent dynamic with rules and networks. Rather it is an ongoing process of making sense in an active process of interpretation situated in the actors' relationship to new rules and the networks to which they belong.

Secondly, a cognitive frame at the level of an industry may be conceptualised as the industry's established sensemaking type. This cognitive frame is drawn from organisational and professional identities. When a rule is introduced that implies a reframing is necessary (or a change in sensemaking type) then this will be initiated through the lens of the existing frame. Changes in the industry and wider workforce changes (such as restratification,

hybridisation, and the limitation of clinical autonomy) were important outside influences on how the industry is organised but did not alter the basic type. A shared type can be a unifying force both within and between field levels enabling resistance to or acceptance of the rule.

Thirdly, in a context with multiple networks there will be differences in prior shared experiences. These result in differences in sensemaking within the overarching sensemaking type. These can be conceptualised as styles of cognitive frame associated with internal networks reflecting the legacy and future-orientation of the actors. This will also have an impact on how the network organises its communication and management systems. These styles also inform the distribution of actors within a network.

Fourthly, in some contexts a variety of sensemaking types may be present. Where this is the case, such as in a public policy partnership, then the alignment of actors towards the goal of collective action is difficult to operationalise. In these circumstances, the emphasis may be on understanding and accommodating differences, or on legitimising a lead type.

Fifthly, the distribution and/or redistribution of networks and/or actors within networks is in itself an active process. Patterns of distribution are created to interpret new rules. This could include separation into differentiated positions of actors within a network, sometimes resulting in the retreat of certain groups to consider and reconceptualise.

Sixthly, in a distributed system at times of field change the developing nature of cognitive frames will be orchestrated. In these situations, OD is important. This can take various forms, depending on the nature of the field rule that was being interpreted.

Seventhly, conflicts and tensions between sensemaking styles or types can exist as well as across field levels. This may be a stage in a process towards the development of a shared cognitive frame

within a field, or it may reflect a redistribution of power in a field change.

8.8 Conclusion

In this chapter I have established and argued the theoretical implications for SP and BF. I have discussed the importance of sensemaking types and styles in distributed sensemaking in a wider context, tensions in sensemaking especially in a multi-levelled field, the importance of different relationships of the past, present and future, and the importance of the role of critically placed socially skilled individuals. Associated with this I have argued that there is a new sensemaking concept of sense suspension. The implication of this is that actors do not all make sense at the same time, but that trusted legitimate individuals can help others to concentrate on another dimension of their role. I have extrapolated from this to describe cognitive frame in BF as having seven dimensions.

Chapter Nine: Conclusions

9.1 Introduction

This chapter is the conclusion of the thesis. I begin by summarising the contributions to SP and BF. Following this, I reflect on the practical implications for health research, policy and management. Next, I outline the limitations of this study and highlight areas for further research. I end with a final reflexive comment. If I have done nothing else, I hope that through the empirical chapters, I have shone a light on the lived experience of the GP as he or she goes about the business of commissioning.

9.2 Theoretical contributions of this thesis

The theoretical contributions to the thesis are at the intersection of SP and BF. By developing a reciprocal relationship between the two theories, I have faced SP towards the macro level, and BF towards the micro level. Although derived through this relationship, the theoretical contributions are to SP and BF individually. These contributions address underdeveloped areas of wider contexts, temporality, and distributed sensemaking in SP, and an under theorised concept of cognitive frame in BF.

9.2.1 Contributions to Sensemaking Perspective

Maitlis and Christianson (2014) identified that an ever-increasing number of specialised forms of sensemaking are identified in the literature, some of which are situation dependent (see appendix 2). I have replaced the word *form* with *type*. The concept of sensemaking type that I propose here is a shared idea about the nature of cues that workers in a particular organisational context will seek to identify when making sense of new rules or contexts.

In some circumstances a new rule may imply a change in type. In others new rules are required to be interpreted in a field of multiple sensemaking types in the same network. The consequent ambiguity

can trigger sensemaking. Tensions in sensemaking may be a stage in resolving ambiguity, or may be ongoing especially in networks with multiple sensemaking types. The concept of sensemaking type is potentially useful in understanding how networks interpret rules, respond to tensions, and succeed or fail in achieving collective action.

Even when an industry has a shared sensemaking type, there will be co-existent variances in how that industry's sub-networks interpret rules. I have conceptualised these differences within an overall type as sensemaking styles. These styles reflect networks' legacy and future-orientation, and influence the distribution of its actors.

Sensemaking, in wider contexts, is an active distributing process. Networks are an adaptive mechanism which alter distribution patterns according to the implications of the sensemaking project. Various active processes were associated with distribution, including sensegivers spanning network boundaries; networks splitting to take differentiated positions; networks taking time-out to reflect; and a uni-professional network retreating to reflect.

Sensemaking is paced over time. Not all actors have the same time horizon. It is not necessary for sense to be made by all actors before action can commence. Leaders, at times when they themselves are interpreting new rules, can suspend sensemaking amongst networks of followers. This is achieved by socially skilled leader-facilitators diminishing resistance by diverting the attention of the wider network onto, in this case, the call to professionalism.

9.2.2 Contributions to Beckert's Framework

Where SP is extended by using BF to face the macro level, in a reciprocal relationship BF is extended by using SP to face the micro level. This extension is in the form of a description of the analytic category cognitive frame, and is summarised in the following points.

Cognitive frame is not a fixed entity. Rather it is an ongoing process of sensemaking situated in the actors' context of rules and networks.

Cognitive frame in an industry context is conceptualised as that industry's established sensemaking type. This type is shared amongst actors and can be a unifying force both within and between field levels. When a rule is introduced that implies a change in sensemaking type then a reframing process will be initiated, and this will be enacted using the lens of the pre-existing frame.

The concept of a cognitive frame as a sensemaking type at industry level does not explain how the networks that comprise that industry interpret rules. Within the overall cognitive frame of an industry with multiple networks there will be differences in sensemaking, which is conceptualised as differences in sensemaking style. Style is a combination derived from legacy, future-orientation, and the distribution of the actors.

In fields with more than one industry or sector, multiple cognitive frames may mean that alignment of actors towards the goal of collective action is difficult to operationalise. In these circumstances, the emphasis may be on understanding and accommodating differences, or on legitimising a lead cognitive frame.

Tensions between sensemaking styles or types can exist within or between field levels. This may be a stage in a process towards the development of a shared cognitive frame within a field, or it may reflect a redistribution of power in a field change. The distribution and/or redistribution of networks and actors within networks is in itself an active process which is triggered by cognitive reframing. Patterns of distribution are created by actors as they interpret new rules. In a field with distributed networks this cognitive reframing can be a managed process. In these situations, OD is important. This can take various forms, depending on the nature of the field rule that is being interpreted.

9.3 Limitations, implications for practice and suggestions for further research

In the following paragraphs I discuss the limitations of the study, and identify areas where further research is indicated

9.3.1 The limitations of a single site case study

This was only ever a study of one CCG, in which I aimed for depth not generalisability, which I discussed in depth in 3.3.2 above. This was a story unfolding with no a priori assumptions. I have not attempted to solve a list of pre-determined problems, neither have I described a model of GP commissioning and evaluated it. What I hope I have done is build cumulative knowledge about how GP commissioning is organised. Despite this limitation, the depth afforded by studying GPs across the range of commissioning duties does, I hope, tell an enlightening story about GPs and their behaviour and motivations when enacting commissioning roles. Especially my findings add a dimension beyond the conflict theory model as called for by Medical Sociology scholars (Kuhlmann and Von Knorring, 2014, Numerato et al., 2012, Thomas and Hewitt, 2011).

9.3.2 Theoretical limitations

Whilst I have identified the concepts of types and styles as a useful way to understand distributed sensemaking in a wider context, these are offered merely as a starting point. I do this on the premise that BF will develop further, and that the combination of sensemaking with rules and networks is a useful way to apply SP to a wider context. In terms of sensemaking types (Maitlis and Christianson, 2014) (Appendix 2) a more comprehensive typology could be developed. I have described styles as being a combination of history, future-orientation and distribution of actors, but there is scope to add further to this description.

9.3.3 Limitations and implications for practice and medical sociology

In line with the purpose of a PhD, the primary contributions of this thesis are theoretical and are applicable more widely than the English NHS. However the theoretical contributions were derived using empirical codes and were guided by the question “Why and how did GPs enact their commissioning duties in the ways that they did?” There are associated contributions and limitations to Medical Sociology, and implications for public policy regarding GPs. I discuss these in the following paragraphs:

9.3.3.1 The interpretation of changes to the profession

The extant health policy and medical sociology literature includes three main strands to explain changes in the profession. These are hybridisation (Kirkpatrick et al., 2009, McGivern et al., 2015, Noordegraaf, 2007, Waring and Currie, 2009), restratification (McDonald et al., 2009b, Sheaff et al., 2002) and the delimitation of clinical autonomy (Allsop, 2006, Checkland and Harrison, 2010, Dixon-Woods et al., 2011, Harrison and Lim, 2003, Kuhlmann et al., 2013, Salter, 2007). My study raises questions regarding the impact of these changes on GPs within the context of medicine more widely. This is especially relevant to the management role of commissioning which GPs are contractually obliged to enact. There was heterogeneity in the pattern of adoption of changes to the profession amongst GPs. Chamber, for example, had accepted hybridity but had interpreted this to apply to all GPs and did not therefore emphasise re-stratification. In this group all practices were encouraged to adopt management techniques in relation to their own practice. Associated with this was a delimitation of autonomy that extended across the group with significant sharing of information for scrutiny. By contrast PC were the highly-stratified with a differentiated elite who were hybridised, but this hybridisation was limited to the elite whilst the rank-and-file were left to work with continued autonomy. At the more strategic level

business was done through highly stratified arrangements. GP leaders were differentiated and hybridised. The varied adoption of changes to the profession by the profession may be contributing to an overall confusion for the GPs themselves about where their loyalties lie, and what is expected of them as “professionals”. More research is indicated on the effect of multiple developments within the profession and the variations that this creates as GPs adopt these changes.

9.3.3.2 Compliance and the shift to professionalism

More research is indicated to explain the passivity and compliance that the GPs in the study demonstrated. This may be linked to 9.3.2 above in that multiple parallel changes have created a confused profession. Government rhetoric on the subject of GP commissioning is about empowering doctors as experts in healthcare. In Castlefield, commissioning meant that GPs were expected to manage demand by controlling the level of referrals and prescriptions, and to work with secondary care colleagues to design services. In my study, the GPs did not appear to engage critically with the role, resisting changes that would detrimentally affect them. Instead, despite some initial grumbling, doctors responded to new rules compliantly. Leaders synonymised compliance with professionalism (Evetts, 2003, Evetts, 2006). The rewards they sought were improvements to services, even when this was at personal cost to themselves. This should be caveated since my observations were limited to those GPs that engaged in CCG processes at some level even if only to attend TM meetings. Nonetheless, in my observations, GPs collectively appeared to be compliant, and orientated towards improvement and sustainability of services for patients, without a strategy to safeguard their own interests. There were numerous examples in the data where GPs appeared to be going to great lengths not to appear greedy. They declared conflicts of interest including those they had in the past, might have in the future, and those of their families and partners.

They agreed to provide services without payment. They were passive at the HWB when the public health budget was reallocated. They pointed out when there was a potential to be over-paid. Even when they were required to compete to continue to provide existing services, with all the potential knock on effects for their businesses, staff, and patients, they simply went along with it, trusting in their leaders to guide them through.

Why was this? And what are the potential consequences of this attitude for the profession? At the time of submitting this thesis, there was an almost 40% vacancy rate on the GP vocational training scheme in the East Midlands area, and this difficulty in recruiting GPs is part of a national trend. Is this linked to misunderstandings regarding the motivation of GPs and how they make sense of their role? Are there specific issues for inner city GPs that need to be addressed if a primary care service is to be sustained? Whilst I can speculate, my thesis has not been focused directly on these questions. Again, I suggest it as an important area for further consideration.

9.3.3.3 The commissioning role and the importance of the NHS Family

One important finding was the impact of belonging to the NHS Family on how and why GPs enacted their commissioning role in the way that they did. The importance of collegueship across organisational boundaries was repeatedly evidenced, and GP-commissioning was a main vehicle for service pathway design across boundaries of primary and secondary care and health and social services. Doctors and other clinicians had shared patients and shared operational responsibility. Problems were repeatedly solved together outside of formal procurement processes. It was these relationships that were potentially destabilised by the implied shift in HSCA 2012 to a market approach to sensemaking. Despite the important unifying effect of the NHS Family network, it remains a fluid and undefined concept. Given its apparent importance in field

stability and limiting effect on the interpretation of new rules, I suggest its mechanisms are an important area for further research, the outcomes of which should be used to inform public policy as more traditional NHS organisations move into new business models, and more NHS functions transfer to LAs.

9.3.3.4 Inner city GPs

This was a study of inner city GPs with a population with relatively high deprivation. The sensemaking of these GPs is likely to be different from those in more affluent areas. Castlefield's workforce had characteristics of ethnic heritage and vocation that were inner city specific and this inevitably affected how doctors made sense of their role. In addition to their own personal attitudes, inner-city GPs report feeling overwhelmed with the social problems of their patients meaning it is difficult to make the space and time to think proactively and critically. My study was not designed to enable me to draw conclusions regarding the specialised nature of inner-city general practice, but the evidence suggests that this is an important distinction about which more research is needed.

9.4 A closing comment

The above points have implications for public policy. Since the early 1990s there have been policy frustrations regarding how GPs have or have not fulfilled the commissioning role. Despite these frustrations there have been increasingly more system-wide roles and structures that encapsulate the idea of GP engagement. It would be useful if future initiatives were grounded in a more sophisticated understanding of GP motivation and behaviour.

Current policy linked to The NHS Five Year Forward View (NHS England and NHS primary care co-commissioning, 2014) and the associated programmes to introduce multi-speciality community provider organisations, and integrated primary and acute care systems could potentially provide a more fertile ground for the involvement of GPs more widely, however the inter-agency nature

of much of this work raises different challenges in the light of the evidence from my study regarding the passivity of GPs in the inter-agency environment at strategic level, and the potential conflicts of sensemaking style between LAs and the NHS. Policy that places GPs at its heart needs to be informed by an in-depth understanding about GP behaviour.

Whilst I have examined GPs and my opinions about them, my original feelings of gratitude and respect remain intact, even strengthened. I hope that in this thesis I have contributed evidence to help reach a better understanding of GPs' motivation and experience. I also hope that I have helped explain why this is important, and that I have opened further questions that will help shape policy which has GPs at its heart.

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Appendix 1 Glossary

Advancing Quality: A voluntary programme that provides financial incentives for improvement in the quality of care provided to patients. It has been implemented in the North West region of England since 2008.

Any Qualified Provider: An initiative to open the NHS resources to competition from a range of providers. Potential providers must pass a standard qualification process to ensure they meet the appropriate quality requirements, and need to be registered with the Care Quality Commission where they are carrying out a service which is already regulated. If a provider does not need Care Quality Commission registration, then other equivalent assurance is required. Once deemed qualified that provider is entered on a register of Qualified Providers and patients can choose their service-provider from that register.

Better Care Fund: A single pooled budget, originally called the Integration Transformation Fund, with the objective to incentivise the NHS and local government to work more closely together and to shift resources into social care and community services. The fund is designated at national level, and in 2014/15 included a further 200 million pounds transfer from the NHS to social care, in addition to a 900 million pounds transfer already planned. The pooled budget was of the value of 3.8 billion pounds.

Choice: A policy in the NHS designed to enable patients to make choices about the healthcare they receive. Originally (2002) it was introduced to allow patients on waiting lists opportunities to choose alternative providers. It has since been extended into other service areas. The Any Qualified Provider initiative is a mechanism by which choice is made available to patients in the form of a register of providers.

Community Interest Company: A type of company designed for social enterprises. The legal form ensures that their profits and

assets are used for the public good. They were initially set up in 2005 under the Companies (Audit, and Investigations and Community Enterprise) Act 2004. They are not charities, nor part of the public sector. They are companies in the private sector as far as legal status, including tax status, is concerned.

Clinical Commissioning Group: An inter-disciplinary group of health clinicians and managers, led by GPs, which holds the health budget for patients in a local area. Membership of a CCG is not optional for GPs; these arrangements came legally into force on 1st April 2013.

Enhanced Services: Primary medical services that can be either designated nationally or locally agreed to meet local priorities. These are described as enhancements to the essential services provided under the core GMS contract. Services included in the enhanced services categories vary from year to year, illustrative examples of national enhanced services include the Patient Participation Scheme, and the Extended Hours Access Scheme. Examples of Local enhanced services include intravenous antibiotics at home, and targeted cancer screening initiatives.

Fundholding: A system that enabled GPs to receive a fixed budget from which to pay for primary care, drugs, and non-urgent hospital treatment for patients. The scheme commenced in 1990 and was abolished in 1997.

General Practice and General Medical Practitioner: A General Medical Practitioner (GP) is a doctor who treats acute and non-acute illness, and provides preventative care for all ages and sexes through the mechanism of a registered list. GPs are based in the community, and employ a practice based team which usually includes nurses, practice managers, and receptionists, and sometimes salaried doctors. This team and the building out of which they operate is known as the General Practice. By definition GPs are generalists not specialists and illnesses often present to them in an undifferentiated way. They treat patients with minor or chronic

conditions, issuing prescriptions for medication and/or referring to other services as appropriate.

Health (and care) Economy: A term that describes the combination of a local area's population, and the organisations that provide health and social care in that area. It is intended to reflect that the population and the various providers are inter-linked and interdependent, and need to design services and allocate budgets with a view to the sustainability of the overall "economy".

General Medical Service Contract: The mechanism by which the core expectation of GPs as independent contractors is specified. The GMS contract is a UK-wide arrangement with minor differences across England, Scotland, Wales and Northern Ireland.

Health and Wellbeing Board: Statutory partnerships of the NHS, public health, adult social care and children's services, including elected representatives of LAs and Local Healthwatch. They are required to identify and meet the needs of their local population and to tackle local inequalities in health and wellbeing.

Healthwatch: A consumer champion arrangement at both national and local level introduced by the HSCA 2012 and implemented in April 2013. National Healthwatch is a statutory committee of the national Care Quality Commission (the independent regulator of all health and social care services in England). Local Healthwatches are required in every single and upper tier local authority and are funded by the local authority.

Joint Strategic Needs Assessment: An annual publication in which the health and wellbeing needs of a local area are described, providing a basis for the commissioning of local services and action to be taken by local partners working together. It is a Public Health framework to examine the factors that impact on health and wellbeing of local communities, including employment, education, housing, and environmental factors. It is supported by a joint health and wellbeing strategy.

Local Strategic Partnership: A partnership arrangement which included the public sector along with the business, community and voluntary sectors. These are non-statutory, non-executive organisations designed to facilitate co-ordinated strategic decisions at a level that is close to the community. These are aligned with local authority boundaries.

Minimum Practice Income Guarantee: An extra payment to some General Medical Services (GMS) practices, introduced as part of the 2004 contract to smooth the transition to new funding arrangements and which is in the process of being phased out. General practices in deprived areas have been the main beneficiaries of the payment.

Monitor: The sector regulator for healthcare, in the form of an executive non-departmental public body sponsored by the Department of Health. Monitor's role is to ensure that independent NHS foundation trusts are well-led so that they can provide quality care on a sustainable basis, that essential services are maintained if a provider gets into serious difficulties, and that the NHS payment system promotes quality and efficiency. One way that this is undertaken is through the regulation of procurement, choice and competition operate in the best interests of patients.

NHS Constitution: A statement that sets out the rights to which patients, public and staff are entitled, and pledges that the NHS is committed to achieving. It also sets out responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

Payment by Results: A system of contractual payments to hospitals based on fixed tariffs per case to create, in theory, strong incentives for hospitals to raise income by attracting and treating more patients, via improvements in quality. The system covers the majority of acute healthcare in hospitals, with national tariffs for admitted patient care, outpatient attendances, accident and emergency (A&E), and some outpatient procedures.

Practice Based Commissioning: A system by which GP Practices held indicative budgets, made commissioning decisions and allocated resources between competing priorities. Their associated Primary Care Trust placed contracts, and enacted administrative functions on their behalf.

Primary Care

Primary Care Groups/Trusts: Primary care groups (PCGs), established throughout England in 1999, operating as subcommittees of health authorities. PCGs were committees of GPs, nurses, other health professionals, managers, and others. From 2001 onwards they migrated to Primary Care Trust status, with appointed boards. The former subcommittees migrated into Professional Executive Committees and where subordinate to the new Trust Boards.

Quality and Outcomes Framework: A pay-for-performance scheme for GPs. introduced in April 2004, based on the delivery of clinical and organisational targets.

Secondary Care:

Single Tier Local Authority: Also known as unitary authority, a local authority that is responsible for all local government functions within its area.

Upper Tier Local Authority: In most areas of England local government functions are divided between two tiers of local authority. County councils are the upper-tier and provide waste management, education, libraries, social services, transport, strategic planning, consumer protection, police, fire education and social care services for a county area. Borough or district councils form the lower-tier, and provide housing, waste collection, council tax collection, local planning, licensing, cemeteries and crematoria

Appendix 2 Specific Forms of Sensemaking

From Sensemaking in Organizations: Taking Stock and Moving Forward (Maitlis and Christianson, 2014:p68)

Sensemaking Form	Definition
Constituent-minded sensemaking	"the process by which an arbiter renders an assignment of blame, guided not only by the arbiter's professional standards and rational analysis but also by his or her own biases and the anticipation of his or her constituents' biases." (Wiesenfeld et al., 2008:p235)
Cultural sensemaking	"how entrepreneurs or communities make sense of venture failures." (Cardon et al., 2011:p79)
Ecological sensemaking	"the process used to make sense of material landscapes and ecological processes." (Whiteman and Cooper, 2011:p889) "how actors notice and bracket ecologically material cues from a stream of experience and build connections and causal networks between various cues and with past enacted environments." (Whiteman and Cooper, 2011:p890-891)
Environmental sensemaking	"actors make sense not only of the event itself, but of the broader organizational field." (Nigam and Ocasio, 2010:p826)
Future-oriented sensemaking	"sensemaking that seeks to construct intersubjective meanings, images, and schemes in conversation where these meanings and interpretations create or project images of future objects and phenomena." (Gephart et al., 2010:p285)
Intercultural sensemaking	"the process involving the selection of scripts that reflect individuals' cultural values and cultural history." (Fisher, 2013:p796) "... can lead to various outcomes such as schema development and a higher level of cultural understanding." (Fisher and Hutchings, 2013:p796)
Interpersonal sensemaking	"the role of interpersonal cues from others in helping employees make meaning from their jobs, roles, and selves at work." (Wrzesniewski et al., 2003:p103)
Market sensemaking	"a macro version of Weick's approach to meaning construction in organizations." (Kennedy, 2008:p272)
Political sensemaking	"how powerful social actors construct the relationship between multinational enterprises (MNEs) and their multiple local contexts." (Glasby et al., 2004:p395)
Prosocial sensemaking	"process in which employees interpret personal and company actions and identities as caring." (Grant et al., 2008:p898)
Prospective sensemaking	"the conscious and intentional consideration of the probable future impact of certain actions, and especially nonactions, on the meaning construction processes of themselves and others." (Gioia et al., 1994:p378)
Resourceful sensemaking	"the ability to appreciate the perspectives of others and use this understanding to enact horizon-expanding discourse." (Currie et al., 2009:p807)

Appendix 3 Schedule of Interviews

Pseudonym	Job role
Conran Brown	Finance Director
Dr Conary	Chamber Executive GP, and lead for CCG-wide practice visits programme
Lisa Diggle	Commissioning Director
Lizzie Gordon	Consultant (non-medical) in public health
Dr Kerala	Chamber Executive GP, and lead GP for ICP
Dr Lovett	PC Executive GP, and lead for education, professional development, research, and safe-guarding
Dr Poona	The Gurus Chairman
Maggie Smith	Director of Primary Care
Dr Strong	PC Executive GP and lead GP for Health and Wellbeing Board
Sarah Tompkins	Programme Manager (Integrated Care)
Jim Wood	Local Medical Committee Chief Executive
Primary Care Middle Manager	Organisation of GP-groups

Appendix 4 Interview Topic Guide

Topic 1: History and memories of the role of the GP in planning/commissioning services in partnerships

Since the focus of the study is changes in role resulting from the introduction of GP Commissioning, interviews will explore the memories of individuals in order to capture what is different now from in the past. This will include questions relating to the changes the individual has made in their own working life to introduce the recent changes, in order to explore whether established coping mechanisms and relationships are being used to implement new requirements.

Topic 2: The effectiveness of GP commissioning

This topic will include questions that examine how effective GP commissioning is considered to be. It will help to identify enablers and barriers to effective commissioning. Questions will explore what is good and what is bad about GP commissioning, including what factors make it work well (enablers) and what factors make it go badly (barriers). Specifically the interviews will contextualise these questions in an interagency/partnership. It will involve comparisons with non-GP commissioning models, in order to be able to identify contrasts and similarities.

Topic 3: The impacts on the relationships between managers, doctors, other staff and patients.

This topic area will focus on how commissioning requirements impact on managers, doctors, and other groups of staff. Changes in the role of the GP will have corollary changes in the role of other types of staff and on patients. Understanding the impacts of the changes on managers, doctors, and other groups of staff will enable a more nuanced understanding to the impacts on the GP profession itself. It is important to note that the study will not include direct interviews with lay people. The patient point of view will be

obtained by interviews with staff who are responsible for patient and public engagement.

Topic 4: Impacts on General Practice as a profession.

This topic will explore the nature and extent of changes in General Practice. It will include the exploration of whether changes have affected all GPs in the same way, or whether groups of GPs are forming to deliver commissioning responsibilities.

Topic 5: What interests are being served or repressed/confounded?

The theoretical basis for the study is Structural Interests Theory (Alford, 1975). The study will problematize the concept of interests. The interviews will include an exploration of the interviewees views of what interests are being served by the new system. They will also explore whether interests are being repressed or confounded by the new system. What may constitute an "interest" is not defined or anticipated at this stage, as this will be a key contribution of the research to Structural Interests Theory.

Appendix 5 Membership of Health and Wellbeing Board

Voting Members

- Three LA elected members
- Two LA directors
- The Director of Public Health; joint with CCG until formal transfer on 1st April 2013
- Three CCG GPs
- CCG Chief operating officer
- Healthwatch representative

Non-voting Members

- Two further LA directors (Adult Provision and Health Integration and Families and communities)
- Housing representative
- Police representative
- Jobcentre Plus representative
- Crime and Drug Partnership representative
- Three health provider representatives, including new Castlecare social enterprise as well as NHS trusts
- Representative from third sector forum