AN EXAMINATION OF THE NEGOTIATED ORDER OF NHS COMMISSIONING:
A CASE STUDY OF A CLINICAL COMMISSIONING GROUP
"DECISIONS IN THE ABSENCE OF OBJECTIVITY"

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> "Reason is, and ought only to be, the slave of the passions and can never pretend to any other office than to serve and obey them."
>
> David Hume (1978)

> "In crashing obviousness lies objectivity."
>
> Daniel Dennett (1992, p.80)[1]

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Abstract

Decision-making is a significant part of the business of board level activity in NHS organizations, including the recently created Clinical Commissioning Groups (CCGs). This research explores the behaviour of decision-makers within a CCG as part of a detailed case study focussing on a major strategic decision and looking at the various influences present. The aim being not merely to describe the decision and its outcomes, but to investigate the social interactions of those charged with making the decision and how the influences shape the eventual outcome.

The analysis used the concept of the negotiated order, analysing the texts produced in a series of decision-making meetings and qualitative interviews with the decision-making participants. Data was analysed through critical discourse analysis within a case study research methodology. Thus, the textual data and generated narratives provided the evidence for how the social relationships and interactions emerged in the case study. The decision-making process demonstrated the negotiated order being created through the power relations of the participants with formed coalitions using and re-shaping cognitive frames. The interpretation of the research findings produced a social power model for organizational decision-making, shaped by the use and exchange of frames within the discourse.

This is considered an original contribution to knowledge and supports the further development of the concept of the negotiated order and the use of cognitive frames within organizations. There are a number of implications for management practice that may improve decision-making and help further explorations into upper-echelon behaviour. The research is one of the first to explore the clinically led NHS CCGs and is and a rare example of detailed scrutiny into NHS decision-making. Furthermore, the research has a relatively unique position of the researcher as a participant observer already established as a senior position within the organization being studied. This provides a significant contribution to the body of knowledge and research practice of ethnography.

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Chapter 1 - Introduction

In the beginning

Theodore Sorensen's (1963) monograph on decision-making remains an important historical text, covering an eventful period of USA history. It contains an illuminating foreword from the man for whom Sorensen worked as speech writer and advisor, US President John F. Kennedy. Allison (1999) quotes from Kennedy's foreword to title his seminal case study on decision-making, *The Essence of Decision* (cited by Yin (2009) as a case study exemplar). In this thesis, however, the starting point is not that of the 'essence of the decision', but Kennedy's later description of the decision-making process as: "dark and tangled stretches in the decision-making process – mysterious even to those who may be the most intimately involved" (Sorensen 1963, p.xiii). The twin aims of the study become both to describe the tangled stretches of decision-making in its real-world context and to illuminate the process, so the stretches observed may appear a little less dark. The approach taken to shed light on decision-making taking place in the NHS was that of ethnography: a longer-time study including observational assessment of the process in action. This aimed to explore in real-time, in situ, the real-world practice of decision-making at work. The conclusion may be that with such study, the observation of decision-making may become less dark. Inevitably, even in the presence of the brightest sun, the cast of shadows will create darker patches. But it may not be the darkness that obstructs understanding of what is happening in the theatre of decision. The complication to providing clarity may be related more to the 'tangled' nature of the stretches, than the absence of light.

One possible reason for the apparent tangling complexity may be the difficulties during major decision-making of achieving a consensus amongst those involved. This may be, perhaps, not just achieving an agreement as to what to do: but even of agreeing what has happened and what presented information can mean to the decision. Thus, the dark and tangled stretches may appear so, due to the struggle to find a common language, information sources, and interpretations to that information. Achieving something close to an objective assessment *may* be possible. Indeed, it may be possible in the world of fiction, as Daniel Dennett describes in considering readers' consistent views of Sherlock Holmes above: "All interpreters agree that Holmes was smarter than Watson; in crashing obviousness lies objectivity" (Dennett 1992, p.80). But in the dark and tangled stretches will crashing obviousness emerge?[2]

The genesis of the project considered not only the need to observe the process of decision-making, and the ways in which consensus to deliver a decision was established: but also, the ways individuals and groups interact to shape interpretation of the subjects under consideration. From differing starting points Strauss (1963) and Cyert and March (1992) described processes of negotiation within organizations. This led to the introduction of the concept of the negotiated order (Strauss 1963, 1982, Watson 2002) as an interpretive lens with which to study how decision makers behave in the case study. Thus, during this journey of exploration the scene was illuminated

by the light of consistent observation and engagement with decision-makers over an extended period. The illumination identified the patterns of individual and group behaviour in framing and re-framing interpretive schemas of the decision subject. This process did not necessarily produce an objective assessment of 'truth': but a means of reconciling competing views and interests to establish a basis for agreement, compromise, and acceptance. Such negotiation and accommodation is not merely a struggle to find objectivity, crashing in its obviousness or not. For all strategic decisions the passions and emotions of the decision-makers will be influential. These passions and emotions may not be seen as merely distraction or 'decision bias' but as a part of human decision-making. If Hume is right, then the inputs of human passions are not only necessary but welcome.

Analysing the research and developing theory in this thesis involved consideration as to how the 'reasons and passions' worked to create a negotiated order and thus how power manifested itself in the organization. Early review of theories of power included the well-established power model of Lukes (2005). Latterly the theory development suggested that even such a multi-dimensional model may not sufficiently address the understanding of power dimensions in the organization. A different model for social power may be required and although other sources provided alternatives (such as Haugaard 2003) a novel solution was the project's conclusion.

Thus, through the dark and tangled stretches, in a world free from objectivity, an organizational order was formed through the competing organizational powers, driven by reason, passion, frustration, fear, and bewilderment.

Research questions and objectives

The researcher's previous post-graduate research was also on NHS decision-making, focusing on use of evidence in decision-making in a Primary Care Trust (PCT) (Cox, 2012). The research here builds on that research and intended to provide more detailed exploration of NHS decision-making through using multiple research methods, such as ethnography in a more detailed examination.

The research question for the project was:

What are the factors that influence strategic decisions in healthcare commissioning: a negotiated order perspective?

The perspective underpinning this research project emerged from consideration of NHS CCGs. CCGs emerged in a context of acute financial challenge (Appleby 2009) within an economic era described as an 'age of austerity'. This challenge promotes greater focus on the allocation of scarce resources. As a major part of the commissioning process is resource allocation, CCGs have come under increasing pressure to justify their decisions: requiring demonstration of efficiency and effectiveness in their decision-making processes. The project explored strategic decision-making by a CCG in this political and economic context. The practical problem facing a senior executive managing an NHS organization is that of how to

manage the potential influences and the factors which may distort the decision-making environment away from optimal decisions. Furthermore, the practitioner is required to assess how the overall strategic decision-making process can be planned and managed with the aim of improving how decisions are made.

The objectives of the research, in the context of a real-world decision-making process, were to examine:

- How do the influencing factors on decision makers present themselves, how do interest groups become involved in the process and how do they exert influence?

- How does this influence manifest itself in relation to the CCG's cultural and power dimensions (its *negotiated order*)?

- How may decision-making processes be improved to maximize utilization of resources consistent with the NHS and CCG strategies?

The decision underpinning the case study emerged in mid 2015. The case related to the future commissioning of community healthcare services for the CCG locality. Although all research data relates to real events and real people names and event titles have been changed to preserve anonymity.

Background, motivation, and practitioner context

The research project was undertaken in the United Kingdom National Health Service (NHS) focussed on the management decision-making in the commissioning (resource allocation) parts of the service. The NHS is a tax-funded service, providing comprehensive healthcare services to the whole of the resident population. The NHS benchmarks well with international comparators for value money and its ability to achieve positive health outcomes at relatively low cost (Davis 2014, Squires and Anderson 2015, see Appendix 1 for an overview of comparative commissioning). Such relatively efficiency, however, does require consideration to the most appropriate allocation of scarce resources. The tasks of deciding on resource allocation fall in large part on the system designated as commissioning: those bodies tasked with planning services to address identified care needs within the available resources of money, buildings, and workforce.

The researcher has been a Chief Officer in a Clinical Commissioning Group (CCG): one of the NHS organizations created through the NHS reforms of the Coalition government (2010-15) (Department of Health, 2010), and enacted in the 2012 Health and Social Care Act (Great Britain 2012). The direction of the 2010 white paper (Department of Health 2010) was to shift responsibility for NHS decision-making to clinical leaders, particularly General Practitioners (GPs). The intention being to put more control under local 'family doctors'[3] who were seen by the then Secretary of State, Andrew Lansley, as being those most sensitive to understanding patient need

and of finding ways of satisfying that need. This focus on GPs was softened slightly as legislation moved from white paper to act of parliament (including a delay in the process, referred to as the 'pause' (Timmins 2012)). Nevertheless, the outcome in CCGs was a much higher level of clinical input than any previous commissioning body, with the board level decision body, a CCG Governing Body, typically having a majority of practicing clinicians amongst their membership.

An element of the practitioner context for this research is the role and functioning of the GP leaders within this new commissioning system. The timing of the study was in the very early stages of this new system becoming operational. As such it may be seen as a useful test of how the system responds to strategic decision-making challenges and whether this new clinical leadership provides additional value to its public. The value adding of the clinical input may be seen to be in its contribution to strategy, and strategic thinking that support creating patient and public value (Moore 1995). It may also assume that medical professionals will be better able to source, interpret, and use available evidence in support of effective decision-making. The concept of evidence-based decision-making in healthcare is now well established (Gray 2009, Greenhalgh 2010). This primarily applies to medical and thus operational level decision-making, not complex strategic decisions: however, the approach of evidence-based decision-making generally, and as applied within medicine, may be seen as a consistent, rational approach to use knowledge to make effective choices. Evans (2003) is one author to summarize the hierarchy of evidence:

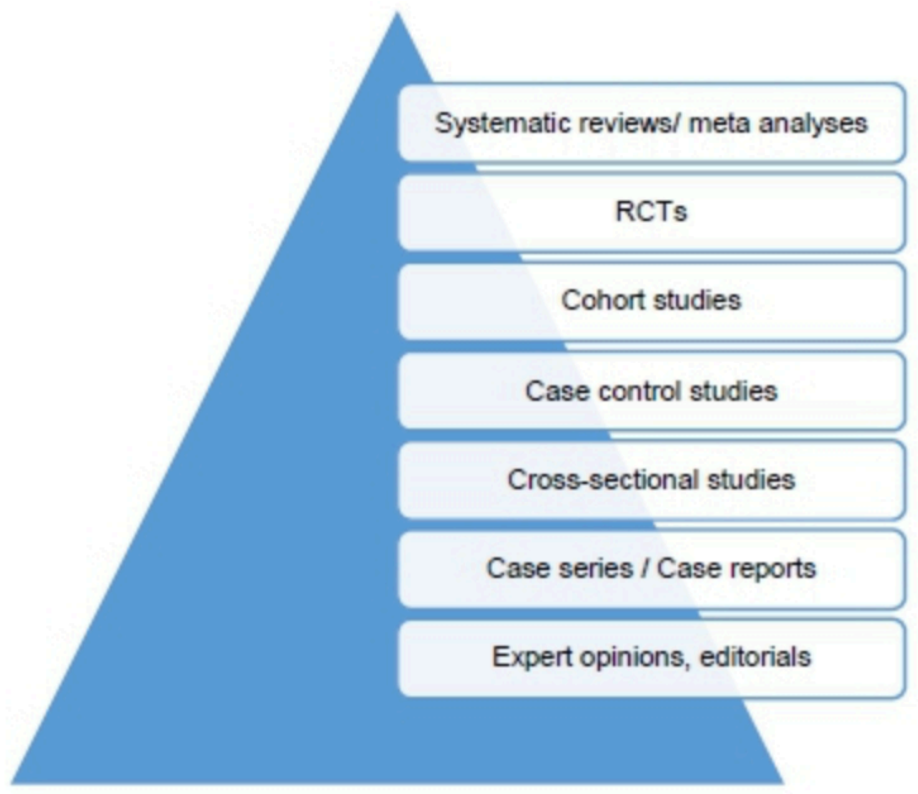


Figure 1 - The Hierarchy of Evidence (adapted from Evans 2003)

Thus, CCG clinicians may be seen as being trained in the understanding of evidence and its uses, although primarily in the context of being a clinical practitioner. Furthermore, clinicians may often occupy a position of 'expert' providing expert opinion; itself a form of evidence (see the hierarchy above). The research thus starts to explore how, in the real-world environment, evidence will be used, and indeed whether the CCG clinicians, as experts, maintain the ordering of the evidence hierarchy.

The presence of local clinicians in shaping strategic decision-making may improve the creation of public value and improve the use of evidence. It may, however, have to be balanced against the potential conflicts of interest. For example, the National Audit Office (2015) paper identifies potential conflicts of interest present within GPs in CCGs: such conflicts may then offset the benefits gained by their clinical expertise. As, discussed above, the importance of an expert opinion may become distorted due to conflicts of interest, external influences, and the position of CCG leaders within the decision-making process.

A test for clinical commissioning in its CCG incarnation is also whether placing the responsibility largely with one clinical sub-set, General Practitioners, is the best form to achieve clinically informed service planning, design, and reconfiguration. Although very much in the spirit of the Lansley reforms of empowering family doctors (Department of Health 2010), there appears to be little evidence, other than the fundholding experience of the 1990s (Webster 2002), that GPs are necessarily the right clinicians to decide on resource allocation. Fundholding itself was a test of GPs directing resource to best effect and had limited evaluation (Kay 2002). Furthermore, there was no test of whether GPs would be any better at resource allocation and commissioning than other clinical groups. In this context there is a further assessment of whether, if the NHS wants to establish clinical leadership, its current configuration of this mainly sitting with GPs is the right approach. For the practitioner there is the question of whether this configuration is the best model to support optimal decision-making.

The GP clinical leaders on CCGs may legitimately be seen as clinical experts: they may not, necessarily, also be seen as 'experts' in the process of healthcare commissioning or strategic management. As such there may be a danger of GPs mistaking their experience and knowledge in clinical practice for expertise in strategic healthcare commissioning. That is not to say GPs may not be expert commissioners: but rather that training as a medical practitioner may not automatically allow an individual to perform as an expert in healthcare strategy and resource allocation.

A practical problem for the researcher, thus, being how to maximize the benefit of clinical input into strategic commissioning without the impact of potentially distorting affects. In such cases, the senior executive may need to assess whether their role is: to facilitate clinical decision-making and allow the resident clinical experts to deliver evidential decisions; to encourage the critical evaluation of the locally provided clinical leadership and guide a path that avoids the various potential distortions; or, perhaps,

to promote challenge of the local clinicians and assume they are but one of a range of decision-makers, who even with their clinical background have no special status in a decision process.

For the practicing manager or leader in such a decision process, there may need to be consideration also to the resources allocated to the search for evidence. Where, a hierarchy of evidence is stated, as above, the implication may be that in the absence of the higher quality levels of evidence substitution with lower levels will necessarily be adequate. Thus, where few or no published studies exist, expert opinion may be considered sufficient. For the practitioner, consideration may be given to whether the process may need to explore and generate further higher quality evidence, if this may improve the ultimate quality of decision-making. Against this, inevitably, will be the balancing need to make decisions against corporate timescales to achieve time-limited objectives, a further potentially distorting factor in any process.

CCGs are in 2018 responsible for the majority of NHS commissioning spend: funding a range of services, including most hospital and community care, mental health services, urgent care and ambulance services. Commissioning organizations do not deliver healthcare, they commission it: a sophisticated form of purchasing from a range of providers. Thus, whilst provider organizations will spend a significant amount of time managing operational issues of care delivery, including staff and buildings, commissioners are spared most of such responsibility. But they do have responsibility for deciding on healthcare strategy and decisions of how to spend, increasingly scarce, public sector resources on healthcare. The present NHS operates in an environment of financial challenge (Appleby et al. 2009). Although the financial resources may be restricted, the public expectation regarding access to high-quality healthcare will almost certainly continue to increase (Appleby 2009). Thus, the decisions on how to spend scarce funds will be increasingly important.

The thesis explores the process of strategic decision-making by commissioners. Although all statutory NHS bodies will have something called a strategy, it is often felt that the forces influencing decision-making have a more significant impact on the decisions taken than the formal strategy itself. It may even be questioned whether a CCG in the current NHS can have its own strategy, in terms of a directional statement broadly within its own control.

Discussions on decision-making when it is easy are, predictably, easy. But complex decision, such as how to commission a new urgent care service, involving services that span different care elements (primary care, secondary care, social care) and different organizations (both public and private sector) are difficult. Decision-makers may expect an orderly walk through a decision process, including a rigorous assessment of the evidence base, aligned to corporate strategy, with a defined outcome at the end. But it often doesn’t go that way.

Is the difficulty level a necessary part of the commissioning business? Or is it exacerbated by an inadequate use of evidence-based approaches, or an inadequate

use of strategic thinking? Importantly, how do the people making decisions behave and interact and how do these relationships shape the decision outcomes? The aim of the research was to explore the area of NHS strategic commissioning decision-making.

Strategic context and organizational strategy

(A more general, overall history of the NHS as an institution, supplemented by analysis of the financial history of the NHS is provided as supplementary information as Appendices 2 and 3. As current strategic decisions in the NHS will inevitably have a financial dimension, particularly in an age of austerity, this is felt to provide important wider background information for a general audience.)

The decision underpinning the case study emerged in mid 2015 just after the General Election of May 2015. The research was conducted within a CCG during 2015. The CCG was one of the smaller CCGs covering a patient population of approximately 130,000 people, registered with 15 different General Practitioner (GP) surgeries across the CCG area. CCGs are ‘membership bodies’ accountable to the GP practices within their own locality. From the introduction of the 2012 Health and Social Care Act (Great Britain 2012) all GP practices are required to belong to a CCG. The CCG locality was broadly split across two main areas: a largely urban area of a seaside town (Ellerton), with some wards of high socio-economic deprivation; and a geographically dispersed rural area (Nortondale) with a central point of a market town (Notlam). Ellerton contained a District General Hospital providing a range of acute hospital services run by a large NHS Foundation Trust based in a neighbouring city. Ellerton also had an inpatient Mental Health unit. The Ellerton population of approximately 100,000 is geographically remote from other large urban areas and provides a challenge to service providers due to its distance from other major units (for example other Accident and Emergency departments). Due this geographical distance from other areas its population is considered to aspire for as many services as possible to be provided locally. (Transport to other centres being considered poor by some of the population.) The Nortondale population, whilst rurally remote, is often closer to other larger centres than Ellerton. Both Ellerton and Nortondale are within the boundary of a large shire Local Authority (South Ridingshire). South Ridingshire includes a number of more prosperous areas with less deprivation than Ellerton, and the most deprived wards in the council lie in Ellerton district. Both Ellerton and Nortondale have experienced difficulties in securing social care providers and, like the local NHS providers (hospitals and GP surgeries), recruiting appropriately trained staff to work in the care sector is seen as a significant challenge.

The CCG was established in 2013. Prior to this the Ellerton and Nortondale areas were part of a much larger Primary Care Trust (PCT) that covered South Ridingshire and a small city authority. The PCT has experienced financial difficulties and was also perceived by GPs in Ellerton and Nortondale to be more focussed on the other parts of the county (where the PCT headquarters were based). The emergence of the 2010

white paper and development of CCGs had promoted a greater focus on local clinical leadership and encouraged GPs in the CCG area to work together to establish a more locally focussed commissioning body covering the two adjacent areas. The CCG operated in shadow form in 2012-13 before going live as a statutory body in 2013.

The CCG achieved its financial targets in the two preceding years up to the time of the case study and were predicting (and secured) achievement of financial targets in the 2015-16 year. As of the financial year of 2015-16 the CCG had a commissioning budget of circa £165 million for its 130,000 population. The CCG had a mixed performance across a number of NHS performance measures, demonstrating significant improvement in some areas, particularly that of Mental Health. A consistent area of performance pressure from the start of the CCG was that of emergency hospital admissions and achievement of the A&E Emergency Care Standard (ECS) of patients waiting no longer than four hours for treatment or admission. The difficulties around emergency care were considered in the CCG to stem, in part, from an inadequate provision and quality of 'community services': those provided in patients own homes in collaboration with GPs and social services. Consequently, the improvement of community-based services formed part of the CCG's overall strategy and was one of its stated three strategic objectives, that of strengthening and integrated home-based care.

Case study decision-making subject

The subject of the case study related to the issue of future commissioning of community healthcare services for the Clinical Commissioning Group (CCG) locality. The clinical services contained within the commissioned service lines included: Community Nursing; Community Therapy; one Community Hospital (in Notlam); a range of specialist nursing services; and certain specialist out of hospital services such as Podiatry. The total potential financial value of the services under consideration equated to approximately £12 million across two main contracts, both with NHS Foundation Trusts. The local Foundation Trust (FT) ran the majority of these community services (with a value of £10m) in addition to managing the Ellerton District Hospital. The other FT was based remotely from Ellerton but provided a range of services across South Ridingshire.

The community services had previously been provided by the PCT. As stated above the PCT had been financially challenged throughout its lifetime and was considered not to have invested heavily in its community services, in part as financial savings and 'slippage' (inadvertent cost reduction through delayed investment) supported the PCT's financial position. The services transferred from the PCT to the FT under an initiative started in the latter part of the Labour administration (1997-2010), subsequently completed in the early part of the Coalition government (2010-2015). This initiative was named Transforming Community Services (TCS). This saw PCTs moving to becoming commissioner only organizations, losing the elements of provider care. (In the case of the PCT in question it ran a number of community and mental

health services.) The speed with which the large-scale transfers were enacted was often facilitated by the use of ‘vertical integration’ moving the community services under the ownership and management of an established NHS acute provider, in this case an established acute FT. The transfer to the local FT included the range of services within the £10m financial envelope and included over 200 members of staff. The summary of the services included within the definition of community healthcare services was:

- Facility-based rehabilitation and intermediate care
- Domiciliary rehabilitation and therapy services, including physiotherapy and occupational therapy.
- District and community nursing services
- Specialist nursing and therapy services (including diabetic specialists, dietitians, and tissue viability specialists)
- Care home in reach support
- Rapid response home based care support
- Bed-based palliative care services
- Case management for patients with long-term health conditions

In addition to this list a further range of services, with a financial value of approximately £2 million was provided by the more remote FT provider, as part of a network of wider countywide service provision (including Podiatry and specialist wheelchair provision). These services were also to be considered as part of the commissioning decision-making.

The case study subject may be considered of strategic importance for wider NHS planning, and thus potentially producing generalizable research conclusions, for two main reasons. Firstly, the services under consideration within the study represented close to 10% of the overall CCG commissioning resource, representing a financially significant commissioning decision. Furthermore, the services were of central importance to the strategic development of healthcare commissioning for the CCG, as indeed such services are to most if not all NHS commissioners. The CCG, as with the NHS, had a direction of moving more healthcare out of acute hospital provision and into care in community setting, sometimes described as ‘care closer to home’. For such transfer to be effective the services outside of hospital need to be of sufficient capacity and quality. Although the range of care provision will include that of primary care (most obviously General Practice) and social care (as commissioned by Local Authorities) it will also involve community healthcare services: such as those considered in the case study. This objective of more community-based care was considered to be an opportunity to both reduce wider system costs (by avoiding some patients using expensive hospital-based care) and to improve system performance (by, for example, reducing the burden of patient using A&E).

Secondly, the possibility of the use of open market procurement provided an example of how NHS organizations (and the wider public sector) may respond to future re-provision of services. The publication of the Coalition Government’s white paper in

2010 (Department of Health 2010) signalled a central policy with a greater emphasis on the use of competition in healthcare. Although subsequent translation of the political direction into actual policy resulted in a more ambiguous assessment of 'competition' (for example, the NHS England Five Year Forward View (5YFV) does not explicitly mention competition at all) there remained a likelihood that where services need re-provision, tendering would be considered. One factor supporting the use of tendering being the aforementioned political direction to competition; another being the possibility that NHS commissioners may be able to respond to the 'age of austerity' through using tenders to drive down cost. In the previous financial year, the CCG had successfully run an open market tender for its Urgent Care services (including GP Out of hours services, GP Walk-in centre, and a Minor Injury Unit). The tendered service was operational from April 2015, immediately before the start of the case study.

The decision facing the CCG in the case study may be considered representative of similar challenges facing other NHS and public sector bodies. Three strategic dimensions may be considered applicable to other organizations: firstly, how to improve the quality of services considered to be performing less than optimally; secondly, how to change services to support a move to achieve care closer to home; and thirdly, whether to use competition through open market procurement to achieve strategic objectives (particularly in the age of austerity).

The task facing the CCG was that of deciding what to do with this group of services in support of achieving its strategic objectives. This required an assessment of the quality and performance of the current services. Where their performance may be considered insufficient, the CCG would then to need to decide how it would improve them in support of its broader aim of transforming out of hospital services to achieve its corporate objectives. In one sense this decision is a strategic decision primarily concerned with the *implementation* of a strategic objective, rather the development of a strategy itself.

The decision-makers and the decision-making bodies

The CCG governance structure provides a committee system with decision-making responsibilities. The bodies involved in decision-making in this case study were:

- Governing Body.
- Business Committee.
- Ad hoc project meetings for community commissioning.

The Governing Body (GB) is the CCG's overarching leading body and is, therefore, ultimately responsible for its major decisions. It is analogous to other leading decision-making committees such as school Governing Bodies and limited company (or FT) Boards. The GB is a formal requirement of a CCG and has defined requirements as to its membership (essentially the same as the membership profile described below). Although CCG Governing Bodies across the NHS have a varied composition, all include a number of GPs: in the case study there were 6 GPs (one being the Chair). With the Chief Nurse and a Hospital Doctor (not from a local hospital provider) this

made a clinical majority of voting members (8-5). The GB includes positions with particular responsibilities: specifically, that of the Chief Officer whose responsibilities include those of being the CCG's Accountable Officer (accountable to NHS England and the Secretary of State for Health) and the Chief Finance Officer (executive lead for financial matters, including responsibility for financial audit and reporting.) In addition to the clinical and executive members the Governing Body included two lay members: one with responsibility for patient engagement, one for audit and governance. Although nominally the lay members provided a non-executive function, in practice both individuals in the case study were quite active participants in other CCG committees and work patterns. Thus, the distinction between executive and non-executive was not always clear. This may be a strength of the CCG, as Beaver et al. (2007) cite research concluding that active board involvement in areas such as developing strategy tends to lead to higher corporate performance. Beaver et al. (2007) further suggest there are three models for corporate boards: rubber stamp (signing off with little challenge the strategy and actions of the executive team); watchdog (actively supervising the performance delivery of the organization and the executive team); and leadership (the whole board actively participating in developing and implementing strategy). The Governing Body in Ellerton and Nortondale appears to conform most closely with Beaver's leadership model, possibly helped by the mature relationships between its membership.

The Governing Body holds its formal meetings in public, with agenda and papers published on its website and made available in local libraries. The public forum and primacy within the governance structure may contribute towards the Governing Body meetings feeling relatively formal, structured, and a little rehearsed. There is typically little free-flowing debate and controversial issues tend to be discussed beforehand to avoid major public disagreements within meetings.

The Business Committee is a formal committee of the Governing Body, which although subservient to it, has delegated responsibilities that allow it to act with a degree of autonomy. Its membership includes most of the Governing Body in addition to a number of senior CCG officers. The meetings are held in private, although the meetings minutes are potentially releasable to the public through the Freedom of Information Act (FOI). The private nature of the session and its less structured format may explain the more free-flowing nature of debate often seen in the committee. The Business Committee includes the members of the Governing Body minus the lay members who are not formally part of the committee, although they frequently have attended sessions for information or to participate in discussion.

In addition to the Governing Body members the process included significant involvement from a number of CCG officers:

- Project manager for the subject of the study
- Assistant Director for Commissioning
- Head of Service Improvement
- Deputy Chief Finance Officer

Prior to the decision by the Governing Body the CCG established a project team. Consistent with project management methodologies, such as PRINCE 2, major projects or programmes often establish a separation of powers between project teams (entrusted with the actions to deliver a project) and project boards (given ultimate responsibility for major decisions and accountable for their consequences).

3 formal committees within the CCG organizational architecture were involved in the decision-making process. Such committees will, however, rarely be the only forums for debate in strategic decisions. In addition to the formal committees, process will create ad-hoc meetings to discuss specific issues (sometimes titled as 'task and finish groups'). Furthermore, Governing Body members and officers will meet and discuss issues outside of formal structures. Thus, the described meeting hierarchy seen here may be typical for such decisions:

Governing Body Formal organizational committee required by terms of authorisation Meetings held in public, meeting papers published prior to the meeting Significant or controversial agenda items may promote attendance at meetings and subsequent reporting by journalists Formal nature tends to produce an atmosphere of structured discussion
Business Committee Formal organizational committee, but not required by authorisation Decision making authority determined by the CCG scheme of delegation (very significant decisions may need to be referred to the Governing Body for approval) Meetings held in private but fully recorded and minutes releasable under the Freedom of Information Act (FOI) Private meeting allowed less formal discussion and potentially more 'open' contributions by participants
Ad-hoc subject specific meeting Not a standing committee and not required by authorisation Usually not defined decision-making authority, decisions require approval by a formal committee Meeting held in private and, as typical, recorded but as 'action points' with less detail than formal minutes Meetings more free-flowing and had wide-ranging debate and greater use of humour
Informal conversation Not recognised as a formal meeting No defined decision-making authority

Meetings entirely private Debate may be very wide, possibly informal, possibly introduction of wider issues Lack of formal reporting or scheduling of discussion makes auditing of the influence of such meetings difficult.

The Governing Body agenda is the responsibility of the Chair and Chief Officer, administered by CCG officers. In practice the full-time Chief Officer may discuss the agenda with the Chair, but then have ultimate practical control over the agenda (here *control* as distinct from *responsibility).* The formal hierarchy suggests that the Governing Body agree and apparently dictate the shape and agendas of the process and thus all lower authority bodies. In practice the Governing Body will set a general direction, but there is flexibility for distinct decision on agenda setting within this framework. Ultimately strategic decisions will need to be made (even if just ratification) through the formal Governing Body, thus there is little point in lower order meetings varying too far from the original senior brief. The interpretation and implementation of the original instruction does, however, become more subject to individual assessment. This may show that power and influence of certain subjects within the decision-making process does vary, in part due to their level of *presence* in the process. Presence here is both physical (were the individuals actually there in meetings and discussions) and how their known views and influence were felt and considered by others when they were not physically present.

The CCG Governing Body membership had been very consistent throughout its short history. All the 13 members at the time of the study had been in place since the start of the CCG as a statutory body in 2013, with all but the Hospital Doctor also in post during the shadow year of CCG operation in 2012-13. Thus, the Governing Body was considered to have mature working relationships.

Original contribution to knowledge

The thesis provides an original contribution to knowledge in four ways: the role of the researcher; the place of research; the nature of study into the negotiated order; and the contribution to improving management practice.

Although there are examples of participant observers within the research literature of ethnography, there may be few that have conducted by the lead executive in an organization (Ram 1994 being a possible exception). The place of an organizational leader as a participant observer within a form of ethnography provides a possibly unique insight into organizational behaviour and management decision-making. This position provides a significant level of organizational access, but also provides an unusual insight, particularly from the perspective of reflexivity (see more below). Hammersley (1995) is positive about the potential benefits of the participant researcher within social science. This study may be the first conducted by an embedded participant observer working at a senior executive level in the NHS.

At the time of conducting the study there was no research investigating the actual decision-making functioning of CCGs. Checkland (2013) looks at the accountability systems in CCGs but not their actual functioning. McDermott (2017) studied the role of GPs in CCGs but did not look in detail at management practice. Even more so this study was a broad assessment of several CCGs and not the 'narrow and deep' research design of this thesis. The design of the thesis, in focusing on strategic decision-making, is considered to be unique, with the level of access to the internal workings of an NHS organization as highly unusual (probably unique at this time). Thus, this provides an original contribution to knowledge in exploring how part of the reformed NHS goes about the business of making major decisions. This exploration includes the functioning of clinical leadership in the decision-making process, testing the assumptions underlying the NHS reforms that clinical decision-makers would add greater value to commissioning.

The third element of the originality is what is considered to be a novel study of power relations and the negotiated order at board level. Many of the studies such as Strauss (1963) examine the order in the day to day workings of organizations. This thesis, by contrast, explores the concept of the negotiated order in a senior decision-making body, with a group of participants that do not work together in a daily, operational environment. Research summarised in Beaver et al. (2007) describes power relations and its impact on the functioning of boards, but at a more general level, without the specific focus of a major decision. Thus, this may be a unique contribution to knowledge in the researching strategic decision-making from the negotiated order perspective. This is a contribution to knowledge in being a twenty-first century and executive management level development of Strauss (1963) and an ethnographic introduction of negotiated order research into an organization at board level.

The author considers the results of the research are potentially generalizable to CCGs throughout the NHS; probably generalizable to other top management teams in the public sector (NHS provider boards and Health and Wellbeing Boards, for example), and of relevance to the functioning and behaviour of any corporate body involved in strategic decision-making. Consequently, the fourth element of the contribution to knowledge is that of deepening the understanding management practice and how board level decision-making in the NHS and elsewhere may be improved.

Tolstoy, the battlefield, and me

In his *War and Peace*, set during the Napoleonic war, Tolstoy's lead characters sit high above the field of conflict, "among the field guns on the brow of the hill, the general in command of the rearguard stood with a staff officer, scanning the country through his field glasses" (Tolstoy 1993, p.146). This is, of course, only one perspective of the action unfolding. A different scan from another hill may be subtlety different. The potentially dramatically different perspective, however, may be provided from that of the soldier at the front line[4]. But both perspectives are real views of the process of battle, both equally deserving. John Keegan, the military historian considers both

perspectives: The Mask of Command (Keegan 1999) on the role of the general; that of the soldier in The Face of Battle (Keegan 1988).

This counter-position and duality illuminates the position of the researcher in this project. Thus, I am not just an NHS Chief Officer: I am the CEO of the organization being researched. I am therefore, part researcher, part element of the thing studied. This is simultaneously, novel (possibly unique in its setting), interesting, dynamic, problematic, and challenging. After securing the necessary consent and permissions to conduct the research, my position gave me an unusual position to undertake an ethnography of the type described below. It is extremely rare for management figures in a central leadership position within a project to undertake such research. Indeed, the researcher could find little equivalent published research (Ram 1994 in the textile industry perhaps the closest). The position provides a high level of insight into the organization and some of its history and allows a dynamic analysis of the research data through providing a reflexive dimension (see Winter 1989). Despite its positives, however, it was recognised that the very nature of the 'view from the battlefield' challenged the objectivity of the project, demanding a transparent approach to research methodology and acknowledgement of potential biases. Furthermore, the project required protection of those involved to satisfy the ethical framework, through the anonymization of those involved. Thus, further steps may be required to preserve anonymity in considering publication. Despite these challenges, the need to be explicit and transparent as to the role and place of the researcher may be helpful. The researcher is not merely an observer, but rather a part of the research that they themselves conduct. In this vein Finlay (2002, p.531) quotes Krieger's comments on researcher reflexivity, that: "The pot carries its maker's thoughts, feelings, and spirit. To overlook this fact is to miss a crucial truth, whether in clay, story, or science."

One important lesson from the project is the benefit of management learning through research, and the belief from the researcher that such exercises are actually of great benefit those conducting the research as well as the wider body of organizational and management knowledge. Moreover, as a researcher and a practicing manager I would wholeheartedly agree with Winter's (1989) statement, "the process of learning must start from reflection upon one's own experience"[5]. In this respect, as a professional manager, I am more comfortable in the middle of the battlefield than as a remote general or detached researcher; however, in choosing to take on the role of researcher I must do both.

Although no Tolstoy scholar, but echoing Winter and the lifelong learning from life itself, I may conclude the introduction with some words from Tolstoy himself, to remind me to keep acting, failing, thinking, and learning:

> No matter how old or how sick you are, how much or little you have done, your business in life not only hasn't finished, but hasn't yet received its final, decisive meaning until your very last breath (Tolstoy quoted in Kaufman 2015, p.10)

Structure of the document

The thesis has the following chapters:

- Chapter 1 presents the thesis and its research objectives.
- Chapter 2 provides the review of the research and theoretical literature on the areas relating to the research subject. This is broken down into several sub-sections:
    - An introduction to the concept of organizational strategy, as although the research is not into strategy per se, it was felt necessary to define strategy before introducing the literature on strategic decision-making. This will cover strategy in both private and public sector contexts.
    - A summary of texts on decision-making generally and specifically strategic decision-making in organizations. This includes organizational decision-making models as applied to strategic decision-making research.
    - Introducing the concept of the negotiated order in organizations and how this relates to group behaviour and group decision-making. This chapter also reviews literature on the behaviour and cultures of NHS boards (their upper-echelon bodies).
    - A brief description of what is commissioning in the NHS and public sector and how this relates to wider issues of strategy and national policy. This defines the specific form of the corporate environment of the case study organization.
    - Lastly the literature on cognitive frames, how they influence behaviour. The framing environment is described as at three levels and this leads into the categorisation of the hypothesised influences on the decision-making process. This leads on to the development of a conceptual framework for the subsequent research.
- Chapter 3 summarises the research strategy and its supporting methodology. It describes how the research data was generated and the tools used, such as qualitative data coding, to analyse the data.
- Chapter 4 Explores the generated data and the approach to analysis, describing the codes emerging from the analysis.
- Chapter 5 provides a detailed of the observed management meetings and themes emerging from the process, including assessment of the management materials seen in the case study.
- Chapter 6 details the analysis of the research data both that from the management meetings and triangulated with the qualitative interview data. This chapter explores the influences that emerge from the data and how they appear within the perspective of the conceptual framework.
- Chapter 7 interprets the analysed research data and develops theoretical perspectives with the aim of establishing plausible causal mechanisms to

explain the outcomes of the case study. The perspectives are synthesised into a single explanatory social power model.

- Chapter 8 describes what are considered to be the significant implications for management practice in the NHS and wider management, that emerge from the project.
- Chapter 9 concludes the thesis with a summation of the research findings, implications, and its contribution to knowledge. The researcher proposes areas for further research and provides a final reflexive view of the research project as seen by the participant researcher.

Chapter 2 - Literature Review

2.1 Introduction

In assessing how we improve strategic commissioning decision-making in healthcare it may be useful to return to first principles. Thus, in the working life of a commissioner one may ask: what is it we are commissioning for, towards what goals and objectives, with which groups of people and partners, and using what systems and processes. This section examines published literature in the area of strategic decision-making in response to addressing the research question:

> ***What are the factors that influence strategic decisions in healthcare commissioning: a negotiated order perspective?***

The literature review addresses the areas of previous research that inform the analysis of the research data and assist in answering the research question. Specifically, the review covers the major areas: healthcare commissioning; strategic decision-making; the concept of the negotiated order in the organizational sociology; and the concept of cognitive frames and how they apply in the research.

The research occurred as a case study in an NHS commissioning organization and thus it is necessary to summarise the process of commissioning in the NHS and wider public sector. Appendix 1 provides a review of comparative commissioning of different healthcare systems that is not directly relevant to the research but provides wider context as to the role and types of commissioning and resource allocation.

The decision subject was considered to be of strategic importance to the organization in question. Thus, the review needs to define strategic decision-making and describe the literature on models of decision-making more broadly. As a foundation to define and understand strategic decision-making, the review will also discuss the concept of strategy itself, before then focussing on strategic decision-making relevant to the research topic in question. The consideration of strategy includes differentiation between the role of strategy in the private and public sectors and how this may apply in the case study.

The literature on decision-making is very large: consequently, the review will provide an overview into decision-making generally, but with a focus on the research relating to organizational and management decision-making. Although much of the literature on decision-making focusses on individual behaviour, this does provide a necessary basis for consideration of decision-making behaviour more generally. The analysis of group decision-making is also considered important both in terms of understanding the decision in the case study, but also in relation to decision-making and the group dynamics of organizational behaviour.

The review will discuss the concept of negotiated order and associated concepts that fall within analysis of organizational sociology. This will be further refined into the analysis of specifically ethnographic board level studies, and any that focus particularly on the decision-making process. Between the analysis of groups and the analysis of

decision-making there is a need to explore studies that cross over both: that is the study of group decisions. Again, the focus will be on organizational decision-making.

It is considered that an important element of understanding organizational social relations and the concept of the negotiated order is the use of cognitive frames. Thus, from the analysis of literature on negotiated order the review concludes with discussion on the use of cognitive frames and how this then shapes the conceptual framework used in the project.

The themes link together to provide a framework in support of the research strategy. Furthermore, the themes of the review are considered to explore the main dynamics of the decision-making processes at work in a CCG.

The content structure of the review is as below:

i. What is strategy, including strategy in a real-world context? This will cover the overarching concepts of strategy, commonly cited models and theories, and a comparison of the role of strategy in the private and public sector contexts.

ii. What is a decision and what is a strategic decision? This section summarises theories of decision-making, including researched challenges to decision-making efficiency. It Includes a review of decision-making models in organizations and the definition of a strategic decision.

iii. Exploring the concept of the negotiated order as an analytical tool and describing research into decision-making in groups. This Includes the concept of the organization as a coalition and the how this applies to the negotiated order.

iv. What is commissioning and healthcare commissioning? Including a review of policy approaches to healthcare and public sector commissioning. A summary of different policy approaches to NHS commissioning is describes demonstrating its relation to political policy influence.

v. The review concludes with analysis of cognitive frames and how they enable the project to stratify the differing levels of influence present upon decision-makers. The literature review ends with the development of the research project's conceptual framework. (The framework is developed further within the research methodology in chapter 3.)

2.2 What is strategy?

Not just any old plan

After yet another request for a 'plan' or a 'programme document' or more often and more grandly, a 'strategy' the researcher in his professional life often yearns for the approach of Karl Weick (2001). Weick is a thought-provoking writer on organizations, including apparently contrarian views on strategy: for example, approvingly quoting definitions of strategy from de Bono, "strategy is good luck rationalized in hindsight" (Weick 2001, p.345), and Burgelman, "strategy is a theory about the reasons for past and current success of the firm" (Weick 2001, p.345). Tired of churning out yet another strategy document there have been times when the researcher yearned for this almost anarchic, postmodern approach to strategy. But back in the rationalism of the real world, the romanticism of the wild-eyed anarchist may start to lose its shine. Particularly if you get lost.

Weick (2001) recounts a tale of soldiers lost on a mission in the Alps, who find their way home thanks to a map found in one of the soldier's pockets. On debriefing with the commanding officer, it emerges the map is not actually one of the Alps, but the Pyrenees. Weick's conclusion is that when one is lost, "any old map will do" (Weick 2001, p.346) and by extension any strategic plan may do. The legitimate points are thus: that in some cases action without a clear plan may be better than inaction; and belief in a plan can be as important as the validity of the plan itself.

This does not, however, invalidate 'strategic planning': the very usefulness of the map is its evident accuracy. Its subsequently discovered inauthenticity has no bearing on the outcome. Indeed, a discovery of inauthenticity at the outset would have yielded it as useless, not as practice confirmed, useful. Furthermore, Gelman and Basboll (2014) criticize Weick's lack of empirical evidence for the narrative, suggesting it is story supported by at best anecdotal evidence. They also point to the possibly obvious benefits of factually accurate maps, "When traveling in central London, for example, we can only assume he [Weick] would prefer the classic Tube map rather than, say, a plan of the Paris Metro" (Gelman and Basboll 2014, p.565). Thus, in its strategic decision-making the CCG needs to avoid getting on the wrong train.

Introduction

If the research is exploring the influences on strategic decision-making, then a precursor to the exploration is to assess the concept of strategy itself. The research is not into the development of strategy in the CCG and consequently this is not an extended discussion of corporate strategy (as for example, provided in a comprehensive overview such as Johnson et al. 2005). It does necessitate, however, a consideration to the concept of strategy in the corporate world and how this may apply to the public sector and a CCG. This will inform the assessment of influences on the CCG and of what type of strategic decision the study is researching. The chapter will discuss:

- The definition and origins of strategy as concept and its application to organizations
- Approaches to strategy as described in the literature
- How the concept of strategy applies to public sector bodies such as CCGs

Definitions and origins

In the corporate environment the word strategy is often used but rarely defined. Its ubiquity may promote its ambiguity. But the evident ambiguity may reflect not merely a lack of clarity on its use, but also the complex nature of strategy as a management concept. Thus, we may start with the Johnson et al. (2005) description of strategy as:

> …the direction and scope of an organisation over the long term, which achieves advantage in a changing environment through its configuration of resources and competences with the aim of fulfilling stakeholder expectations. (Johnson et al. 2005, p. 9)

This would appear to be a mainstream definition and one that is consistent with much of the published thinking on planning and 'strategy' within the NHS. However, further research and analysis into strategy develops the concepts not merely as a definition of a term, but also a description of management practice. Before exploring the current definitions and approaches to strategy, it may be helpful to explore the origins of the term and its emergence into a management concept.

Evered (1983) discusses the origins of the term *strategy*. The word originates from the Greek *strategos*, meaning a general of an army, the word itself derived from *stratos*, meaning army, and *ag*, meaning to lead. Evered's (1983) investigations reveal the emergence of the *strategos* was accompanied by the roles of the *strategos* as administrative as well as military rulers.

Much of the subsequent literature on strategy up until after World War 2 (WW2) was military in nature. Classic authors who shaped strategic thinking being von Clausewitz (1976) and Liddell-Hart (1991): their thinking reflecting not merely an interest in battle plans and weaponry, but a desire to establish a deep understanding of resource allocation, psychology, and the moral purposes of the exercises at hand. (Quoted in Liddell-Hart (1991, p. 4) Napoleon's dictum, "the moral is to the physical as three to one", may be an early advocate of a value-based approach to strategy?)

The emergence of strategy as a management term may not have a clearly defined start, but a classic and commonly cited text, which may herald the emergence of strategy as a field of study as well as a practice, is from Ansoff (1965). This describes strategy as a form of long-term planning. Such a view may be seen as the modern foundation for the concept of corporate strategy. Some authors (Mintzberg 2007) may contend that the long-term planning approach to strategy is in part divergent from some of the military considerations on strategy. Thus, through the literature on strategy over the last 50 years there have been attempts to both develop strategy as an area of management practice and to define it as a concept.

Strategy as a management concept

Mintzberg et al. (2009) describe strategic approaches along a deliberate (intentional) to emergent axis. Thus, the classical approach to strategy of an intentional plan can be contrasted with the more modern emergent approach of strategy as a consistently evident pattern. The axis is illustrated in the diagram below.

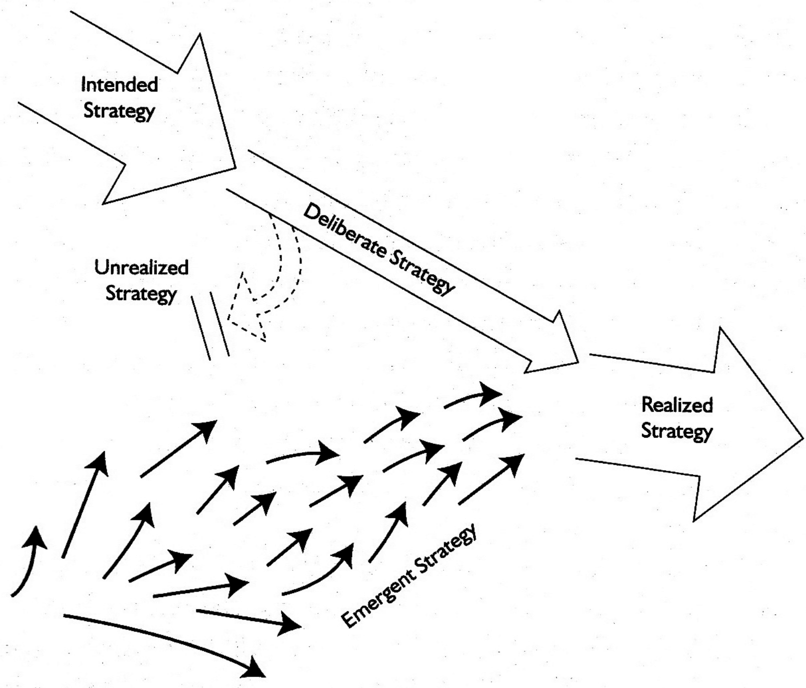


Figure 2 - Mintzberg's strategic relationship of intention and emergence (from Mintzberg 2009)

However, there is separation between the dimensions of strategy type and organizational type: the suggestion being that the organizational type will influence the type of strategy. Furthermore, there is a distinction identified in Mintzberg (2007) between strategic thinking and strategic planning. The former being primarily concerned with the generation of direction, superordinate corporate objectives and higher-level values: the latter with the detailed planning to implement an already agreed (implicitly or explicitly) set of objectives and direction. Consequently, there is an implication that these two types of 'strategy' may at times be mutually exclusive: detailed analytical thinking crowding out the intellectual space for more expansive, less defined creative thinking. Thus, 'analysis is not synthesis': the detailed separation of corporate elements (analysis) supports strategic planning, but works against the task of integrating, fusing, and conceptualizing corporate dimensions (synthesis). In a similar vein Miller (1992) describes the relationships between different types (internal and external) of corporate 'fit'. Organizations most able to adapt to a changing external environment (good external fit) may have less internal consistency and strong corporate process. The different types of fit are seen as trade-offs between each other, not as complementary dimensions of one strategy.

The views of authors such as Mintzberg and Miller may in part reflect their proclivity towards more emergent strategic themes. Thus, in what may be seen as more intentional and less emergent approaches, for example, Porter (1984) or Rumelt (2012), there is no suggestion the strategic approaches described involve any less 'thinking'. Furthermore, Mintzberg et al. (2009) and Miller (1982) imply a need for multi-dimensional approaches to strategy (in some works this may be represented as a *configuration* approach). Whilst the approach appears to have merit, it does not appear to avoid the need for some form of intention, and indeed some form of strategic plan.

Porter is one of the most widely cited authors on corporate strategy (Ramos-Rodriguez and Ruiz-Navarro 2004). Focussed on private rather than public sector bodies Porter (1985) describes three approaches to strategy: cost leadership; differentiation; and focus. The three approaches are developed from the five forces determining profitability (Porter 2008):

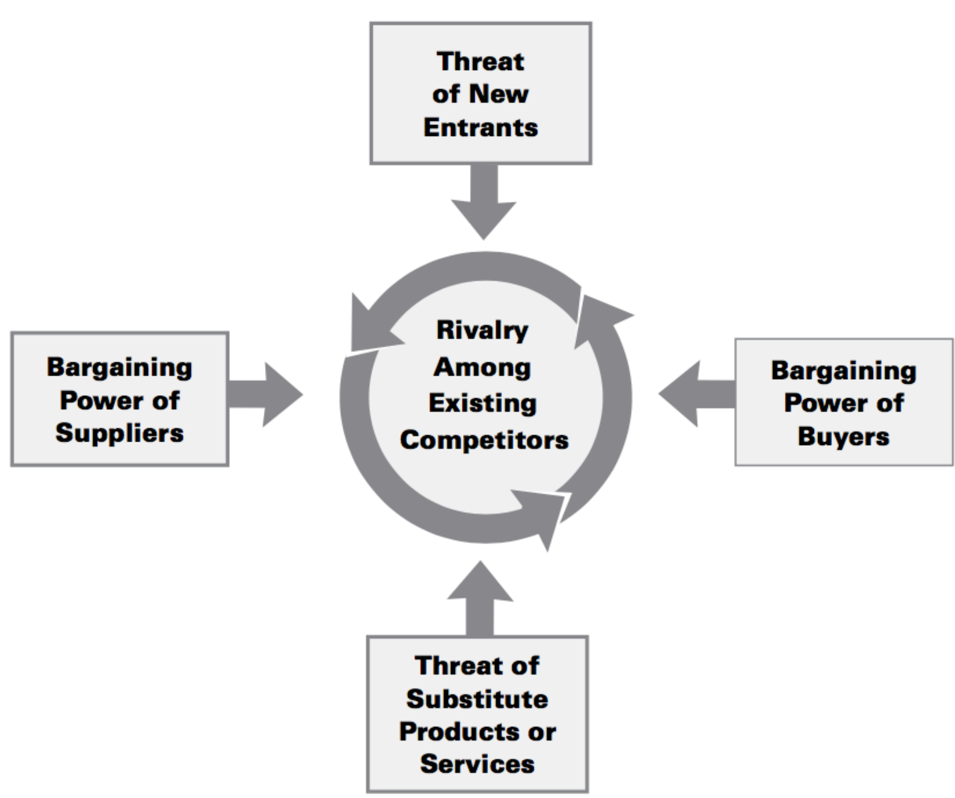


Figure 3 - Porter's (2008) forces shaping competition

The forces are considered to vary from industry to industry and may be seen to have less relevance to public sector bodies, although as Porter states the forces define industry profitability, a similar force analysis may be applied to public bodies. Thus, the three approaches may be summarised as (from Porter 2005):

- Cost leadership is a strategy for a firm to become the lowest cost provider in an industry. Ways in which companies may seek to establish cost leadership may vary (access to raw materials, economies of scale, use of novel technology).
- For differentiation, companies attempt to become unique in their industry, identifying features a market segment may value and thus may be prepared to pay premium prices.
- Focus is separated into strategies of cost focus and differentiation focus. In focus strategies companies target a small section of a market, seeking either to target the population based on cost, or on product differentiation.

Although Porter describes three generic strategies, there are the two basic dimensions of corporate strategy in the search of competitive advantage: cost management and differentiation (product or market).

Porter’s initial works focussed on companies working in the private sector and, furthermore, on companies deciding which market sector to enter. Even so, in public sector strategies there may be relevance in the statement:

> Competitive strategy must grow out of a sophisticated understanding of the rules of competition that determine an industry's attractiveness. The aim of competitive strategy is to cope with and, ideally, to change those rules in the firm's favour. (Porter 1985, p.4)

The inclusion of the analysis of Porter is justified due to its wide-ranging influence on strategic thinking, including on public sector strategy. The approach may be more applicable to private sector strategy, but to exclude Porter may be to ignore an author who may be one of the sector’s most influential thinkers.

Thus, for a CCG there may be no need to understand the rules of competition; but rather the rules of the public sector and specifically the health sector. Misunderstanding the rules of the CCG environment may lead to poor strategy. Changing the rules may be difficult in a government led service; but interpreting the rules effectively may allow NHS organizations to develop strategies that support national and local objectives.

Mintzberg et al. (2003) list the ‘5 Ps’ of strategy, describing strategy as: plan; ploy; pattern; position; and perspective. There may be beneficial perspectives from all five of the ‘Ps’ in this work, but the dimension of strategy as a ‘plan’ or at least some form of intended approach may inevitably be a fundamental element to a consideration of strategy.

Whittington (2001) provides a 4-element framework of approaches to strategy (Figure 4 below).

- The classical approach sees strategy as planning and direction, with the belief the corporate world can be influenced by direction and intention of the organization. The classical position is considered as rational. Porter (for example, 1996) may be seen as a representative of the classical position.

- The processual approach (for example, Simon 1997) provides an approach that describes a corporate world of limitations, where rationality is *bounded*. Although planning still has a primary place, its impact will be affected by a

number of influences, beyond the control of the strategist. Mintzberg (1994) is both a representative of the approach and a critic of more classical approaches.

- The evolutionary approach suggests the strategic environment is so volatile as to infer there is little point in longer-term planning. Rather corporate strategy has a role in making the organization as efficient and agile as possible to adapt to the changing environment. An example text of the approach is Henderson (1989).
- Lastly is the systemic approach. As with the evolutionary approach, for the systemic the main point of strategy is to align the organization to its environment: but here with the socio-economic and political environment. Examples include Granovetter (1985), and Boyacigiller and Adler (1991).

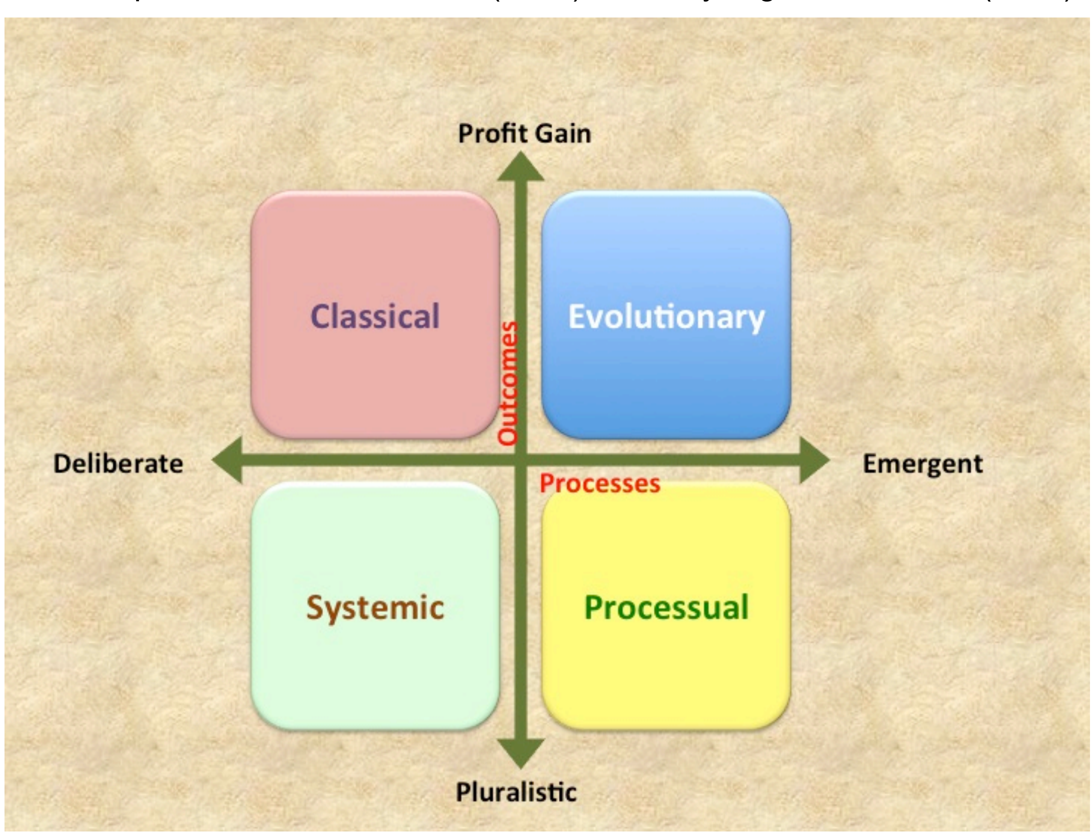


Figure 4 - Adaptation of Whittington's (2001) matrix of strategic approaches

It may be noted that the condensation of strategic thought into these four approaches does require a degree of artificiality. None of the major references for each approach would necessarily only fit neatly into one category and there is a danger of assuming one must subscribe to one view of the world. Whittington (2001) asserts the approaches present radically different management recommendations. But the assertion may not be justified. The Mintzberg et al. (2009) tour through strategic thinking provides ten alternative views, which provides an alternative perspective to Whittington, whilst essentially covering the same scope of strategic thinking.

I. The **Design School** regards strategy formation as a process of conception, matching the internal situation of the organization to the external situation of the environment. The strategy represents the best possible fit.

II. For the **Planning School** strategy formation is seen as a formal process, which follows a rigorous set of steps from analysis of the situation to the development and exploration of various alternative scenarios.
III. In the **Positioning School** influenced by the works of Porter, strategy formation is an analytical process placing the business within the context of the industry that it is working in, looking at how the organization can improve its competitive positioning.
IV. **Entrepreneurial School** regards strategy formation as a visionary process occurring in the mind of a founder or inspirational leader of an organization.
V. The **Cognitive School** is based upon the science of cognitive functioning, seeing strategy formation as a mental process, and analysing the perception of patterns and process of information.
VI. In the case of the **Learning School** strategy formation is an emergent process, where the corporate management pays attention to what works and doesn't work over time, incorporating the 'lessons learned' into an overall plan of action.
VII. For the **Power School** strategy development is seen as a process of negotiation between those holding power inside the organization, or between the company and external agencies.
VIII. The **Cultural School** approach sees strategy as a collective process involving various groups and stakeholders within and outside the company; the strategy consequently developed becomes a reflection of the culture of the organization.
IX. Strategy formation in the **Environmental School** is seen to be a reactive process: a response to the challenges imposed by an external environment.
X. Lastly the **Configuration School,** which sees the purpose of strategy development as a process of transforming the organization from one type of decision-making structure into another.

Few managers may only subscribe to one of these approaches (or descriptions). Mintzberg et al. (2009) suggests an appropriate view of strategy and strategic thinking (as distinct from *strategic planning* (Mintzberg 1994)) is to accept elements from different strategic approaches.

The approaches described by Whittington (2001) and Mintzberg (2003) provide an assessment of strategy as practice, often in retrospect. Whittington (1996) is one author describing 'strategy as practice' as a defined stream of strategic thinking. Although developing its own body of research, 'strategy as practice' appears to focus more on the management task of conducting strategy, than the strategy itself. In some respects, one may associate this approach with the procedural and resource-based views, described below. But in reviewing strategic decisions it may be necessary to describe strategic approaches as intentional and *a priori*. That is, what a strategy aims to be, as much as what it actually becomes.

We may describe strategy in terms of both its approach (fundamentally based on practice and environmental context) and its intention (what it seeks to achieve and its plan to realize the achievement). It may be an over-simplification to describe the separate and possible antagonism between intention and practice as merely another example of Argyris's (1976) 'espoused theory' against 'theory in practice'. Instead it may be seen as a necessary, dialectical tension arising in the organization. Thus, the organization may develop plans and make statements of its intention to achieve, and

of its way of behaving. In one sense, such statements are useful tools of management practice. The utility may be described at three levels. Firstly, the level of corporate direction informing decision taking. Secondly, the level of communication to stakeholders, as to what the organization is about and intends to do. Thirdly, as a means of performance management for others, particularly authorizing bodies, to assess success in achieving corporate objectives. In the UK public sector since the introduction of much greater performance management and target setting, the last element may have particular significance.

The three levels of direction, communication, and validation may help to explain the continued need and relevance for elements of hard planning. Thus, those from 'non-classical' strategy schools may be critical of 'strategic planning' (Mintzberg 1994) but the evident separation of intention from practice may not necessarily remove its usefulness. But neither point vitiates the need for well-developed strategy. Mintzberg's critique of classical strategy is subtle and in the Strategy Safari (Mintzberg et al. 2009) the aim appears to be to provide a more holistic view of strategy as a process.

It may be helpful to recognise strategic approaches that fall somewhere in the middle of the intentional-emergent axis, specifically the processual (or cognitive) approach and the resource-based (alternatively cultural) approaches. They may be briefly summarized as:

- Processual/Cognitive. Deriving much of its knowledge from the work of Simon (1997) and colleagues (for example, Cyert and March 1992), the learning here is primarily that of how organizations work, and the restrictions imposed upon behaviour by the nature and functioning of those organizations. Thus, the main features of this as an approach are to understand how 'administrative behaviour' (Simon 1997) limits both the development and implementation of strategy.
- Resource-based/Cultural. In this approach the strategic direction is less on how to achieve specific goals or establish direction, but more of how to develop and enhance organizational resources (Wernefelt 1984). As such this accepts the need for the organization to be flexible and aware of its environment, with the resources making it able to respond to that environment. Such responding becomes arguably more important than direction setting, as the environment will influence to such a degree as to make directional, intentional strategy difficult or impossible.

Both approaches have been criticized due to a view that although they provide learning and insight that is useful to the strategy process, they are not really strategies at all (for example Johnson et al. 2002). Thus, for the processual approach the learning is fundamentally about how organizations function: for the resource-based approach, how to enhance its ability to function. However, in both cases the analysis is more helpful as explanatory rather than normative assessment. Thus, this section may be concluded by asserting that 'harder' strategic planning of the type described by Porter is beneficial and necessary for public and private sector organizations. Limitations on the effectiveness of intentional planning should be seen as assisting in organizations in being more effective at strategic implementation, developing organizational flexibility

and improving organizational culture. The limitations and boundedness of strategic planning do not, however, invalidate its use.

The case study of the 'Honda Effect' may be instructive. According to different authors from different perspectives (summarised in the California Management Review 1996) the great success of Honda's motorcycle business entry into the USA had different explanations. One, from a BCG review of the decline of the UK motorcycle industry suggesting Honda had a clear strategy to develop and expand in the US market, contrary to the UK where companies had no effective strategy and were very traditional. This allowed Honda to dominate the small bike market before then expanding into the larger vehicles. Pascale's (1984) later study interviewing the Honda managers involved, suggested the development in small bikes was partly accidental, as initially these were only used by managers to ride themselves and were thought to be too small for the US market. As interest in small bikes increased Honda shifted focus to this area, then started to dominate, followed by moving latterly into the larger bike market sector. Thus, the BCG analysis is of a 'design' intentional strategy approach; Pascale's of an 'emergent' or 'process' school. Rumelt (1996) reviewing the various documents written on the case suggests there is truth in both accounts and that despite the apparent difference both accounts agree on that Honda had: superior technical excellence in product design; previous success with small bikes in Japan; and the move into larger bikes happened after the early success. Thus, Rumelt suggests both accounts have some value, but that success was helped by technical competence and an efficient ability to manage costs in production. Interestingly Rumelt (1996, p.110) states he believes, "strategic thinking is a necessary but greatly overrated element of business success"[6]

Thus, it may be concluded by asserting that 'harder' strategic planning of the type described by Porter is beneficial and necessary for public and private sector organizations. Limitations on the effectiveness of intentional planning should be seen as assisting in organizations in being more effective at strategic implementation, developing organizational flexibility and an improved organizational culture. The limitations and boundedness of strategic planning do not, however, invalidate its use.

Approaches to strategy

Miles et al. (1978) approach strategy from the perspective of organizational adaption and assess how strategies develop in the corporate environment. This may assist in looking at strategy as a real-world discipline and also one that does not require aligning with one discreet type (as in one of Whittington's 'approaches' or Mintzberg's 'schools'). Miles et al. (1978) describe organizations needing to address three 'strategic problems': entrepreneurial (what products are developed and brought to the market); engineering (how products get to the market); and administrative (how the organization manages itself to address the two other problems). In addressing the three problems Miles et al. (1978) provide a strategic adaptation typology of four types: defenders; prospectors; analyzers; and reactors. The defender strategy focusses on

market protection, including targeting cost efficiency and customer satisfaction. Prospectors are highly innovative and seek to find new products or new markets. Analyzers take elements from both defender and prospector strategies. Reactors work primarily to adjust to their environment and are seen as perpetually unstable.

Just as Porter (1985) describes three approaches that can be condensed down to two (essentially cost or differentiation) so for Miles et al., the three problems are fundamentally only two. The entrepreneurial problem is what to do; the engineering problem how to do it. The administrative problem is an ever-present part of any strategic issue (that of the implementation and management of actions to achieve strategic ends) and as such should not, arguably, be considered a separate strategic problem. Similarly, rather than treating the Miles et al. (1978) approach as an alternative to Porter (1985) it may be seen as complementary. Boyne and Walker (2004) confirm this assessment of a complementary approach by referring to the Miles et al. (1978) typology as 'strategic stance' (the broad approach) and Porter (1985) as 'strategic actions' (specific steps to take). Thus, competitive advantage strategies require consideration of which industries or markets to work in; the two generic strategies propose choice between cost focus and differentiation focus. From this basis organizations will tend to balance between defender and prospector strategies within their market: thus, all organizations will be 'analyzers' in this respect, just differing apportionment between the two types. (Boyne and Walker (2004) merge the Miles and Porter typologies into a single matrix.) Consequently, schools such as the cognitive and resource-based, rather than strategies in themselves may be best seen as ways of enabling corporate capacity and capability in the delivery of strategic objectives.

The degree to which the 'reactor' type is seen may be largely dependent on the wider corporate context, including the industry or market segment. (Although Miles et al. (1978) suggest the reactor type may be the least successful approach in the private sector.) As in this project the reactor model may be seen as a common strategic behaviour type seen in the public sector, with Boyne and Walker (2004) commenting that political centralization and the role of regulation will increase the likelihood of organizations being reactors. In the current NHS the strong hand of regulation is evident, as in the regulatory role of NHS England on the CCG in the project case study.

Regardless of how emphasis has been provided on more emergent approaches to strategy and of more holistic and less planning styled theories, there appears to remain a need for strategy to always involve an element of planning. Thus, the approaches beyond the classical can be best seen as providing a level of richness and depth to the concept of strategy beyond mere simple planning: but again, they do not invalidate planning as a necessary element. The LTP and SMJ reviews fundamentally validate strategy as a modern management discipline. Within this strategic decision-making should be seen as a strand of this discipline.

The assessment of ‘what is strategy’ is a necessary step before seeking to understand how strategic decision-making occurs in this study. The analysis above allows further assessment of the role of strategy in policy and practice in the public sector.

Strategy in a real-world public sector context

CCG strategic decision-making will not happen in isolation and its context will shape the influences on how decisions are made. As with all strategy, there will be significant environmental influences and public sector organizations may demonstrate different features and experience different pressures to the private sector (Johnson and Scholes 2001, Moore 2000, Nutt and Backoff 1993):

- The corporate goals of public sector bodies may be multiple, vague, and possibly conflicting (Nutt and Backoff 1993). Decision-making may thus become more complex in the absence of a clear overriding corporate objective, such as a financial bottom-line.
- Strategy will need to fit within the authorizing environment, created by political processes (Moore 2000). Long-term direction is less concerned with the longevity and sustainability of the organization as an independent body and more with its relation to the current (and possibly future) political priorities.
- Value may be identified as more important than profit. Moore (2000) describes value as the achievement of social purposes, rather than creating financial revenues. Even against this definition, value may also be more difficult to determine and be subject to political influence. Porter (2010) has defined value as the improvement in health outcomes for every ‘dollar spent’: but this does not necessarily address who agrees the assessment of improvement; which health outcomes matter most; and whose ‘dollars’ are used to fund the care.
- Whereas private sector bodies may receive most or all their income from customer purchases, public and non-for-profit organizations will receive most of their revenue from sources such as taxation funded allocations, or charitable donations (Moore 2000). (Care may be taken not to over-emphasize this distinction as public sector bodies may generate revenue at point of service delivery, for example through individuals paying for pharmaceutical prescriptions in the UK. Furthermore, private sector bodies will often benefit from state funding either directly through subsides or indirectly through changes to taxation and rent regimes.)
- Linked to the point above, “there is no automatic relationship between increments of achievement in the organization’s mission and increments of revenues earned” (Moore 2000). Thus, the challenge for public strategists and decision-makers is the achievement of certain critical objectives may have a limited, or negative impact on the organization’s financial health. Arguably, there is closer alignment of value maximisation, financial health, and corporate survival in the private sector (Moore 2000).
- Although often financially constrained public sector bodies may have a much greater focus on performance and service improvement than a financial bottom line (Boyne and Walker 2010). The increasing focus on performance targets was demonstrated in the target setting emerging from the 2002 NHS Plan. The

relative importance of performance targets may be further complicated by the presence of “scheduled interruptions” (Nutt and Backoff 1993): periodic elections and political appointments that may adjust performance priorities or abandon some altogether.

- The authority to change and re-shape services and systems may be more limited (Nutt and Backoff 1993) and managers may need to take greater account of a wider range of stakeholders. For example, healthcare units that may be seen as ‘underperforming’ may not easily be radically changed or closed, where there is significant public opposition to such a change. Whilst discussing value, however, Moore (1995) does infer that an important role for public services may be its entrepreneurial one: that is not merely implementing policy but realising opportunities to provide value for the public they are there to serve.
- Competing influences may distort strategy: balancing the need to achieve consistency with political leaders, members of the public, and achieve financial balance. The 2012 Health and Social Care Act may itself be seen as a pragmatic compromise that was as much to do with accommodating competing voices and pressures as with implanting an overall strategy (see Timmins 2012)

All of these pressures are likely to be evident with NHS commissioners, and they consequently helped to shape the hypothesized influences described in the conceptual framework. Although arguably the strategic approaches and intentions described above remain just as relevant to the public sector as the private. If Mintzberg (2007) is correct that the nature of the organization influences the strategy type, and the nature of the organization is heavily influenced by the corporate environment, then the influences apparent on a public sector organization will be significant. In the case of Air Canada (Mintzberg 2007) there is an organization described as very effective at strategic *planning*: at the expense of strategic *thinking*. This may be seen as a critique from a sharp critic of strategy as planning (that is Mintzberg). But if there is some truth in the assertion that planning and thinking can work against each other in the sphere of strategy, the influences upon CCGs may restrict opportunities for strategy development.

Joyce (2015) concludes that strategy in the public and private sector is concerned with similar things: defining goals; analyzing situations; planning resource use; finding courses of action; and planning for longer-term outcomes. Whilst Joyce does identify that the role of strategy is broadly similar, the differing pressures and environmental context as described by Johnson and Scoles (2001) appear to suggest that public sector organizations need to accept modified approaches to developing effective strategies. Nutt and Backoff (1993) question whether the assumptions of private sector strategy will necessarily apply in public sector and not-for-profit bodies. They develop a detailed matrix describing the different factors that make private and public sector bodies distinct from each other in terms of strategy development. Many of the factors cited by Nutt and Backoff (1993, p.211), such as relationship to markets, political influences, statutory constraints, and performance expectations, appear relevant to and consistent with the macro level influences on decision-making as described below

in the development of the conceptual framework in the current project. Nutt and Backoff (1993) conclude that public organizations need to incorporate ways to deal with the factors of their 'publicness' (those that are distinct from private sector bodies) and managing the factors will then influence the production of public sector strategy.

Not only may there be different private-public factors for strategizing: the industry itself may provide particular challenges, healthcare being one of the most complex. Thus, Porter (2010) has written

> In any field, improving performance and accountability depends on having a shared goal that unites the interests and activities of all stakeholders. In health care, however, stakeholders have myriad, often conflicting goals, including access to services, profitability, high quality, cost containment, safety, convenience, patient-centeredness, and satisfaction. Lack of clarity about goals has led to divergent approaches, gaming of the system, and slow progress in performance improvement. (Porter 2010, p.2477).

Whilst Porter (2010) eloquently discussed the concept of value in healthcare, he appears less clear as to how to unify the myriad of conflicting goals within a single strategic framework[7]. CCGs may need to continue to use strategy as both a tool to achieve organizational objectives and to unify (if only partly) the interests of its stakeholder base.

Moore (2000) describes a public/non-for-profit 'strategic triangle' based on three points considered as critical for the development of effective strategy: value; legitimacy and support; and operational capacity. Value being the purposes the organization has for existing and its objectives in satisfying the expectations of its stakeholders. The direction as to where support for achieving value comes from is determined by legitimacy and support. Operational capacity determines whether the organization has the expertise and capability to achieve results and satisfy it value proposition. Although the specific description of the three in the public sector context is illuminating, it is not immediately apparent whether this is qualitatively different to some descriptions of wider strategic approaches. For example, Thompson (1993) describes a three-dimension model of environment, values, and resources ('EVR Congruence') that appears to closely match the model of Moore (2000). Nevertheless, Moore's (2000, p.199) comment "political management as important to public managers as organizational management" remains valid and important for public sector bodies in developing and implementing strategy.

Joyce (2015) comments that most of the research into corporate strategy has been in the private sector, with much less conducted in public sector bodies. Exceptions to this include Boyne and Walker (2010) who summarize evidence from a number of mainly UK based local government studies, and the Johnsen (2015) study of the public sector in Norway. Johnsen (2015) uses the Mintzberg et al. 10 schools as framework to explore how different approaches are used in the Norwegian public sector. The conclusions are that the most evident schools in practice are the design, power, environment, and learning schools: but with the most evident being the planning

school. Linking to the earlier statement of the multi-dimensional role of strategy (possibly more so in the public sector) Johnsen (2015) discusses the factor accountability being an important reason why strategy as planning may be important for public sector bodies. Thus “All organisations have stakeholders, but to the degree that public sector organisations are more prone to political processes than other organisations using tools such as stakeholder analysis… as well as using missions for motivating employees… and collaborators may also be relatively important. Thus, strategic management in the public sector is important.” (Johnsen 2015, p.246).

Boyne and Walker (2010) test the link between public sector performance and the assessed categorisation of organizations within the Miles et al. (1978) typology. Their conclusion being that overall a prospector (innovator) strategy is linked to better performance (although the authors recognise the number of studies is limited and the prospector role appears more suited to Local Authorities than the NHS, where new markets are less easy source[8]). Furthermore, they recognise that public sector managers will often exchange one performance variable for another depending on the context (for example, sacrificing service performance for financial improvement). In a similar vein Andrews et al. (2009) research public sector organizations against the Miles et al. (1978) typology, with reference to whether there is an observed fit between strategic type and organizational structure. Miles et al. (1978) infer that corporate success may be linked to an alignment of strategic with structure: for example, prospector strategies align most effectively with decentralised management structures. Andrews et al. (2009) confirm that public sector bodies demonstrate consistency with the Miles typology. They did not find, however, the corresponding alignment of strategies with management structures. For NHS bodies in this case, such as conclusion may not be entirely surprising. Structures of corporate governance, particular upper-echelon (board level) bodies, will often have certain prescriptions as to membership. In the CCG case this required certain statutory officers (CEO, CFO), specific clinical posts (executive nurse and hospital doctor), a minimum number of lay members, and a significant number of representative GPs. Other functions required by legislation (data protection, freedom of information) or regulation (various performance reporting processes) will further determine elements of a CCG management structure. As such it is unlikely a CCG management structure will ever be wholly dependent on its strategy. Thus, it may be hypothesised that if the Andrews et al. research was repeated in CCGs, and possibly a range of other NHS bodies, it would produce similar conclusions to their original research.

Concluding discussion on strategy

The review above has covered strategic literature covering both the private and public sector. This is considered necessary as there is a significant cross-over between the private, for-profit sector and the public, non-for-profit sector. Some authors, such as Mintzberg (2007) frequently do not differentiate between sectors when analysing strategic management. Others (such as Joyce 2015) identify similarities between strategic management in both sectors. Furthermore, the development of a greater

focus on business-like thinking in the public sector, including the use of techniques such as service outsourcing and open market tendering, suggests public sector management should seek to learn lessons from private sector organizations.

The assessment of 'what is strategy' is a necessary step before seeking to understand how strategic decision-making occurs in this study. The analysis above allows further assessment of the role of strategy in policy and practice in the public sector. Returning to the three dimensions of strategy discussed above (intentional planning to support decision-making, communication to stakeholders, and validation through performance management) CCGs as public sector bodies may demonstrate a greater emphasis on the second and third of these dimensions than a private company. Although privately listed companies will need to manage the expectations of their shareholders, the stakeholder base may be less complex than an NHS body or Local Authority, as indeed may be the requirements for formal consultation on major changes. The age of austerity appears to be seeing a greater focus on central government top down performance management and regulatory control, which may further emphasize public bodies need to 'deliver what they promise'. Such central control may, therefore, be a major influence on CCG commissioning decision-making.

From the published literature on strategy we may conclude that as a concept it is multi-dimensional and multi-factorial. Thus, strategy is:

- Contextually dependent: from the influences of the external environment (including the operating corporate context but also the national culture) and the internal environment (culture and structure) of the organization. Due to its tax-based funding source NHS bodies may be acutely influenced by the wider context.
- Best described not merely as a plan or a pattern or a culture, but a corporate discipline that requires different elements. The apparent conflicts between different approaches and factors may be seen as a necessary dynamic feature of what is strategy. (Thus, attempts to eliminate tensions may be misplaced: even reconciliation between plan and pattern may be difficult.)
- Despite the emergent nature and cultural factors relating to the concept, still an organizational tool that requires a degree of intentional direction and hard planning. Although for a CCG the role of strategy as a communication and performance management tool should not be underestimated.
- Particularly in the public sector the three-dimensional nature of strategy (plan, communication tool, performance assurance tool) suggests strategy as object and practice is multifactorial.

This introduces an area of exploration in this research project: that of how much actual strategic thinking can be undertaken by a public sector health commissioning organization? How will the evident influences shape strategic decision-making?

2.3 What is a decision? What is a strategic decision?

Sociology and strategy

Sorensen (1963, p.68) describes the cultural complexity of White House decision-making and those involved:

> …each department has its own clientele and point of view, its own experts and bureaucratic interests, its own relations… its own statutory authority, objectives, and standards of success.

Thus, for Sorensen (1963) however large (or strategic) the decision, multiple social factors come into play. This may be obviously true in 'big P' Politics, but probably also true in the more mundane politics of organizational life.

The genesis of the project was the desire to explore and understand what goes in the process of decision-making in a CCG. The use of the negotiated order as a conceptual lens may question whether this really is a study of strategic management, or of strategic decision-making, or is it actually a study of organizational sociology (not unlike Watson 2003)? Well, perhaps it is, and must be, a study of all these elements. Understanding the sociology[9] of the CCG may first require an understanding of what it is they are doing when they are at work. If the case study is of a large scale, significant and thus, strategic, decision, the observed behaviours will occur whilst this work is underway. Just as we may want to try and avoid barking up the wrong tree, or boarding the wrong train, so it may be best to avoid assuming that decisions are something they aren't. Or that what is presented as a strategic decision actually is the thing the organization says it is.

Introduction

In the last chapter we define strategy, in the research context, as the means by which the CCG would state its scope of operation, its corporate direction and how it seeks to allocate and use its resources to address the needs of its population and manage the expectations of stakeholders. Thus, if strategy relates to large scale scope, longer-term direction, and significant use of resources, what then conforms to the definition of a strategic decision and does the decision-making observed in the CCG fit such a definition. This chapter covers:

- The definitions of a decision, a strategic decision, and decision-making
- Described models of organizational decision-making in the literature
- The concept of prospect theory and bounded rationality as a major decision-making model as central to the analysis in the project
- A short summary of strategic decision-making tools and approaches that have been used in private and public sector organizations.

Definition

Having defined strategy and its application to the CCG in the current NHS, the subject of strategy then informs how strategic decisions are defined and described. Eilon (1969) comments that while there is large literature discussing definition of *decision-making*, there is comparatively little defining what is a decision. Defining the concept of decision, we will maintain consistency with the previous research (Cox 2012, p.12):

> From Eilon (1969), Baron (2000), and Levin (1972) we may assert a definition that a decision is: a judgement to take action made from a range of alternatives, to achieve an objective, or bring resolution to an indeterminate issue. Decision, therefore, requires choice, a goal towards which the process strives and an action resulting from the judgement.

This definition recognises, particularly so for decision-making in an organizational context, a decision will have three dimensions: an event; a process; and a narrative explanation[10]. Thus:

- Event – what happened when (this may involve multiple dates and times)
- Process – when was the start of the decision-making (initial genesis may often be long before something described by decision actors as a decision) and when was the implementation of the perceived intention to act?
- Narrative explanation – why was the 'decision' made, under what circumstances and for what reasons?

But many decisions are operational or tactical in nature: that is, they are made in a short-term timescale, on a small scale, and may not change significantly resource allocations. Thus, Eisenhardt and Zbaracki (1992, p.17) define strategic decisions as "those infrequent decisions made by top leaders of an organization that critically affect organizational health and survival." In some respects, definition may be easier by describing what strategic decisions are not. Thus, they are not operational decisions: such decisions being smaller scale, of immediate or short-term timescale, being concerned more with implementing an agreed plan or established course of action. Mintzberg (1976) thus discuss strategic decisions as being particularly important to the organization in terms of actions, resources, and precedents set. (This suggests strategic decisions will have significance beyond the decision actions in the moment.)

Whittington (2001, p. 58) states that, "Almost all strategic decisions involve an investment of some sort". Although plausible, little evidence is provided to support this assertion. However, in the arena of NHS commissioning, essentially a function of resource distribution, the assertion would appear to hold true. That is not to say that all NHS commissioning decisions are strategic. Nevertheless, major decisions regarding direction of healthcare policy implementation will invariably tend to involve at least some element of resource allocation. A further sensitivity to the statement may be required, in that almost all strategic commissioning decisions involve investment or *disinvestment*, of some sort.

Johnson (2005) summarising strategic decisions states they are concerned with:

- The long-term organizational direction
- The scope of the organization's work
- How to gain advantage over competitors (but only in situations of competition)
- Addressing the changing corporate environment
- Building resources and organizational capacity
- Responding to the values and expectations of stakeholders

Consequently, they will be:

- Complex
- Made in situations of uncertainty
- Impact on operations decisions
- Involve the internal facets of the organization and its external relationships
- Involve significant degrees of change

Along more animated lines, Pidd (1996) describes strategic decisions as 'messes'. Other management challenges such as 'puzzles' (agreed formulation of a challenge and agreed solution once found) and 'problems' (agreed formulation but no agreed solution) are seen as relatively straightforward. Messes, however, are complex and have (at least at the outset) no agreed formulation of the management challenge and no agreed solution (even at a late stage of a process). For Pidd (1996, p.69):

> Strategic decision-making is often characterised by ambiguity about objectives (other than survival), uncertainty about outcomes (they may be several years ahead) and great risk if things turn out badly.

March (1988) identifies a number of ambiguities in organizational decision-making: ambiguity about preferences; ambiguity about relevance; ambiguity about history; and ambiguity about interpretation. Thus, for strategic decisions participants may face an environment where there is uncertainty over available preferences, the relevance of options, a differing narrative on the preceding corporate history, and competing interpretations of objectives and solutions.

In a similar vein, Grint (2010b) provides a typology of management challenges of: tame problems (solvable by rational management thinking); command problems (dealt with by command and control); and wicked problems. Wicked problems for Grint (2010b) are similar to messes of Pidd (1996):

> A *Wicked Problem* is more complex, rather than just complicated – that is, it cannot be removed from its environment, solved, and returned without affecting the environment. Moreover, there is no clear relationship between cause and effect. (Grint 2010b, p.12)

Strategic decision-making process and structure

As strategic decisions are not merely events, being large scale and not merely operational, there are *processes* and *structures* that may be described in decision-making. Mintzberg et al (1976, p.133) define a decision process as, "set of actions and dynamic factors that begins with the identification of a stimulus for action and ends

with the specific commitment to action". (Mintzberg et al (1976) discuss strategic decisions as 'unstructured', that is being untypical and with no obviously predetermined order. This is considered consistent with the definition of strategic decision above and thus the additional descriptive 'unstructured' is deemed unnecessary as being a typical part of strategic 'messy' decisions.) Mintzberg et al (1976) further define strategic decisions according to their *stimulus*: opportunity decisions being purely voluntary to improve a stable or adequate situation; crisis decisions in response to a critical pressure; and problem decisions, that whilst not as urgent as crisis do present the organization with a significant challenge. The decision in the case study is considered to be consistent with that of problem: it was not a crisis and although sought to improve a service it was from a baseline position assessed as sub-optimal by decision-makers.

The 'simple' decision process emerging from their research (Mintzberg 1976, p.158) lists the stages of:

- Recognition of the decision problem
- Diagnosis of what exactly the problem is and entails
- Search for options to address the issue
- Design of options either modification of pre-existing options or creation of new options
- Evaluation and choice of alternatives
- Authorisation of the choice recommended

Mintzberg et al (1976) despite producing a simple model, do recognise the complexity of strategic decision-making and also include in their model the likely input of 'interruptions': whether through political or external factors, or the emergence of new options and alternatives within the process.

Witte et al (1972) summarises a body of management research that describes a similar decision process: a) identification of problem or issue to be addressed; b) gaining necessary information on the issue; c) find possible solutions; d) evaluate proposed solutions; e) selection of preferred option; and f) actual action taken. Witte et al's (1972) research concludes that the orderly process of decision phases may not be seen in management practice. Rather the different elements of a decision process will tend to overlap and intermingle. Thus,

> We believe that human beings cannot gather information without in some way simultaneously developing alternatives. They cannot avoid evaluating these alternatives immediately, and in doing this they are forced to a decision. This is a package of operations, and the succession of these packages over time constitutes the total decision-making process. (Witte et al 1972, p.180)

Therefore, if this research is valid, the elements in the decision process may be present but not happening in a logical order. Furthermore, the conclusions of Witte (1972) align with the Garbage Can model (Cohen 1972) suggesting a complex decision environment with contains pre-existing solutions looking for decision problems.

Decision-making models

Following the definition of decision and decision process, the project uses the decision-making form described by March (1991). Thus, decision-making is seen as an intentional process that includes four elements:

- A set of alternatives for action (there is no decision to make without choice).
- Some knowledge, however limited, of the potential consequences of the alternatives.
- A preference ordering with which to compare and evaluate alternatives.
- Decision rules with which to select the preferred alternative, whether formal and explicit or informal and implicit.

It may be observed that for decisions generally, and particularly for strategic decisions the knowledge for all four elements may be imperfect. March (1991) describes the challenges to decision-making in situations of uncertainty (picked up in more detail on the discussion of bounded rationality below).

The decision-making literature includes the development of a number of conceptual models of decision theory. The 'base' decision model may be seen as the rational model: originating in the literature of economics (Smith 1950, Muth 1962) it assumes decision-makers make decisions that are in their rational best interests. Many economists, particularly those supporters of free-market economics, continue to support the general notion of rational decision-making as the default model (Blume and Easley 2007)[11].

Stanovich (2011) has an extended discussion of the concept of rationality. This separates the definitions into: the "weak" definition as commonly used of rationality as 'based on reason'; and that used in cognitive science as "the actions of an entity in its environment that serve its goals" (Stanovich 2011, p.5). Stanovich (2011) also infers that for cognitive science rationality must assume the possibility of irrationality: that is, for behaviour to be rational there must be the possibility of irrationality. Furthermore, Stanovich (2011) see a rational model as fundamentally normative, not descriptive. Thus, in describing actual real-world decision-making, a truly rational model is a hypothetical concept against which actual practice may be compared, but it may not represent how practice is actually conducted.

Other decision research has questioned the degree of rationality evident in decision-making. Simon (1997) defines rationality as to do with the evaluation and selection of alternatives as part of a value system where knowledge of the consequences of the alternatives can be assessed. This is further separated into 'objectively rational' where a decision would be seen as rational if it maximized the outcomes in a situation; and 'subjectively rational' where it is seen to maximize the outcomes given the known information at the time of the decision, although subsequent knowledge may show this information to be inadequate. The still further separation relevant to this context is that between 'organizationally rational', directed to supporting the goals of the organization, and 'personally rational' directed towards the interests of the individual. Thus, a

summarized rational decision-making model would be one where the decision-makers acted in the best interests of themselves (individual or organization), using the best available knowledge, following a logical decision process of: recognition, diagnosis, search, design, evaluation, and action.

From the earlier assessment of rationality as a general concept, Simon (1997) introduced the concept of *bounded rationality*. Although decision-makers may try to act rationality, *organizational man* (as opposed to the *economic man* of the rational model) is constrained by boundaries imposed by the modern organization. Decision-making in the modern organization is complicated by factors that limit rationality (Simon 1972): the cognitive limits of individuals; the complexity of the decision environment; decisions are often taken under conditions of risk and uncertainty; and the information of decision choices and options may be incomplete. Thus, limiting boundaries of information show that it is almost always sub-optimal (too much, or too little, at the wrong time, or in the wrong form); and secondly, administrative targets that influence performance towards maximizing *target achievement* more than overall corporate gain (the concept of *satisficing*). Schutz (1943, p.142) in an extended essay on rationality in the social world, states, “that rational choice would be present only if the actor had sufficient knowledge of the end to be realised as well as of the different means apt to succeed”[12]. Bounded rationality infers that such knowledge may always be imperfect. Although not specifically within the context of organizational decision-making, the review of rationality conducted by Mercier and Sperber (2011) infers that overall human decision-making is rational, despite its flaws.

Mintzberg et al (1976) suggest, consistent with the bounded rationality concept, that rational model literature on strategic decision-making should be seen as normative rather than descriptive of actual practice. Thus, Mintzberg et al (1976) and Nutt (1984) infer that the analytic phase of a decision process, critical to the rational model and where facts are established and value assessed, is actually little used in practice.

From the 1950s onwards, research into management decision-making has produced a number of competing models to explain decision behaviour. All of them conclude a truly rationalist model is not descriptive of actual decision-making. (The rationalist model may, therefore, have value as normative more than descriptive.)

Following the emergence of alternatives, typologies of such models provide an attempt to understand management decision-making beyond the purely rational (Eisenhardt and Zbaracki 1992, Das and Teng 1999). Described decision models are:

- Rational/Boundedly Rational (Simon 1997, Allison 1999)
- Political (Pfeffer and Salancik 1974)
- Organizational Behaviour (Allison 1999)
- Garbage Can (Cohen et al. 1972)
- Logical Incrementalism (Lindblom 1959, Quinn 1980)

The selection above is in part derived from the Das and Teng (1999) overview of management decision models, and those that appear in a number of decision typologies. The list is not exhaustive but is considered to involve the main decision-making themes produced in the literature. The models above assume that bounded rationality is but one of several models. However, the assessment of a multiplicity of models may underestimate the complexity of the concept of bounded rationality and indeed mistakes elements of the model, particularly those that represent boundaries, as suggesting a different paradigm. Thus, we may contend that a fuller assessment of the dimensions of the other models shows them not as separate concepts, but rather displaying boundary like behaviour which belongs within a more complexly developed description of bounded rationality.

Thus, the political model describes a pattern of competing interest groups (originally for Pfeffer and Salancik (1974) within academic institutions) where power and influence are the main drivers. Although this seems less than rational, that is the decisions are not made to support core corporate objectives, we may assert: the core corporate objectives may not be completely ignored; the structure of large academic institutions may promote a multiplicity of objectives for different departments; for each individual department, the decision motives may indeed be rational (at least in part). Decisions with political type features are likely to be more complex: the level of difficulty rising where there is more conflict among key players, greater capacity for stakeholder objection, and more relations to historical debates on similar ground (Nutt 1998).

The Organizational Behaviour model (Allison and Zelikow 1999) describes a routine following of organizational procedure, using tools such as standard operating procedures. The routine use of such procedures regardless of circumstance, with no direct attention to corporate objectives or rational benefit, may produce sub-optimal and non-rational decisions. However, the development of standard procedures may be considered to provide consistency of corporate delivery, organizational efficiency and thus to be largely rational in creation. In this respect the model describes, in a detailed manner, the *satisficing* behaviour depicted by Simon (1997). Furthermore, the decision-making behaviours described originally by Stanovich and West (2000) and latterly by Kahneman (2012) separate the psychological processes of organizational decision-making into two types: 'System 1' is quick and intuitive, efficient, and requiring little consideration; 'System 2' is longer and more contemplative, considering information and evidence. For Kahneman problems occur when decision-making would benefit from the resources of System 2, but the decision-makers use System 1, sometimes out of habit. This may explain certain types of sub-rational decision-making, driven by human tendencies to be influenced by biases and heuristics (mental short-cuts or 'rule of thumb'). But it does not suggest System 1 type thinking is in itself not rational. Thus, for standard operating procedures, their use, in effect, provides an organizational form of systematised System 1 thinking. An approach that is often very efficient and effective. At times, a blind adherence to such procedures will be problematic and their very presence may discourage more consideration in the decision-making process.

The Garbage Can model (Cohen et al. 1972) collects in its wheelie bin the disparate parts of the decision process within organizations described as “organized anarchies” (Cohen et al. 1972, p.1). The main factors in decision-making for the Garbage Can model are three elements all with their own diversity at the point of decision (a ‘choice opportunity’): participants; problems; and solutions (Cohen et al. 1972). The motivation for the process, however, may still be rational: and the elements described suggesting the garbage-like processes are further examples of decision boundaries. For example, the *variable attention level* of participants is consistent with Simon’s assertion of information limitations as a rational boundary. A significant finding in the Garbage Can model is that solutions in a decision process are rarely novel (Watson 2002) and produced through the decision process (that is they are ‘solutions waiting for a decision’). Nutt (1984, p.443) quotes Wildavsky, as suggesting “managers don't know what they want until they see what they can get”. This may not be adequately covered in the original bounded rationality model: but this may reflect two elements. Firstly, the complexity of information management includes that of developing and assessing solutions. Secondly, the classical rational model is inconsistent with the demands of modern organizational decision-making. Thus, the occasions where a decision process will have the time, management, and financial resources to develop novel solutions will be rare (but possibly not non-existent). Nutt (1984), however, states that empirical research shows the solution-to-problem approach of the Garbage Can theory is only demonstrated in a minority of cases where decision-making is stimulated by problems. The original Garbage Can research (Cohen et al 1972) was conducted in academic institutions and thus may be seen to be more strongly reflect decision-making in this particular environment, than more generally. Not surprisingly where decision processes are opportunistic they may be more obviously solution driven (Nutt 1984), in part, presumably due to the solution often containing the opportunity. Nutt (1984, p.443) also concludes that although decision-making may have similarities with the Garbage Can, decision processes “were neither capricious nor whimsical, and each had a clear purpose”.

Lindblom (1959) describes a corporate world of public administration similar to the type of Simon (1997) and Cyert and March (1992). A rigorous study of values and alternatives is not observed in the decision-making process. Rather, a limited set of alternatives is available, due to the pressures of the political and administrative environment. Quinn (Mintzberg et al. 2003) describes not only cognitive limits (what can be known) but also ‘process limits’, what can be done at what time with what resources. Consequently, although progress is observed, it is often due to a series of small-scale ‘incremental’ changes, working within the confined choices of any given situation. The available choices may in part be the product of ‘framing’ effects (Tversky and Kahneman 1981). Critically for Incrementalism, decision-making (even at a strategic level) may not involve many (if any) large one-off events. Instead, “Policy is not made once and for all; it is made and re-made endlessly” (Lindblom 1959, p. 86). Importantly for Quinn (1980) logical incrementalism is not ‘muddling through’ but rather an example of pragmatic but essentially effective management.

The five models described above may be more constructively seen as elements within one model. For convenience we may describe the one model as bounded rationality and consider each of the descriptions above as sophistications and elaborations of that model.

It may be necessary to reflect at this point that the concept of bounded rationality and the research into decision-making bias and imperfection does not necessarily infer that organizational decision-making is *irrational*. The ongoing development of technological progress, economic growth, and (more controversially) moral advancement suggests society does make decisions that are generally, and over the longer-term, in the interests of those who make them. This assessment may well apply equally to modern healthcare. Thus, Le Fanu (2000) may describe an end to the rapid progress of earlier phases in healthcare development: but its development to this point is not in question. Later progress may be slower but genuine progress in improving health outcomes is still observed. For Simon (1978) bounded rationality may suggest a distinction between substantive rationality, where the objectively most appropriate course of actions is taken, and procedural rationality, where the appropriateness has to be balanced against the limitations of bounded rationality. Within this definition it is suggested that a procedurally rational decision-making process is defined by “the extent to which the decision process involves the collection of information relevant to the decision, and the reliance upon analysis of this information in making the choice” (Dean and Sharfman 1993).

Prospect Theory

If Bounded Rationality is defined as the mainstream decision model, the self-proclaimed authors of its road map are Kahneman, Tversky, and colleagues (see Kahneman 2003). The bedrock of the road map is the concept of Prospect Theory. This appears to be one of the most significant developments in recent decision theory, spawning a large volume of research and discussion (Barberis 2013). At its core it presents a theory of decision linking it to decision makers’ assessment of risk and reward (in a literal sense the ‘prospects’ of a decision process). The theory suggests decision-makers are risk averse for gains (that is will conservatively protect gains rather than seeking greater rewards for greater gain); and risk seeking for losses (that is where loss is perceived, greater losses will be risked to recover a loss).

The theory also breaks down the decision process into editing (framing) and evaluating. The framing element shapes the decision process: Kahneman (2003) describes prospect theory as a ‘map of bounded rationality’ and as such Prospect Theory may be seen as a development in the concept of the rational boundaries. Framing in this sense is the process of constructing the boundaries: arguably, different boundaries in every case (Cox 2012). Importantly, the aversion to risk seeking relationship is, in part, influenced by how the decision frame is constructed. Thus, the framing process influences how decisions are taken: presenting a decision process as a choice of managing either gains or losses will affect how the decision is made. (There

will be a return to framing in more detail in the development of the conceptual framework).

Prospect theory also describes and develops the concept of decision *heuristics*. Tversky and Kahneman (1974) described the impact on decision-making of bias and heuristics (mental short-cuts or 'rules of thumb' that support rapid decisions). This has spawned a large volume of research into their effects on decision-making. The overall conclusion is seemingly that they do affect judgement. However, the research does appear to be largely experimental in design: thus, several celebrated decision study types, such as the 'Asian Disease problem'[13] (Tversky and Kahneman 1981) may have only limited applicability to real-world strategic decisions, such as the current research. But there is evidence that heuristics should be considered in decision-making, and that certain strategies appear to reduce the negative impact of bias, particularly that of the 'framing effect'. These may include: promoting diversity of opinion within the decision process; more thorough consideration of options and problems; and framing problems from different perspectives.

Biases identified in the literature include:

- Availability heuristic: 'if you can think of it, it must be important'. The easier it is to remember something the more its consequences are considered important. "Tornadoes were seen as more frequent killers than asthma, although the latter cause 20 times more deaths" (Kahneman 2012, p.138).
- Representational heuristic: where features commonly found in a population are considered as overly present. In one sense this is judgement by stereotype and can mean decision-making is influenced by provided information, regardless of its accuracy or relevance (Tversky 1974).
- Affect heuristic: in simple terms the emotional impact of certain terms. 'Do I like it? Do I not like it?', emotion often being more important than evidence. "If their feelings toward an activity are favourable, they are moved toward judging the risks as low and the benefits as high; if their feelings toward it are un-favourable, they tend to judge the opposite—high risk and low benefit" (Slovic et al. 2004).
- Anchoring heuristic: judgement based on the impact of an initial value, even a completely random value. Thus, in many cases the first number presented influences the effect of any subsequent number (Tversky 1974).
- Hindsight bias (Stanovich and West 1998) is seen where individuals overestimate what they would have known due to knowledge of an outcome. This 'rewriting of history' is also described as the 'narrative fallacy' (Taleb 2007) where history is written backwards from the known outcome.
- Confirmation bias (Nickerson 1998, Mahoney 1977) involves searching for data that supports an existing opinion or position, at the expense of information that may contradict these existing opinions. Nickerson (1998) describes different forms of confirmation bias and related biasing tendencies such as overconfidence.
- The Endowment effects: there is a discrepancy between 'willingness to buy' and 'willingness to sell' (Kahneman et al. 1990). People appear to assign much

greater value to something when they own it; conversely by comparison non-owners do not endow properties with additional value. This discrepancy may negatively affect the ability for individuals to make effective trades.

- The Peak and End effect shows that when experiencing uncomfortable experiences, such as colonoscopy, (Redelmeier and Kahneman 1996) people will remember the most intense pain and the pain felt at the end of the event more than the length. Long and uncomfortable events may be seen in a more positive light if there is no extreme pain and the last few minutes feel more comfortable.
- Framing effects (Kahneman 2003) most obviously described through the conclusions of prospect theory and the Asian Disease Problem (see section 2.6). Nickerson (1998) infers that biases that have been attributed to motivational factors may be due as much to cognitive factors such as framing.

West et al (2012) indicates that cognitive ability may not reduce the likelihood of decision bias.

Whilst biases may be evident in any decision process, it may be helpful to explore how the influences discovered in the case study create, amplify, or mitigate heuristics and biases.

System 1 thinking as Fast and Frugal Heuristics

The dual-process decision system of Stanovich and West (2000) and Kahneman (2012) has been summarised as ‘System 1 and System 2’. This identified problems when the intuitive, shorthand decision process of System 1 was used where the more deliberative, considered approach of System 2 might be more appropriate (see Evans and Stanovich 2013, for a summary of recent debates on dual-process theories). However, there was no suggestion that System 1 was redundant, rather that its reflex use may produce sub-optimal decisions. The confirmation of the benefits of heuristic (essentially System 1 type) decision-making is emphasised by Gigerenzer (1996): summarised as ‘Fast and Frugal Heuristics’. Simplistically this celebrates the approach of System 1 and suggests the critiques of human decision-making as by Kahneman and others minimises the benefits of heuristics. Furthermore, Gigerenzer and Todd (2001) approvingly quote Herbert Simon as not seeking to optimise the decision-making process. Evidently for Gigerenzer, and at least the interpretation of Simon he favours, decision-making research should focus on understanding and exploring, more than in trying to establish normative models. Although Gigerenzer is critical of the Kahneman approach, he still seeks to work within a framework of bounded rationality. Thus, where Kahneman claims to draw the bounded rationality road-map, Gigerenzer (2001) proclaims to develop its ‘toolbox’. It may be inferred that rather than producing alternatives to bounded rationality or indeed different variants within it, there may be an overall systematic approach to decision-making that may be labelled bounded rationality. To some degree the Kahneman-Gigerenzer opposition (explicitly recognised by both sides of the debate) reflects the different starting points. One seeking to explain inefficiencies in a decision-making process and finding reasoning

in bias and framing effects: the other seeing the same processes (shortcut rules of thumb and intuitions) which produce consistently effective decision-making over the longer-term. This may be a false opposition with a possible need to synthesise the 'road-map' with the 'toolbox'. Vranas (1999) suggests there may be more consistency between the two approaches than accepted by either side. In part Gigerenzer's wish to not see decision-making behaviour in terms of 'errors' perhaps strays too far to imply that few errors are present. One element of Gigerenzer's critique is the potentially empirical weakness of the Kahneman school approach. Some authors (Vranas 1999) suggest this assessment may be over-stated. However, although there is a consistent body of research on the accuracy of actuarial decision models (Meehl 1954, Dawes 1999), Dana and Davis-Stober (2016) infer that overall a heuristic or fast and frugal approach may approximate closely to the effectiveness of actuarial models. In the context of this project it may be stated that not only may a good deal of the research utilising experimental methodologies have weak ecological validity; but this weak ecological validity may be amplified when attempted to generalise to *strategic* decisions.

Klein (2008) has developed a naturalistic decision-making model. This has some similarities to fast and frugal, in that it seeks to describe how effective and positive is much of actual real-world decision-making. A major element in Klein's (2008) thinking and the naturalistic model is the importance of context. Thus, the potential weak ecological validity of Prospect Theory type research is considered a fundamental flaw in assessment of decisions in practice. Although Klein is critical of what is considered a tendency to over-estimate the weaknesses of System 1 type decision thinking, the overall project of naturalistic decision-making theory may be seen to be to complement, rather than replace, the analysis of Kahneman and colleagues (for example see Klein 2013). There may be similarities between Klein and Weick (2001), both of whom have studied the decision-making behaviour of fire-fighters. Thus, both conclude real-world decision-making may be messy and complex, but is generally effective, if not necessarily compliant with a linear rationalist model. Similarly, Nickerson (1998) describes a number of factors which mitigate against decision-making short-cuts and heuristics (such as the confirmation bias) being considered as 'errors'. Thus, real-world decision behaviour may not always comply with an abstract normative model: but it may still be effective.

Overall, therefore, the definitions of rationality as consistent with that of Simon (1997), as described above, may infer that intuitive decision-making models (whether described as System 1, fast and frugal, or naturalistic) may still be broadly rational. They do appear to use knowledge to evaluate options to maximise outcomes: even more so they may be subjectively rational (Simon 1997) in that they aim to maximise outcomes with the known information at the time of decision. This may not necessarily be objectively rational; but this may only be known either by the use of other knowledge (potentially outside of the knowledge base of the decision-makers at the point of decision) or at some future point after the decision is made. In some cases, it may be argued that decisions judged as non-rational, due to outcomes that do not maximise

for individuals, can only be judged as such by the use of hindsight or outcome bias. Furthermore, following Stanovich (2011), if the objectively rational model is seen a primarily normative, then one may argue that a rational approach and rational steps may be taken in a decision-making process, even if the behaviour may vary from a fully rational normative behaviour. The rationality then being *procedural,* rather than objectively or substantively rational (Simon 1978, Dean and Sharfman 1996). Similarly, it may be incorrect to describe behaviour which varies from the normative model as 'irrational'.

The 'rational' role of System 1 type thinking is given further support by the somatic marker hypothesis (SMH) (Damasio 1996, Dunn 2006). SMH suggests that: there is a neurobiological explanation for differing approaches to decision-making; and that the different parts of the pre-frontal cortex involved in decision-making do, nevertheless, work in concert. The 'somatic markers' are intuitive cognitive markers derived from previous experience which guide later cognitive consideration. An absence of somatic markers may produce sub-optimal decision-making (Bechara et al 1999). If the SMH is correct then the dual-process, System 1-System 2, approach cannot be seen as being entirely separated into two parts. Furthermore, System 2 may be both enhanced (or at least directed) by System 1 and subject to its own bias and mis-directions, without intuition. Despite its enthusiasts, and a plausible neuro-biological explanation, doubts exist as to whether the limited experimental empirical evidence is sufficient to move the SMH from hypothesis to theory (Colombetti 2008). Further research may be required to take a hypothesis, grounded in some evidence and a biological description, to a more consistent casual explanation for decision-making and a possible clear link between System 1 and System 2.

Consequently, it may be concluded that the System 1/fast and frugal approach can still be considered broadly rational and may conform to the steps of rational decision-making described above (recognition, diagnosis, search, design, evaluation, and action). The sub-rational elements of a decision-making process, and where System 2 thinking may be beneficial is less in following of a rational process (such as the six steps) and more in the level of analytical scrutiny, use of evidence, and balanced evaluation used at each of the six levels. System 1 then may be efficient and still rational for most decisions. In strategic decision-making an over-reliance on System 1 may provide decision errors, and despite the claims of Gigerenzer (1996) and the claims of cognitive benefits of the SMH, the role of a System 2 approach may be necessary to support the most effective and, arguably, most rational decision-making.

Decision-making behaviours: heuristics and biases; and habits and backgrounds

In this research explanations may be forthcoming in how CCG decision-makers use heuristics (in both positive and negative modes) and how the external influences shape the decision-making process, and thus produce framing effects. Such effects may produce distortions to decision-making behaviour or may provide reaction from

decision actors that may mitigate framing effects. From either perspective, we may see the impacts on the decision-making process that promote and allow heuristics and the potential effects where decision-making behaviours work away from achieving corporate objectives.

The fast and frugal concept may have relevance for this study due to the presence within the decision-making body of a large proportion of GPs. GPs in their clinical life will typically have a large number of clinical contacts, often of short duration (in many cases 10 minutes). Such a clinical decision-making environment will promote the use of shortcuts and intuition ("intuition is nothing more and nothing less than remembering" Kahneman 2012, p.237). This approach will often be generally effective (that is achieving a clinically desirable outcome) and invariably efficient (that is producing the outcome at a cost-effective value). Thus, the question is raised as to what happens when such an approach is translated into strategic commissioning decision-making. Will the instinct to be fast and frugal (and efficient) overcome any desire for consideration or search for evidence? Or will the lack of anything to remember (for 'intuition is remembering') provide an unwillingness to make snap decisions in areas where decision actors are unfamiliar?

A further factor worthy of exploration is not merely the role of heuristics and biases (good or bad) from the individual decision-maker, but also how they are displayed and managed within the group. Besharov (2004) suggests attempts to reduce the impact of biases in decision-making may be self-defeating and produce more negative results than the biases themselves would promote in the first instance.

Strategic decision-making tools

Flowing from earlier consideration of strategy reference may be made to strategic tools to support organizational decision-making. Johnson (2005) summarises one of the commonest tools supporting decision-making on corporate portfolio management, the Boston Consultancy Group (BCG) growth-share matrix. This is aimed not merely as assessing the status of a company portfolio but to assist in decision-making as to future investment decisions. Thus, Cash Cows represent established services in mature sectors with low possibility of growth but a steady stream of profit. Dogs have low chance of growth, make little money and may be seen as a drain on corporate resources. Stars may be new services in sectors with high growth prospects. Question marks are possibly stars and their answering will move them into one of the other boxes. Thus, for investment decisions this may suggest: cash cows need support but limited investment and a focus on cost management; stars need investment while in a growth phase, before they mature into cash cows; question marks need to be answered as soon as possible; and dogs need to be transformed or jettisoned. Criticisms of the matrix have labelled it simplistic, reductionist, and mechanistic amongst other descriptions (Madsen 2017). Although described as being "largely discredited in academic circles" (Madsen 2017, p.19) it, nevertheless, appears to persist as a planning tool.

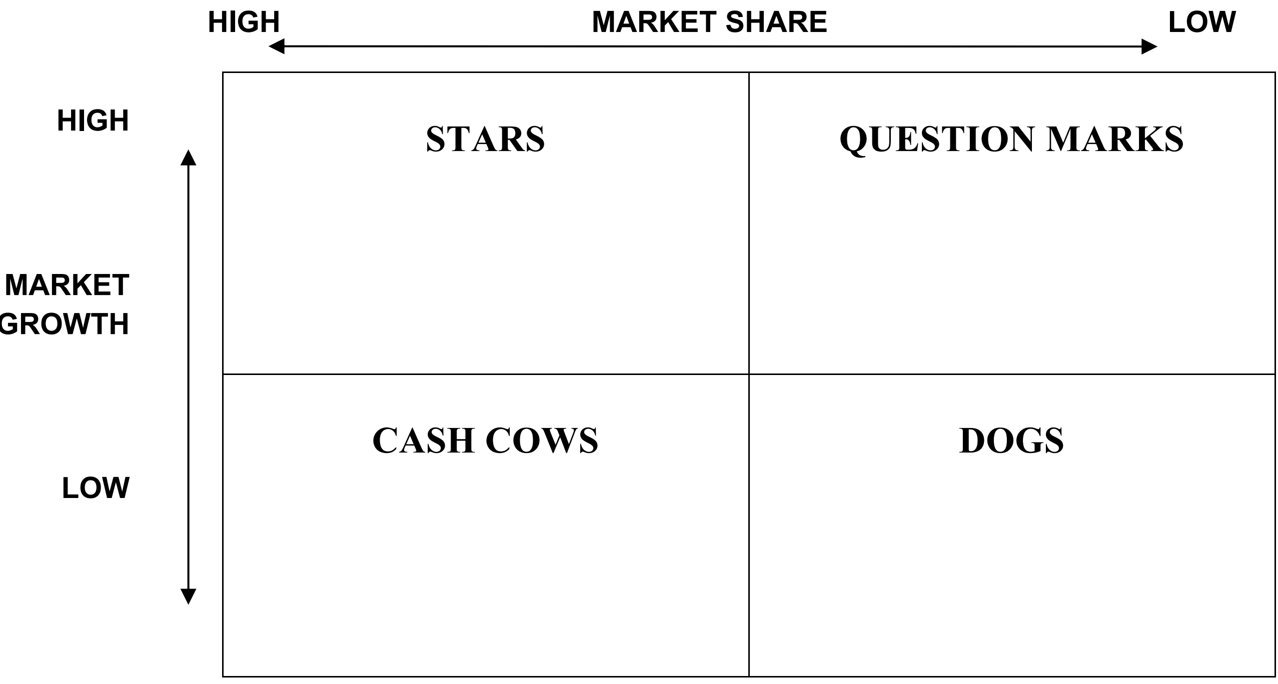


Figure 5 - BCG Growth-Share Matrix (from Johnson 2005)

Montanari and Bracker (1986) provide an attempt to use a variant of the matrix in a public sector setting. Here growth and market share have been replaced by 'public need and support' and 'organizational capability'. Thus, the dimensions represent what an organization's public may need or desire and what an organization is capable of doing in response. Although possibly useful as a tool to assist in decisions, there would

appear to be a need for more obviously strategic thinking in terms of longer-term objectives and corporate direction to inform the production of strategic options in the first place. Even then it is not clear that choosing between options based primarily on public popularity and capability is necessarily strategic behaviour: rather this may be seen as opportunistic. Such opportunism may be warranted but possibly only if informed by a wider strategic view.

Figure 6 - Public sector portfolio matrix (from Montanari and Bracker 1986)

PUBLIC NEED & SUPPORT	HIGH ORGANIZATIONAL CAPABILITY	LOW ORGANIZATIONAL CAPABILITY
HIGH	**PUBLIC SECTOR STAR**	**POLITICAL HOT BOX**
LOW	**GOLDEN FLEECE**	**BACK DRAWER ISSUE**

Johnson (2005) lists a number of other matrices like tools that are developed to assist in decision-making. (Madsen 2017 lists seven variants of the BCG matrix alone.) Although all of interest as potential use, none may be a substitute for a clear articulation of strategic direction and may be criticized as a slightly artificial attempt to present management templates as scientific decision-making.

Concluding remarks on strategic decision-making

The literature on decision-making in its more general sense is illuminating and helpful to frame the discussion on strategic organizational decision-making. However, much of this literature on wider decision-making, for example, much of that produced by Kahneman (2012), is experimental in design and may be seen as having limited ecological validity when applied to organizational decisions. Despite its possible limitations, it appears difficult to effectively discuss decision-making without reference to Kahneman and colleagues and their subsequent critics. Recent developments linked to neuroscience (for example, Damasio 1996) may also inform decision-making assessment but may need to be tested in practice for consideration in terms of organizational decision-making.

The project uses a definition of strategic decision-making combining Eisenhardt and Zbaracki (1992), Johnson (2005), and Whittington (2001), a strategic decision is thus defined as:

> An infrequent decision made by leaders of an organization that critically affects long-term organizational health, survival, and involve significant changes to resource allocation that impact on the organization's stakeholders.

The five decision models identified above may appear unrelated at first glance but can be described as appearing along a typological axis. As suggested, it may be considered as part of a bounded rationality continuum, with different models or elements of models evident in particular types of decision. (This is more straightforward to assume, if for the purposes of this project the truly 'rational' model of free market economics (for example Muth 1961) is considered to be rarely demonstrated in organizational, and possibly all strategic, decision-making.) Thus, in addition to a definition the project uses a working model of organizational decision-making based on bounded rationality (Simon 1997) incorporating prospect theory (Kahneman 2003). The exploration with CCG decision-making is how the influencing factors and the organization of the negotiated order may create or change the boundaries of bounded rationality.

2.4 Negotiated order and group decision-making

No such thing as…

Kenneth Clarke's Prime Minister whilst Health Secretary was the formidable Margaret Thatcher, who famously stated "there is no such thing as society" (Thatcher 1987). Arguably the famous Woman's Own interview is often taken out of context and a later part of the interview elaborates further: "There is no such thing as society. There is living tapestry of men and women and people…" (Thatcher 1987). The anthropologists such as Geertz (1973) may conclude that the living tapestry is just another way of describing society[14]. Either way, society or living tapestry, there seems a consensus that the individual cannot exist for too long on their own…particularly in the modern form of organizations. Human beings live in groups: the human an essentially social animal. The corporate world has a wealth of literature on 'leadership' (Grint 2010a) implying in some cases the benefits of the individual over the group. Nevertheless, organizations still entrust much of their major decision-making to some form of group: be it called a Board, or a committee system with another nomenclature. In the case of the CCG its leading decision-making body is a Governing Body. Beyond the leading decision-making bodies, organizations themselves are collections of groups, with their own sociologies (Watson 2003). But the collections produced may not be free of tension. Watson (2002) identifies the inherent, necessary, and arguably irreconcilable conflict between: the organization's need to control its resources to maximise efficiency; and the requirement to allow (often promote) autonomy for those within the organization. How the groups develop, interact, and reconcile their contradictions may be through the process of negotiation: such processes within the field of decision-making shaping the decisions that are eventually made.

Introduction

This chapter reviews literature on group decision-making in organizations, leading on to an introduction and exploration of the concept of negotiated order. Negotiated order considered the practical process through which a manageable order of organizational life and decision-making is possible: and the frame through which the research question was explored. The chapter discussed:

- The dynamics of group behaviours in decision-making and the influences of group behaviours on decision outcomes
- The concept of organizations as coalitions and the emergence of the concept of the negotiated order
- Reviews of NHS senior decision-making bodies and how they behave, including how they are seen to make decisions
- The role of power in organizations as a tool of negotiation
- The interplay between different roles in organization as covered in the agent-steward problems

- A return to the question of 'what is commissioning for' through the lens of the negotiated order

Group behaviours in decision-making

Studies of group decision-making suggest there may be differing dynamics at play than those seen with individuals? (Baron 2003). We may categorize conclusions from previous studies into those identifying positive and negative impact of group dynamics.

Negative decision behaviour identified in the literature includes the concepts of groupthink (Janis, 1982) and group polarisation (Isenberg 1986). Janis (1982) originally coined the term *groupthink* defined as "when the members' striving for unanimity override their motivation to realistically appraise alternative courses of action" (Janis 1982, p.9). It appears it may be related to the type of group members (as with the 'Jupiter Effect' (Belbin 2010). Although, however, the experimental research into groupthink is somewhat equivocal, there is descriptive evidence that conclusively supports the assertions of this view (Baron 2005). Group polarisation (Isenberg 1986) suggests that group decisions in certain situations may be riskier than the individual decisions of group members. In some respects, this is similar to groupthink, but rather than suggesting a general tendency to conformity, it proffers a group decision model where strong views become ever stronger through the decision process. Factors moderating against group polarisation (Isenberg 1986) are suggested as processes that become more factual and a greater focus on decision-maker values.

Evidence supporting the positive effects from group decision-making includes two related but independently conducted studies from central banks (Blinder and Morgan 2000, Lombardelli et al. 2002). The studies, experimental in design and relating to economic decision-making, conclude that groups not only make more accurate decision and predictions, they also tend to do this more quickly than when the same tasks are conducted by individuals. The two studies would appear to support CCGs in using an established board to make its major decisions. Ferguson (2006) infers that a factor in the outcome of the World War II was the competing decision processes: decision by committee (on the Allied side) being slow, bureaucratic, requiring huge efforts to achieve consensus, but ultimately being more effective than decision by an individual. The suggestion here being that decision by committee is more precise and removes bad ideas (or at least weaker ones) than a fast, individual decision-making process. (This suggestion may need to be tempered by recognising the quality of group versus decision-making will depend on the quality and state of mind of both the relevant groups and individuals.) The benefits of groups in a decision-making process appear in part to be generated by the presence of challenge within the decision-making body. Thus, the 'weeding out' of weaker ideas described by Ferguson (2006) requires a suitably diverse group, with members willing to adopt different positions.

The related concept of *Devil's Advocacy*[15] (DA), is summarised in the meta-analysis of Schwenk (1990) as superior overall to expert decision-making. Furthermore, the

more complex Dialectical Inquiry approach, which goes further in structured debate and evaluation than DA, was not seen to be superior to DA. Evidently a simple level of challenge and debate may be sufficient. Although the absence of a formal or informal DA role may not *necessarily* promote groupthink, its presence may well work against both groupthink and group polarisation. However, Schwenk (1990) also concludes that expert decision-making is superior to DA when “when the state of the world conforms to the expert’s assumptions” (Schwenk 1990, p. 172). Therefore, to promote most effective decision-making it may be necessary for a CCG to understand those cases which are more certain and fit within an established body of knowledge. But as one of the elements within a definition of *strategic* decisions is that of uncertainty, it appears decision by an expert alone may not be optimal in strategic contexts. This may also be influenced by the role of information in the decision-making process. Hall et al. (2007) infer that additional information may reduce the quality of decision-making. This is a laboratory study of participants judging future outcomes of baseball games where the group given the additional information of the names of the teams under scrutiny performed worse than those with less information. The conclusion here though may be not so much that ‘less is more’, as the authors state (in support of the Gigerenzer fast and frugal hypothesis), but rather that some information which appears useful (the names of teams in this case) may actually be extraneous and unhelpful. The Hall (2007) study is not of group behaviour and thus one conclusion may be that the influence of superficially useful, but misleading, information may be mitigated by the use of group decision-making.[16]

A review of ‘work group diversity’ (van Knippenberg 2007) summarized research into group dynamics in two broad types: social categorization (simplistically the level of team cohesion and consensus within the group) and decision-making. The summary suggested that greater intra-group diversity (for example, group demographics) reduced group cohesion and contentment; but may increase the effectiveness of decision-making. But the review also concluded research was often conflicting and that further research into the field would be beneficial. Furthermore, the studies summarized were not limited to senior (board) level groups or decision-making processes.

George and Chattopandhyay (2008) reviewed group decision-making and discussed three aspects: access to information; information processing; and commitment to the decisions made. They conclude group decision-making may be a strength and the facility to access and process information may be improved, possibly more so in diverse groups (with possibly wider access to information sources and more diverse processing skills). However, diversity may work against group commitment to decision implementation. Thus, the quality of the initial decision-making process may be improved: but in a very diverse group, commitment of members to implement the decision effectively may be weaker. Furthermore, the tensions within diverse groups may be initially productive but act to destabilize groups in the longer-term.

The hypothesis tested by Simons et al. (1999) was that for group diversity to be constructive there needed to be the opportunity for debate. This seeks to use 'debate' as proxy for the factors of information access and processing discussed by George and Chattopandhyay (2008). Thus, "Without a debate, a team's diversity may remain an untapped resource" (Simons et al. 1999, p. 664). The Simons et al. (1999) research concludes that while diversity is beneficial it needs to be matched by an appropriate 'process'. Thus, the conclusions of this and other group decision-making research may be seen as displaying the benefits of group diversity (whether organic through group member characteristics, or artificial through intentional disharmony, as in DA) but only conditionally. Conditionality may involve the nature of the decision to be made and the resources available for the decision.

The organization: as a coalition

Cyert and March (1992) describe the organization as a coalition of different elements. This description of the 'firm' (organization) shows not a uniform set of actors working for a unified set of objectives. It describes a diverse series of interest groups and influences, with all different groups shaping different goals. Moreover, the different goals may not necessarily be complementary. This whole approach, if accepted, provides a significant sophistication to the issue of group dynamics. Thus, in this analysis it is not sufficient to only analyse group behaviour within the group environment, or indeed to assess the composition of the group. It is necessary to also assess the interests and groups of each inner faction within a group. In this analysis the group dynamics reflect the pre-existing positions of the different groups, with goal directed decision-making less in terms of one overall objective and more in terms of a patchwork of competing interests.

Bloom (2013), summarising research into early child development with a perspective on moral behaviour, concludes one of the strongest human drives from the earliest observable ages is the one towards *coalition*. Thus, it may be that the appearance of coalitions within organizations is not merely observed behaviour: it is necessary behaviour of the human beings involved in that organization. It may, therefore, be expected that in an organizational form such as a CCG, there will be an inevitable impetus towards establishing group identities and formal or informal coalitions.

Cyert and March (1992) have a model of the 'firm' that appears to provide a description of extreme consistency with the compositional dynamic of a CCG, and its Governing Body (GB). The CCG Governing Body has the following composition at the time of the research (consistent with most other CCGs to varying degrees):

- Full-time executive management officers (Chief Officer and Chief Finance Officer)
- Full-time clinical management officers (Chief Nurse)
- Part-time primary care leads (6 GPs including the Chair and 1 GP practice manager)

- Lay member as secondary care (hospital) clinical lead
- Lay member with responsibility for patient and public involvement
- Lay member with responsibility for audit and governance
- Other co-opted, non-voting, members from partner organizations (Local Authority, Public Health, and Local Medical Committee)

Therefore, although all members of the GB are formally committed to the corporate objectives of the CCG, the variety of backgrounds and associated interests of the individual GB members is likely to manifest itself as the group appearing a coalition. Cyert and March (1992) discuss the effects of the organization as coalition on corporate goal setting. Thus, the different elements of the coalition promote different goals. Not only different goals but also differing goal priorities at different times (referred to as variable 'attention focus'[17]. Therefore, we may attempt to describe the different priorities that may be present within a CCG, priorities that we may seek to explore and test within the research.

Governing Body Role	**Primary Goals and Priorities**
Chief Officer	Overall corporate success, trying to balance the competing priorities and interest groups in the organization. Also mindful of maintaining external relationship (a goal in itself) and may sacrifice organizational priorities to maintain them. As accountable officer will ultimately tend heavily towards the ultimate 'must-dos' of securing safe services and achieving financial balance.
Chief Finance Officer	Financial health (not just balance but whatever the current determined target may be) and value for money. Although will have the goal of financial probity will be prepared to be 'flexible' in finances to achieve goals. Will see that ultimately finances support delivery of care but will seek to make the money fit.
Chief Nurse	Major focus on patient safety both through commissioned services (such as safe hospitals) and provision of appropriate safeguarding mechanisms (for example, in support of vulnerable adults with learning difficulties). Although focussed on clinical outcomes, will have less attention to whether a service is at the very edge of best clinical practice and more on whether the basics of care are secure.
GPs	Major focus on improving clinical care and clinical outcomes. May take some elements of safety for granted (in some cases wrongly) and may only see

Governing Body Role	Primary Goals and Priorities
	money as an enabler to achieving clinical outcomes, not financial targets as an end in themselves.
Hospital Doctor	Primary role as a check and balance against the enthusiastic GPs who may seek to change services without appropriate regard to the impact on hospitals. Limited exposure to the CCG business means access to information is limited. Main goal to avoid chaotic disruption being produced by CCG decisions.
GP Practice Manager	Provides focus on development of primary care, primarily from an organizational perspective. Although has the goal of developing clinical services, principally in primary care, also provides a check and balance against GPs attempting to achieve the impossible in primary care.
Lay member – public involvement	Goal of engaging public, patients, and partners. Will seek to maximise attention given to engagement through any CCG process. Attempts to bring public and patient interests into the decision-making process, even though these may work against the stated objectives of the CCG.
Lay member – audit and governance	Prime focus on probity and good governance. Less worried about hitting the financial targets than how they are hit. One eye often directed towards the opinions of external bodies, such as auditors and statutory regulatory organizations. May well like process and transparent audits trails for decision-making.
Co-opted members	Priorities and goals will be in large part determined by their parent organization. Thus, although in theory their role is a GB member, will take their own goals into any decision-making process.

In one sense the range of goal priorities, described above, provides balance within the senior decision-making team; therefore, the range works against subjective and overly prejudicial decisions. This may help to reduce the likelihood of behaviours such as groupthink (Janis 1982), evidenced, for example, through the research of Hong and Page (2004) into the benefits of decision-maker diversity. However, it may dictate an approach in the decision-making process of negotiation between actors to achieve a consensus: this consensus being not just to achieve an agreed organizational objective, but to establish what *is* the goal. There can be no necessary assumption that the goals in a decision-making process, even where relating to an explicit stated

organizational objective, are jointly owned, and clearly understood as the same goal by all decision makers.

Negotiated order and negotiated environment

The dynamics observed in the coalition of the organization are considered to produce a “negotiated environment” (Cyert and March 1992, p. 168) that appears consistent, if subtly different, with the concept of the *negotiated order* (Strauss 1963, Watson 2002). Negotiated order is defined as, “the pattern of organizational activities that has arisen or emerged over time as an outcome of the interplay of the variety of interests, understandings, reactions and initiatives of the individuals and groups involved in the organization” (Watson 2002, p. 76). Negotiated environment is the product of a desire to “devise and negotiate an environment so as to eliminate uncertainty” (Cyert and March 1992, p. 168). Furthermore, the corporate world produces a planning process that “provides a negotiated internal environment. A plan within the firm is a series of contracts among the subunits in the firm” (Cyert and March 1992, p. 169).

One of the first approaches exploring the concept of the order within the decision making process, implying order is a negotiation of the various parties, was proposed by Strauss et al. (1963). Highly influenced by the work of Goffman (1961), Strauss et al. (1963) examined relations within the setting of a psychiatric hospital, exploring the creation of contracts, pacts or agreements between individuals and different groups within the organisation. These agreements were the subject of the negotiation process, which would draw upon hospital rules, policies, procedures, and the relative position of persons in the organization's structure. This approach is anchored in the symbolic interactionist tradition of social psychology, which explores the reality and identity construction of the individual through the process of interaction with others. The interaction in this context can occur via a multitude of mediums such as sight, language, or a compendium of cultural images. The study explored the process with different disciplines within the institution and the patients. It concluded that the agreements emerged from the negotiation process and that such agreements were always in the process of forming and changing. The term 'negotiated order' as a general application to the exploration of organizational life was not identified by his initial study but in his later work (Strauss 1982).

Ram (1994) in a detailed study of working practices in clothing firms, describes a continual process of workplace negotiation and ‘muddling through’. Thus, “neither harmony or autocracy was an adequate categorisation with which to grasp the informal, complex and conflictual make-up of the workplace” (Ram 1994, p.150). Ram (1994) suggests that a great deal of time in the working environment relates to ‘effort bargaining’ in the negotiation of workplace order.

Fine (1984) summarises four main elements of the theory of negotiated order.

- All social order requires some form of negotiation;

- The negotiations conducted are contingent on the structural conditions of the organization concerned and follow patterned lines;
- Negotiations are time-limited and require an iterative process of review, renewal, or revision;
- Major structural change in an organization involves a change of the negotiated order.

Nadai (2008) provides a summary of a number of criticisms of the theory of negotiated order. Firstly, that everything is negotiable, although the quotation of Strauss himself that “important things are always non-negotiable” (Nadai 2008, p. 5) suggests this observation may be a simplistic assessment. Secondly, those practising negotiated order give too much weight to the personal views of research subjects. This suggestion of subjects having perceived greater power than actually present in practice has been countered by suggesting that the concept involves assessment not merely of negotiation between individuals, but also of the impact of processes. Consequently, the research process identifies and explores the processes and structures at work within the social environment, not merely the negotiations of the individuals in practice. A third and more basic charge against negotiated order is the lack of rigorous definitions. Thus, although widely used as a core concept, major theorists appear not to explicitly define ‘negotiation’. In Strauss’s work on negotiated order there is reference to *negotiation* at times as distinct from other relational terms such as ‘coercion’, ‘manipulation’, and ‘persuasion’ (Nadai 2008). Depending on one’s definitions, such concepts may be opposed to negotiation or included within it as a concept of organizational interaction. Nadai (2008) describes necessary conditions for negotiated order to happen: tension between subjects’ interests (without which there would be no need for negotiation); and some capacity for exchange between the subjects providing some degree of opportunity for consensus. From the range of texts on negotiated order, such as Watson (2002) and Nadai (2008) we may propose a working definition of negotiation as: *observable attempts by decision actors to influence the organizational structures, power relations, and decision outcomes in the observed situation in accordance with the decision actors’ interests and objectives.*

It appears likely the dynamics of the negotiations arising through the establishment and maintenance of the ordered environment may influence the decision-making behaviour. Baron (2003) remarks that individuals may play different roles at different times, both formal and informal roles: for example, chairperson as a formal role, ‘clown’ as an informal role. From the table above, we may identify that individuals will not have only one goal. Furthermore, GB members may occupy a ‘corporate’ goal position: that is addressing the overall organizational objectives, rather than a sectional ‘interest group’ goal position at different times. This suggests a highly dynamic cultural environment. We may hypothesise the fluctuating relationships and balances of power and influence may be constantly recreating both a negotiated environment, who plays what roles at what times in what positions, and a negotiated order: which goals are consensually agreed are paramount, what secondary, and what discarded. The

organizational cultural environment may demonstrate *morphogenesis*: that is how much flux is present within the decision-making body, how roles evolve and the degree of goal shifting and prioritisation. This morphogenesis (shape creation in the decision-making process) of the group may show fluctuating roles of both the formal and informal types. Thus, a table describing GB roles may be complemented: by one showing informal roles taken my individuals whilst acting as members of the group. Boards may take such analysis into the field of organizational development by commissioning personality trait studies of group members that identify personality types, for example Myers-Briggs Type Indicator analysis (Gardner 1996).

We may describe the internal dynamics of the organizational coalition as stratified in three levels. One level is the formal structures and roles in place: job descriptions, committee terms of reference, schemes of delegation, budgetary responsibilities, etc. The 'lowest' level may be considered as the corporate culture (the informal shared meanings, values, and behavioural norms existing in the organization). In between these two then exists the level of the negotiated order. Therefore, the negotiation establishes the framework of informal personal, departmental, and corporate relationships. This framework allows distribution of organizational powers and influence and thus drives the prioritisation and goal setting.

In decision-making terms, the negotiated order is reminiscent of the Pfeffer and Salancik (1974) description of the decision process as a political struggle. Fine (1984) uses the term *micropolitics* in discussing negotiated order and the elements are consistent with the models of: bounded rationality (not only limited information, but an organizational struggle for who owns information and whose information evidence is primary); and the garbage can (variable attentional levels leading to variable attention on prioritising goals). Furthermore, Quinn (1980) describes the role of the manager in decision-making as working with different organizational 'sub-systems' involving different groups at different times. Thus, applying an incrementalism approach to negotiated order supports the assertion of negotiation being a dynamic and on-going phenomenon across a decision-making process.

With a theoretical foundation that has been traced back to Cyert and March (1962), Hambrick and Mason (1984) developed a framework for studying so-called 'Top Management Teams' (TMT) within an overall description of the *upper echelon* (UE) of organizations. This paper appears to have stimulated a whole sub-genre of group dynamic research, under the heading of UE (summarised in Carpenter 2004). The focus of UE research is into the group behaviour of those at the top of organizations, who we may assume are those most likely to be involved in strategic decision-making. Furthermore, although most of this is outside the NHS or similar organizations, it may have some comparisons with a CCG Governing Body. (Carpenter (2004, p.754) provides a typology of definitions of who is considered to comprise the *upper echelons*.) The UE research appears to support some conclusions from the organization as coalition concept. Manager demography (experience and background) appears as factors in UE behaviour, as do values held by TMT members. However,

research appears to highlight possible mediating factors, such as intra-group communication and the level of debate (Carpenter 2004), evidently supporting some of the broader group decision-making conclusions on information processing and avoidance of a strong desire for consensus. An interesting development is the shift for some authors from TMT to TMG (that is Top Management *Group*). This emphasises the dynamics of the senior body as often lacking harmony: the use of the term 'team' cannot be assumed to mean teamwork is happening in practice. Furthermore, Carpenter (2004) suggests that although much UE style research focussed on senior groups, it may be unwise to discount the impact of individuals within the group. Whilst the studies through the UE genre are helpful to inform the dynamics within a decision-making group, it may be appropriate to place the demography and values of individuals and groups within context: broader environmental influences will remain very strong and may not be overridden by a senior team.

A further dynamic within group decision-making is how the group members use evidence to support their decisions. Kovner et al. (2009) conclude evidence-based decision-making is more effective and should be promoted. However, they also conclude its use is not systematically applied across healthcare decision-making. This research is confirmed locally in the NHS by Cox (2012), who suggested one factor in the degree of evidence-based approaches used is the composition of the decision-making body and whether clinicians (doctors and nurses) were part of the process. Thus, not only will different personalities, backgrounds, and roles shape how individuals behave in the decision-making process, but also their approach to using available evidence and information will vary. Clarke et al. (2013) surveyed NHS commissioners and found that the use of evidence in decision-making was variable, and that "Only 50% of respondents stated that clinical guidelines and cost-effectiveness evidence were important for healthcare decisions". Furthermore, those who most used empirical evidence came from Public Health backgrounds. The greater the seniority of the manager the less empirical evidence was used, with practical ('local' or 'soft' intelligence) used more frequently. For CCGs the presence of medically trained individuals *per se* may not necessarily improve evidence-based approaches (although this may be likely overall). Consideration will be needed to the involvement of different clinical disciplines (such as Public Health professionals) to improve the balance in the decision 'team' and the benefits of evidential techniques.

NHS Boards

There are a small number of published papers on the NHS and negotiated order: but few looking specifically at board level behaviour (Exworthy 2001). This suggests there may be paucity of ethnographic research into NHS Board behaviour, and an even further lack of such studies into board or board level decision-making. Exworthy's (2001) study explored negotiated order and role theory relationships between Chair and Chief Executive Officer (CEO) across 17 NHS organizations. The study used qualitative interviews within an analytical framework derived from the realist approach of Pawson and Tilley (see Pawson 2009). Exworthy (2001) found distinctions between

Chairs and CEOs. CEOs tended to have a large amount of NHS experience, Chairs typically much less so: over 20 years for a typical NHS CEO; less than 10 years for an archetypal Chair. In terms of roles, there appeared to be a more clearly *external* role for Chairs (referred by some respondents as 'public relations') and *internal* for CEOs. The relationships were labeled according to quality, from 'strong', through 'comfortable', to 'satisfactory', inferring there is a likely span reflecting both the relationships between individuals, and the context within which such relationships occur. Where differences were identified between the roles, these appeared most frequent in the early stages of relationships, suggesting the process of negotiation required time to reconcile disagreements. Critical incidents (Exworthy 2001) were seen as an important factor, which may cement or weaken relationships, depending on their outcome and how the incident affects the relationship. Although the research highlights the benefits of role definition and, probably more importantly, role demarcation it also concludes on the importance of how the relationships develop. Thus, Exworthy (2001, p.90) states: "The evolution of the relationship over time was especially significant, as this was mostly conducted informally by reaching a set of tacit understandings and agreements". The tacit agreements appear to reaffirm the role of the negotiated order concept in board dynamics, at least between the two lead participants.

Published papers on NHS Board performance included a mix of guidance and research. The tendency was towards guidance rather than primary research. Where research was published its methodology was in most cases that of qualitative interviews. Seven recent papers receive more detailed examination below.

Davies (2007) does not provide any primary research but is rather a review of commissioning in the 'New' NHS (no longer new following the latest reforms) from a legal perspective. The paper includes concerns regarding both the dual provider-commissioner role of PCTs and issues in relation to its disappearance. Although this is primarily an issue of the past (CCGs having no defined provider functions) it may re-appear should CCGs gain a greater responsibility for the commissioning of primary care. Further concerns were raised regarding conflicts of interest, particularly through the potential use of private companies to provide commissioning support functions. However, this appeared to be identified as a potential risk rather than an observed behaviour. Overall, the paper is written primarily as a critique of the then initiative of Practice Base Commissioning (PBC) rather than a critique of Boards per se.

Veronesi et al. (2012) seeks to test the impact on corporate NHS performance of clinicians being a formal part of the board directors' team. The research sought to examine Trust performance over a three year-period against two main measures (Healthcare Commission rating and patient morbidity data collected by the Doctor Foster research institute). The study was of provider organizations only and did not explore any similar theme with commissioning organizations.

The research concludes that the inclusion of clinicians (essentially medical doctors) on NHS Trust Boards was beneficial in terms of the measures identified in the study. However, the paper also colludes the causal factors as to why the greater presence of

clinicians on boards would have a beneficial effect was unclear. Although no causality was established, if there is the possibility of some form of causal link between performance and clinician involvement, the development of clinically led commissioning organizations seems to be worthwhile.

The Chambers (2012) paper is placed within the context emerging after the enquiry into Mid-Staffordshire NHS Foundation Trust (MSFT), with its associated concerns for patient safety and compromised governance. The paper provides no primary research but 'draws' from social science literature on board working. Chambers identified three issues:

- There is no consensus or consistent evidence as to an ideal Board form. (The basis for the original model of NHS Trust boards in 1991 is considered inadequately explained.)
- Local circumstances are as important as any overarching principles for board working.
- There is said to be an, 'emerging proposition' of effective boards needing to have: trust between the directors; robust challenge; a grip on the delivery of quality patient care; and delivered in a financial sustainable way.

The first two points have some evidence and may be helpful in producing a better understanding of board functioning. The third point, whilst not necessarily incorrect, appears to, in large part, merely state significant elements of what a successful board would achieve. As such it may be as much an aspiration to a performance level, rather than tools to achieve an end. (How many boards wouldn't want to be challenging and trustful, delivering high-quality patient care within financial resources?)

Chambers (2012) does make the point that the close adoption of the private sector board model in the NHS from the 1990s was never reviewed in terms of its utility in the public sector. Chambers (2013) later produced a second review built on the summary of Chambers et al. (2012). As with the earlier paper, there was no primary research, but rather an extended review of associated evidence (reviewing 670 articles). The paper provides a very comprehensive summary of theories of board behavior across both private and public sector organizations. The conclusion from the research was the authors found no simple formula for successful boards. However, they suggest elements required for a successful board include "high challenge, high trust and high engagement" (Chambers et al. 2013, p.8). Chambers et al. (2013) recommend further research into NHS boards into their composition, ability to influence on clinical quality, and the impact of organizational development activities with boards. Governance failings are associated with (if not causally linked) to a lack of focus on clinical performance. Financial matters are sited as both preoccupying some boards away from clinical quality or being largely ignored by others. Some of the literature reviewed here critiques board performance as often lacking a focus on strategy: generally accepted as a major role for a board. However, arguably little of such critiques define what they mean by the term strategy. As our review of strategy infers, strategy itself is

a complex concept and thus we may question whether judgements as to how ‘strategic’ boards behave may be in part dependent on one’s definition of the term itself.

Bevington et al. (2005) summarizes work related to “250 NHS Boards” over a four-year period. The paper does not describe a methodology for the research with the NHS Boards, and therefore it is difficult to critique the paper as primary research. It was also written before the establishment of the current system of Foundation Trusts and as this is produced in part as a guide for good practice it may be considered a piece of its time, with more limited relevance to current practice. The article states, from the boards sampled, they tended to be either good at challenge or good at trust: but rarely good at both simultaneously. Some interviewed board members described the risks of groupthink in the higher trusting environments. There seemed numerous examples of this type of low challenge behaviour (references include terms such as ‘club culture’ and senior cliques). The main conclusion and recommendation of the paper was that effective NHS boards needed to balance trust and challenge, with the key role in the body being that of the chair.

The Ramsay et al. (2010) review has a broader scope than just board functioning and includes descriptions and assessment of corporate governance. As with Chambers (2013) there is an assessment of different models of board behaviour and governance. The review includes statements (common to a number of papers) regarding the importance of strategy within the role of the board. However, it also describes the importance of quality and safety and how high-performing organizations have this as a central and standing item on board agendas. Whilst the review covers many topics in other papers on NHS boards it also describes innovation as a foundation of good board practice. It does, however, recognise that the evidence for boards influencing innovation is limited. This may in part link to a deep concern in much of the literature with board accountability and responsibility, with governance at times being a synonym for organizational control. The Ramsay et al. (2010) review provides another useful summary of literature and views on board behaviour and performance; however, it also has no original primary research on NHS boards.

The ICSA (2011) report collected data from NHS Board level Directors (through online surveys) and studied papers and agendas from NHS Board level meetings. There was some limited observation of actual board meetings (20 in number). From all data sources Board meetings tended to have a minority of issues that were considered as strategic, despite all respondents suggesting the main purpose of the Board being strategic issues. Examples were cited of board non-executives not challenging executive directors, even in the face of severe performance challenges. The research infers that from the Board papers scrutinized included only a minority (2%-18% depending on definition) of items explicitly presented as for a decision. This may be interpreted either as: an inappropriate form of agenda drafting with an excess of papers ‘to note’ with less focus than optimal on decision-making; or alternatively that as strategic decisions are large and infrequent, the ongoing work of a Board will include monitoring and assessment of services that are the product (or the

prequel) to a strategic decision. The research identified the major board priorities including "safe, high quality care" and "accessible responsive services" (ICSA 2011, p.16) as two of the top five. More so than the two most obviously 'strategic' themes: "shaping future healthcare" and "Resources used effectively, efficiently" (ICSA 2011, p.16). This may imply that although the Boards consider their major roles to be driving strategy and direction, their practice implies that oversight of operational delivery and performance is actually a greater concern. (For all types of NHS Trusts studied the overwhelmingly largest agenda theme for every type was operational performance (ICSA 2011, p.17-22).

Despite all the NHS bodies researched being public bodies, holding some of their Board meetings in public and employed as being servants acting on the public interest, only 1% of respondents stated involving the public in shaping healthcare was a Board priority. The ICSA (2011) paper suggests an inadequate focus on strategic issues and too great a focus on operational issues. Decision-making was considered to involve too little challenge with a variable quality of supporting information for papers presented as for decision.

The 'strategic' role of boards has been discussed, but not always defined. If this is one of, if not the most important, roles of a board, it may require further consideration, particularly where research seeks to describe just how strategic boards are behaving. Furthermore, patient quality and safety are also identified as high priorities in high-performing boards. This may be seen as potentially contradictory, as much of the focus on quality and safety will be inevitably operational in nature. This is not to suggest it is inappropriate, but rather we may question whether the assumption of boards being largely 'strategic' is actually the case in practice. Some authors may suggest a board is strategic by its nature. Alternatively, it may be that boards are not necessarily strategic in nature at all and that the governance requirements involved in providing oversight and assurance into patient safety and quality are so important as to be a necessary function of NHS boards, whether they qualify as strategic or not.

Similarly, the conflict between governance as a system of control overseen by the board; and innovation as a practice promoted by the same board may not be easily reconciled in practice. It may be that organizations accept different methods to promote innovation and accept that the requirement for the board to deliver organizational control and accountability as a body will not allow it to be particularly 'innovative'. This may still allow the promotion of innovation within an NHS organization but not specifically by the board as a formal body.

The scope of this research study does not allow consideration as to the 'optimal' configuration of a CCG Governing Body: the main constituents of the body are mandated in the 2012 Health and Social Care Act. Although there is the capacity for local implementation, there is relatively little discretion as to its composition.

NHS Boards as negotiated orders

The research and papers summarised above can be considered through the perspective of the negotiated order. Thus, Exworthy (2001) identifies role definition and professional background as influencing factors and the negotiated order process may be seen as the mechanism through which the alignment of roles and individual expertise profiles are managed. The perceived benefits of group diversity in decision-making committees suggest a need to promote a level of role, and possibly individual, divergence; however, for the group to allow effective decision-making, diversity requires reconciliation. The desire to promote a sense of 'checks and balances' between power groups (as in the Chair-CEO relationship described by Exworthy (2001)) may necessitate such reconciliation. Consequently, the charge that boards may not always behave 'strategically', in that their agenda setting may include only a minority of strategic issues (and therefore, strategic decisions), may be misplaced. Consideration of operational issues, wider organizational development discussion, and a range of agenda items that may fall outside of a definition of 'strategy' may all facilitate group working. Such time may allow the process of negotiated order to resolve disagreements and allow definition of power relations.

Bevington's (2005) described polarity of 'good at challenge' or 'good at trust' may illustrate how negotiated orders evolve in practice. This evolution will be influenced by the composition of the groups, this determining the potential balance between challenge and trust. The wider environmental context may allow an assessment of whether the balance produced is considered 'best fit' with its own environment? As described in the example of a CCG Governing Body composition detailed above, the evident range of individuals in board level committees suggest ongoing negotiation in the group may be a continual feature of strategic decision-making.

Agency and Stewardship Theories

Discussion on the dynamics of board decision-making and the negotiated order may be further informed by an assessment of the role and nature of the board in the corporate environment. Consideration may be given to the concepts of agency and stewardship theory. Both attempt to analyse the relationship between the senior executive functions in an organization (primarily senior managers or boards) and those whom the executive represents (shareholder and owners in the original models). Public sector organizations have not been central to the early developments of the theories but have emerged as legitimate areas for consideration in contemporary research.

As a brief summary, agency theory describes the Principal-Agent problem (PAP) (see Eisenhardt 1989 for a review of agency theory):

- Organizations will have principals (owners, shareholders) with specific interests in corporate performance. The principal will appoint someone (usually

a senior manager or managers) to carry out work on their behalf, defined as the agent.

- The interests of the principal and agent have the potential to diverge. For example, in managing risk, a shareholder would mitigate risk through a balanced share portfolio and may be best served accepting high levels of risk within an organization if it is accompanied by the potential for high rewards. A manager (agent) may seek to mitigate the risk through diversification into other economic areas that balance the risk: but this may be accommodated by lower overall returns. Thus, addressing the interests of the agent (lowering corporate risk to make sure the company stays in business) conflicts with that of the principal (who may accept the risk of corporate failure if it maintains higher short-term gains).
- The principal and agent will experience information asymmetry. The agent (likely to be closer to the day to day business of the organization) may have greater access to information and may be able to use this to further his interests, at the expense of the principal. (For all three points see Jensen and Meckling 1976.)

Agency theory appears to have emerged from the economic environment of the early 1970s and in part reflects concerns regarding the attitude towards risk in major corporations. The theory has been subsequently finessed and critiqued (Eisenhardt 1989) and may be seen, at least in its initial incarnation, as simplistic and reflecting a base in a rational economic decision-making model. Donaldson (1989, 1990) has produced an alternative model to agency theory, explicitly accepting that the motivations for actors are more complex than the classic decision model (and consequently agency theory) assumes. Donaldson's model (1989) is consistent with a bounded rationality model and describes agents acting as *stewards*: working in consistency with principals for a common corporate goal. This suggests interests are more complex than merely simple economic self-interest and that principals may need to invest less heavily in performance management and control measures.

The dynamics of agency and stewardship theories (sometimes included within a discipline description of *organizational economics*) may have relevance to one of the earlier questions raised and which may appear repeatedly through the review and possibly through the subsequent research itself: that of "what is commissioning for?" Thus, with the concept of strategy we identified tensions between strategy as long-term planning and strategy as strategic thinking. This can be seen to lead to different approaches and influence how decisions are made. The nature of the organizational coalition within the negotiated order will influence both the approach and nature of corporate strategy (potentially in different ways at different times). Similarly, the dynamics within the coalition may influence the practical application and answer to the question of "what is commissioning for?"

The challenge for describing agency theories for a CCG is in the first instance to define whom is the principal. This may be one of a number of possible stakeholders or,

probably more likely in practice, a network of stakeholders and interest groups. This provides a starkly different comparison with that of early agency theorists (for example Jensen and Meckling 1976). For Jensen (1976) the interests of the principal (primarily shareholders) are defined narrowly in terms of share price and profit. This provides a clear definition of interest and therefore allows straightforward assessment of the corresponding interests (divergent or otherwise) of agents. However, such a simple definition of interests has been criticised even in terms of its applicability to companies limited by shares (Donaldson 1989): such a simple definition may be even more problematic for a public sector organization. Thus, it may be concluded there is identification of the 'principal' role as being provided through a network of stakeholders, producing a complex web of associated (but potentially conflicting) interests.

If the task of identifying the agent (in this case the CCG Governing Body) is straightforward, describing simple agency interests may be as complicated as with attempts at doing so for the principals. The attempt at such an exercise and the consideration of "what is commissioning for?" confirm the assessment of Cyert and March (1992) as to the complexity and dynamic environment of the coalition.

Tools of negotiation: exploring the role of power

The concept of negotiation demands an assessment not merely of those negotiating or the outcome of that negotiation: be it ordered or otherwise. It also recognises that the process that creates negotiated order involves the members of the negotiating environment requiring tools with which to negotiate. Possibly the most important aspect in the negotiation and the one that may be the largest dependent factor influencing the outcome of the order creation is: power.

Lukes (2005) discusses definitions relating to the term power, suggesting difficulty in clearly defining power as one term. Dahl (1957) in an early essay on the subject provides a basic definition of power: "*A* has power of *B* to the extent that he can get *B* to do something that *B* would not otherwise do" (Dahl 1957, p. 202-203). Dahl's approach focuses primarily on the element of power as a relational concept and Lukes (2005) develops the concept to a more sophisticated level but maintaining the possibly of one comprehensive definition of power. Thus, power is described as having two variants: 'power to' and 'power over', the latter being a subset of the former (Lukes 2005, p.69). Thus, *power to* may not necessarily have a relational element, whereas *power over* will be primarily relational. This also allows power to be conceived as more than merely a feature of domination. Similarly, Giddens (quoted in Gaventa (2003)) describes power as, "both as transformative capacity (the characteristic view held by those treating power in terms of the conduct of agents), and as domination (the main focus of those concentrating upon power as a structural quality)" (Gaventa 2003, p.7).

Lukes (2005) describes three 'views' of power, documented as three dimensions. The one-dimensional view of power (often seen as referenced to Dahl (1957)), also titled a pluralist approach, describes power in the field of decision-making and explores how

the various parties involved in a decision-making process exercise their powers. This view assumes power is primarily overt and visible to the parties and observers. In the two-dimensional (reformist) view (attributed to Bachrachand and Baratz, see Clegg 1989), also focussed on decision-making, there is an acceptance of not only overt power, but also covert power and the ability of those in power to remove certain issues from the decision-making forum. In the three-dimensional (radical) view there is an identification of power, in addition to its overt and covert elements, as that of power over latent conflict. Thus, in the three-dimensional view those with power may not only remove items from decision-making, but to avoid their very appearance as issues in the first place. (Lukes' three-dimensional model has been empirically tested in a real-world setting by the case study of Gaventa (1982).) Clegg (1989) summarises the Lukes model in tabular form

Table 1 - Summary of the Lukes 3-Dimensional Power Model (from Clegg 1989)

	Three-dimensional view including one and two-dimensional views		
	Two-dimensional view including elements of one-dimensional view		
	One dimensional view		
Element	**1st Dimension**	**2nd Dimension**	**3rd Dimension**
Objects of analysis	Behaviour	Interpretive understanding of actions	Evaluative theorization of interests
	Concrete decisions	Non-decisions	Political agenda
	Issues	Potential issues	Issues and potential issues
Indicators	Overt conflict	Covert conflict	Latent conflict
Field of analysis	Preferences revealed in participation	Preferences embodied in sub-political grievances	Relation between revealed preferences and 'real interests'

Lukes' (2005) three models may be theoretically applied to the CCG as a negotiated order in its decision-making.

- One-dimensional. Through this view the negotiated order is played out in plain sight. The information and evidence used in the decision-making process are made visible to all decision-makers. Their interests are explicit as are their

points of view and background. The decision debates play out openly. The outcomes of the decision-making process are clearly defined, even if a consensus cannot be achieved.

- Two-dimensional. Although the elements described in the one-dimensional view appear present, there are also identified elements in the decision-making process that are hidden. Access to information is unequal across the members of the decision process. Certain parties may promote selective evidence and information in support of interests that may be both overt and covert. Some elements of the decision process may be presented as fait accompli: assuming some decisions need not or cannot be made.
- Three-dimensional. The overt and covert elements of the two-dimensional process are present, but some important factors may not even be considered. This may be through deliberate exclusion from the decision debate ('they do not need to know this') or through cultural influences that establish a 'common sense' acceptance that assumes some factors do not even deserve consideration.

Lukes (2005) references Gramsci's concept of hegemony in developing his three-dimensional view in support of its dimension of ensuring consent. Thus, from this perspective consent and an acceptance of power relations is not necessarily a resignation to others power, but possibly a willing acceptance. In a similar vein Harvey (2005) describes Gramsci's definition of common sense as not being good sense, but rather "profoundly misleading, obfuscating or disguising real problems under cultural prejudice" (Harvey 2005, p.39). Hegemony here, therefore, is defined as the cultural predominance of a set of ideas and beliefs that is accepted by a social group.

In its original form, Lukes (2005) three-dimensional view has the role of domination as significant. Domination being a constituent of the power of the powerful and by definition is a relational element of power as 'power over'. Lukes self-critique appears to possibly soften the 'power over' aspect of power to fit the 'power over' as a sub-set of 'power to'. This is consistent (and possibly prompted by earlier considerations) with the Morriss (2006) definition: power being the 'ability to effect outcomes'. Thus, although the original three-dimensional view may emphasise the factor of domination, we consider the 'one-two-three dimensional' power framework is applicable to the analysis of the negotiated order of CCG decision-making. Without research we could not assume that domination was present or absent. The possibility of latent power within individuals or groups during the process bears consideration: through research it may be possible to explore the levels of overt, covert, and latent power. As such the Lukes power framework, possibly with necessary adjustment, supports analysing the systems of negotiation within the organizational coalition. It should be added that the use of the three-dimensional approach in the research is within an organizational context and elements of Lukes' model are more obviously applicable to a wider socio-political context. For example, the third dimension borrowing from Gramsci's concept of hegemony and the wider Marxist conception of false consciousness. This may not apply directly in an organizational context in quite the same ways as the Marxists may

see false consciousness from a class perspective. Benton (1981) is critical of the role of false consciousness in the Lukes model and describes Marxism's 'paradox of emancipation'. In this project the third dimension is less related to false consciousness and more to how organizational decision-making works within unspoken and unchallenged cognitive frames. Frames that may provide power to certain groups that are then exercised, consciously or unconsciously.

Morriss (2002) discusses at some length a definition of power and suggests a lack of definition is present in a number of works on power (Lukes possibly being one). For Morriss (2002) power is seen primarily as a capacity. He is at pains to separate a definition of power as a capacity and a *potential*: from its use as a *thing* (a resource or vehicle to demonstrate power) and as an *event* (the exercise of power). The perceived mistakes are labelled as respectively the vehicle fallacy and the exercise fallacy. Although the focus on potential and capacity may provide some degree of clarity, it may be a step too far to assume there is no vehicle or exercise element to power. For without a vehicle to exercise power or some evidence that power can indeed be exercised, how powerful would a potential be? Morriss may be correct to question a direct convergence of the three elements of capacity, vehicle, and exercise into one definition of power. Without the evidence of all three it may be considered that power, as a social phenomenon, may not really exist. Continual action (exercise) would presuppose no unrealised potential and thus there would no facility for capacity. A vehicle to exercise action but no capacity to actually act would be, almost by definition, absent from potential and thus powerless. The presence of capacity to use a vehicle to exercise action does presuppose in addition to the presence of capacity, the presence of some vehicle (resource), which produces the potential to exercise the potential (power) through action. Consequently, we may infer that the three elements should not be conflated into one: but also, that they are necessarily inter-dependent.

Morriss (2002) describes concepts that are either related to power or often conflated with it: influence; control; and coercion. Along with power itself this can form a basis for a typology of negotiation tools within the negotiated order. Although Morriss (2002) describes power as different from the elements often confused or conflated with it, there is little attention given to defining these other elements. Mintzberg (1983) infers that the seemingly interchangeable terms of power and influence should actually be the same thing. Thus, influence is merely a description of power itself. Mintzberg (1983) discussed definitions of power but doesn't explore in detail whether influence is the same concept or an alternative. Rather the evident ambiguity of the term influence and its exchange with the term power in everyday use is seen as sufficient cause to abandon a distinction between the two. The consideration of the literature and practical experience of management may side with Morris (2002) in seeking to avoid conflations that blur the definition of power. In this case it seems necessary to maintain a distinction between the terms of power and influence. Power for this project is seen as a capability (for Morris (2002) an 'ableness'): an ability to affect outcomes. Whereas influence is seen as a potential ableness: an ability to possibly affect outcomes. Although clearly related, from this assessment influence may be seen as

more wholly dependent on contextual, cultural, and environmental variables, than power. As a real-world example, it may see that the CCG Chair has the power of a vote in the Governing Body. This is unconditional and exists by the very fact of being in the post. (How the power is exercised, voting positively, negatively, or through abstention, does not affect the presence of the power to vote.) The Chair may also possess influence over how others may vote: but this is conditional upon the decision in question and relation of the chair to other voters. It may be seen that influence can be either used as a basis for power or in some senses be translated into power. The Chair working with other Governing Body members may establish an organized group voting in concert in such a way as to effectively move beyond merely 'influencing'. This is not sufficient, however, to conflate influence with power as one term. They remain related, overlapping, but essentially distinct.

Morris (2002) further discusses the measurement of power, with particular consideration as to voting, ability, and ableness. Despite the development of mathematical models to assist in such measurement, it is unclear whether they can be applied in a useful fashion in the current research. It is helpful, however, to recognise the assessment of Morris (2002) that power is not necessarily a fixed quantity. Thus, Morris (2002) suggests some authors have considered power a 'zero-sum' concept: for some to gain power others have to lose it; however, this negates the possibility of power being created. In the current project the influence of the external environment on the decision-making group may result in power shifts that may involve some members or sub-groups gaining power (through, for example, a change in government policy) that may not directly reduce the absolute power of another group, but rather their relative power within the decision-making body.

Whilst not discussed in terms of measurement, in a similar vein Mintzberg (1983) describes a view of the bases of power. The five are listed as: control over a resource; control of technical skills; control of a body of knowledge; rights to impose choices; and lastly the access to those who possess the other four. We may consider that although Mintzberg's bases elaborate a view of power in the organization they are not necessarily exhaustive or may not significantly extend the concept of power beyond that described alternatively through authors such as Lukes (2005) and Morriss (2002). Thus, whether 'power to' use resources, skills, or knowledge, the typology of the 1-2-3-dimensional models appear valid as a model for the project and helps understanding the role of power in the negotiated order. Mintzberg (1983) explores further how power is used within the organizational coalition. This approach identifies 4 'systems' of power: authority; ideology; expertise; and politics. This confirms the assessment above of the different groups within the organizational coalition (see the Governing Body table above) and not only their relevant interests, but also the way in which different members within the negotiated order may seek to gain and use power. Thus, we may explore the power 'systems' in the context of the research:

- Authority – Who has authority (formal and informal) and how does this affect the potential and exercise of power.

- Ideology – What ideologies are in play and how do they affect the power relations.
- Expertise – What technical knowledge systems are in use and how is the expertise used to gain power.
- Politics – What internal and external political factors shape how power is used.

Whilst on the subject of power, the project reaffirms the benefits of analysing decision processes as an effective means of examining the presence and exercise of power. This is in contradiction to Morriss (2002), who is critical of work by Dahl (1961) exploring decision-making in USA local government. Morriss asserts it is incorrect to explore power through decisions ('issues') and that researching power requires a more holistic approach (as was approvingly, for Morriss, provided by Gaventa (1982)). This seems possibly contradictory in terms of methodology, for elements of Gaventa's research do focus on decision-making. Furthermore, Morriss (2002) does not dispute that decision-making is an element of the exercise of power; rather he sees the focus should adjust to that of outcomes for participants. Although a focus on outcomes may be beneficial, it may downplay an important part of decision-making itself: that it is indeed an exercise of power (using capacity as a vehicle) and thus is appropriate and arguably essential as a subject of study in researching power. In the case study strategic decisions would appear to be one of the main ways in which the balance of power between decision-makers, and how power is actually exercised, can be effectively explored. Furthermore, in organizations decision-making may be one of the most obvious areas where the practice of power in use can be observed: thus, providing empirical evidence for the analysis of power. Clegg (2009, p.5) describes two main differences in classical approaches to power:

> Hobbes and his successors may be said to have endlessly legislated on what power is, Machiavelli and his successors may be said to have interpreted what power does.

In this case we may add that it may be only through the analysis of what power does, that we can fundamentally understand what power is. Thus, the empirical assessment of power use is not merely an observation of the practise of power, but also reveals more completely what power is (or may be). Conducting the research into CCG decision-making may allow exploration into how and why power is used in the creation of negotiated order, and how in practice it relates to the other tools of negotiation.

Concluding remarks on group decision-making

The concepts of negotiated order and the organization as a coalition provide a potentially rich basis of knowledge and evidence upon which to build a conceptual framework for the research. Watson (2003) discusses organizational study, including negotiated order, as in part a sociological examination. Thus, this current project would appear to be a sociological study of decision-making practice within a CCG. The concept of a sociological study is helpful to frame the research within a wider environmental context. The early studies developing the concept of negotiated order

may imply its use is primarily focussed into the internal dynamics of an organization. Such an inference may be an over-simplification. In later work Strauss (1982) describes the place of order negotiation as having both internal and external dimensions. Thus, “when a single organization is being studied, it should be viewed as embedded in a matrix of other organizations” (Strauss 1982, p. 350). Furthermore, Strauss (1982) discusses organizations as engaging in “arenas of participation”, arenas that involved negotiation between the various participants in any given arena.

Although the negotiated order concept is described in various studies, it may be difficult to determine it as a precise social form based on empirical studies. The research is a novel study of the concept as how it may apply at upper-echelon management in the NHS. This picture of negotiation and ordering at different levels fits within an assessment and analysis of organizational behaviour beyond the internal dynamics of a CCG. Of necessity it warrants consideration as to the corporate environment within which the CCG operates. Such a multi-layered approach suggests analysis and understanding of the agents of commissioning decision-making (be they individual or organizational) and the structures where such agents practice. This may demand a more developed discussion on the concepts of structure and agency.

The consideration of negotiated environment and negotiated order may help illuminate the question asked earlier of ‘what is commissioning for?’ Traditional approaches to public sector commissioning consider assessment of the need to be addressed as the origin of a commissioning process. This needs assessment, however, may not necessarily be straightforward or value free. In a consideration of NHS commissioning in the 1990s North (1997, p.382) concludes: "Even when reduced to the more manageable proportions of a single health problem, such as mental health, stroke or head and brain injury, the process of determining those needs is a complex and uncertain one”. Furthermore, where complexity of subject matter and diversity of interest groups collide, the establishment of something close to an objective assessment of need may be difficult or impossible. Consensus may be established but facilitated only by the arrival of simplicity and repetition.

As the question of assessing need (the supposed foundation for commissioning) is considered to be complex and multi-factorial, the potential complexity may increase further by grounding the needs assessment within the organizational coalition. Although the grounding may increase initial complexity, the ensuing richness may enhance the understanding of how the commissioning process functions. Thus, we may describe differences of ‘what for?’:

- Differences of outcome: improvement in service delivery through change; improvements in safety through focus on maintaining consistency; improvements in access to promote patient experience.
- Differences in target groups: focusing on the elderly as the major users of services; focus on the young as the ones where the gain in life years may be greatest; focus on the deprived as the ones with the worst health outcomes;

focus on prevention and early intervention; focus on evidence-based interventions (regardless of where they are).

All of which will be influenced by the position of individual members of the coalition. What may be tested through the research is the respective positions adopted in terms of 'what is commissioning for?' related to the individuals as agents within the coalition and the group behaviour as a coalition. In some respects, commissioning becomes as much as question of not only 'what for?' but 'who for?'

2.5 What is commissioning and healthcare commissioning?

Still barking up the tree

Kenneth Clarke is considered a major political figure in the history of the NHS as the Secretary of State for Health from 1988-90 (Webster 2002 and see Appendix 2). Two decades after being a major architect in the emergence of the modern form of health commissioning in the NHS, he commented, that if commissioning was seen as a failure then "that would be the biggest blunder of them all. If one day subsequent generations find you cannot make commissioning work, then we have been barking up the wrong tree for the last 20 years" (Timmins 2008, p.28). At the time of the case study, as the NHS moved towards its 70th birthday, the definitive judgement as to commissioning in the NHS was still unclear. However, success or blunder, at the time of the research, commissioning was alive and well. Well… it was certainly alive, having just created over 200 commissioning bodies in the form of CCGs. The research thus observed the commissioning CCG dog barking: up a tree of possibly uncertain status.

Introduction

The NHS reforms introduced by the UK coalition government (2010-15) included changes to the commissioning system and the creation of a national body with responsibility for healthcare commissioning: NHS England (established following the Health and Social Care Act 2012 (Great Britain 2012)). The 2012 Act (Great Britain 2012) defined commissioning as:

> Commissioning is the process by which future health and social care will be developed and, as such, has a significant role to play in service transformation. It involves much more than procuring services and managing transactional issues as they arise. It is the process commissioners use to plan, deliver and monitor services for their local population, based on strong leadership and effective relationships, great outcomes and best value (NHS England 2014).

The origins of current NHS commissioning may be traced to the development of a policy initiative in the late 1980s of the internal market (Webster 2002), partly introduced during the stewardship of Kenneth Clarke. The internal market was aimed at introducing elements of market competition into public services. Specifically, for the NHS it involved the emergence of the 'purchaser-provider split': the separation between the functions of, on the one hand, planning and buying healthcare (commissioning) and on the other the delivery of care services (provision). Thus, the need to design future service provision against identified need; to target resources to achieve specific ends (sometimes politically motivated); and achieve value from taxpayer generated funding streams, results in commissioning being seen as much more than simply purchasing.

The process of commissioning may be understood through the commissioning cycle: a circular, dynamic, and continuous process of needs-based planning, procurement, and performance management.

Figure 7 - The Commissioning Cycle (from Department of Health 2007)

Similarly, the Local Government Association (LGA) describes commissioning as "activities that combine to achieve efficiency and maximize value" (LGA 2012, p. 3). The activities include:

- Understanding need and desired outcomes
- Optimizing resources
- Targeting
- Choosing the right mechanisms

This is also summarized graphically as (from LGA 2012):

Figure 8 - The Local Government approach to commissioning

Murray (2008) provides a summary of definitions and descriptions of commissioning in the UK public sector. This concludes the common features of a commissioning cycle being: strategic needs assessment; deciding priorities and outcomes; planning and designing services; options appraisal; sourcing; delivery; and monitoring and review (Murray 2008, p. 91).

Therefore, for both the NHS and the wider public sector the concept of commissioning is: needs based (what is the need to be addressed); outcomes focused (how will the need be addressed with what intended results); and resource driven (what resources will be used to achieve the intended outcomes). Increasingly commissioning may be seen to have a strong focus on performance management (how do commissioners know when they have achieved their outcomes and satisfied needs?).

Murray (2008) identifies that although widely used the term of commissioning is not regularly defined and may be used interchangeably with similar but distinct terms such as procurement and contracting. The formal descriptions of commissioning include the elements of procurement and contracting (both being narrower terms relating to purchase and the establishment of contractual relationships) but are considerably broader, with particular reference to the elements of planning to address need, prioritization of resource allocation, and monitoring of delivery to achieve outcomes. Murray (2008) summarizes in graphical form the relationship between procurement and commissioning:

Figure 9 - The relationship of the commissioning and procurement cycles

Strategic needs assessment
Decide priorities and outcomes
Plan and design services
Optional appraisal
Sourcing
Delivery
Monitor and review
The commissioning cycle
procurement
Determine the need
Supplier selection
Contracting
Ordering
Expediting
Follow-up/ evaluation
The purchasing cycle

Having established a definition of commissioning it may be beneficial to explore how different healthcare systems use resources.

Comparative commissioning

Differences exist between countries in their approaches to providing healthcare for their populations. Analysis of different systems and the evident differences in outcomes assured for the system's populations is explored in more detail in Appendix 1. Although it may be possible to identify forms of planning and funding healthcare that are analogous to that of the UK NHS system of commissioning, there appear to be no direct comparisons. Furthermore, although evidence supports the assertion of the relatively poor cost to health outcome results delivered in the USA (see Appendix 1); the rapidly changing political landscape may make such comparisons redundant. In the USA case, the Patient Protection and Affordable Care Act (in early implementation stage at the start of this project) may significantly change how the USA supports its population accessing healthcare. Consequently, international comparisons are of interest, but possible more in terms of the potential lessons NHS commissioners may learn from other areas, than in finding a replacement model for NHS commissioning as a whole.

We may infer that analysis of current comparative international health systems presents the following, tentative, conclusions:

- Increased healthcare funding may often be associated with improvements in life expectancy, but continued improvement will not be linear.[18]
- The overall shape of healthcare systems, particularly its degree of population coverage and degree of focus on health improvement, will have a significant influence on health outcomes.[19]
- Publicly funded healthcare can achieve good health outcomes and higher value for money by restricting access to marginal benefit health interventions.[20]
- High-cost specialist hospital care may improve individual health outcomes, but the benefits at a population level are less certain.[21]

Despite the difficulties of comparing different health systems, the international evidence does appear to confirm there are benefits to some form of healthcare strategy within a form of healthcare resourcing consistent with the NHS definition of commissioning. Furthermore, comprehensive access to care requires fitting healthcare usage within a limited, indeed increasingly limited, resource envelope. Consequently, achieving value for money from healthcare is a strategic issue: arguably for NHS commissioning the major strategic objective.

Policy approaches to healthcare commissioning

Some of the examples below demonstrate healthcare commissioning at a national, largely policy, level. They may not describe the process of strategic thinking within individual commissioning bodies: but they do describe approaches as they emerge from national policy, which may well be mirrored within organizations tasked with implementing NHS policy. This may prompt the question whether genuine, autonomous strategic thinking is possible at lower level commissioning, for example, in CCGs and formerly Primary Care Trusts (PCTs).

a) Introducing the internal market in the UK NHS. A series of reforms, introduced from the late 1980s through until the mid 1990s, saw a government committed to a general approach of free-market economic liberalization seek to develop a form of free-market style competition and market mechanisms within the NHS (Webster 2002). The strategy appeared as straightforward: find ways of replicating the market (through initiatives such as GP fundholding); and through the use of competition and market mechanisms drive cost-savings (for example, through service out-sourcing to cheaper private providers). The strategy may be seen as having few output objectives, other than saving money, and was directed towards operational functioning rather than outcomes.

b) The NHS plan, initiated in 2000 lasting until the end of the Labour government in 2010 (Webster 2010, NHS 2000). The NHS plan was part of a sustained effort by the government to invest in public services and bring the NHS spend to the level of comparative European health services. This represented a large attempt at strategic planning on a national scale, and whilst suggesting there was scope for 'local determination' its large number of targets and nationally developed service frameworks, directed the majority of service development as consistent with the government intentions. This had a national development vision and involved the NHS moving towards service delivery around performance management of mandated targets. Rather than promoting autonomy at the periphery, the strategy assumed top-down direction would deliver the improvement in outcomes and outputs,

c) The NHS reforms of 2010, with major implementation at organizational level in 2013 (NHS 2010), following the introduction of the 2012 Health and Social Care Act (Great Britain 2012). The overall approach was initially a small move away from performance targets, and instead an emphasis on developing local clinical leadership. The original spirit of the reforms appeared to suggest targets and priorities would be primarily the responsibility of local clinicians. But the early evidence implies that any government of the day may find it difficult to let go of responsibility for target setting, suggesting there may be a dissonance between word and deed.

d) The Wanless report, "Securing Good Health for the Population" (Wanless 2002) was commissioned by the then Chancellor of the Exchequer to provide an assessment of how health improvement and healthcare could be delivered within affordable public sector resources. The report described three levels of scenario built around how well the NHS and the population engaged with public health initiatives, thus shifting resources from expensive down-stream hospital care into more upstream preventative services. By implication the report suggested a 'strategy' (of sorts) for the NHS of focusing heavily on public health. But an interim assessment of implementation (Wanless et al. 2007) concludes the 'full engaged' scenario of a population seeking to maximize its health was far from in place.

All of the examples described above emerged in their own political climate and consequent motivations. Thus, for a) the motivation was to make the NHS behave more like a market with the belief that market mechanisms and competition would improve care and efficiency. For b) there was a belief in a return to more directive national planning and a more whole-scale adoption of performance targets. The reforms in c) were conceived in large part as a way of shifting decision-making authority to clinicians, whilst d) represented its original political sponsor (The Chancellor of the Exchequer) in seeking to achieve greatest value for money for NHS resources. All four in part reflected the policies of their respective governments and to some degree political party ideology.

What is also evident when working through the examples is the degree of political compromise and pragmatism present in the policies at the point of implementation. Thus, the most obvious solution to developing a market environment in healthcare would be to privatize a nationalized system and introduce fully fledged private capital markets. In the late 1980s, however, privatizing the NHS was considered politically impossible (Timmins 1996) and thus a 'virtual' market system was developed. Although market-like this inevitably produced compromises that diluted some of the potential benefits of free-trade exchange in a fully market-based economy. The introduction of the NHS plan focused on performance targets, but also recognized the difficulty (often impossibility) of removing poorly performing health providers, and where clinical guidelines suggested greater service centralization there appears little appetite to be seen to promote unit closures or to tackle local political influences. The 2010 White Paper originally described commissioning as led by GPs. The controversy surrounding the reforms led to a 'pause' (Timmins 2012) in the reform programme with a number of resulting changes to the initial programme. It may be too early to tell whether such changes have improved or deteriorated the programme (it is likely such an assessment may be impossible in any remotely objective sense). What the changes did appear to do was increase the number of organizations created and to probably complicate the whole commissioning process (Timmins 2012). In the Wanless case, the 'fully engaged' scenario, whilst evidence-based and possibly deliverable, required initiatives and actions which political parties may have felt unachievable (at least in terms of them staying in power through re-election). Thus, it took several years to gain the political consensus to introduce plain packaging for cigarettes, even though there was evidence to suggest it deters cigarette smoking, the reduction of which was a prime action within Wanless (2002). This practice of policy implementation only within the scope of what is considered as electorally acceptable is consistent with the concept of the Overton Window (Russell 2006). This also implies that the guidance and policies that emerge from central government departments, such as the Department of Health, will already be heavily influenced by external and internal factors before they are communicated to front-line commissioning bodies such as CCGs. These influences are likely to continue to be present when CCGs themselves are involved in strategy development and implementation.

Concluding remarks on commissioning

The literature on commissioning appears relatively limited in terms of high-quality research. Definition documents and 'how-to' guides, relating to either the NHS (Department of Health 2007) or local authorities (Murray 2008) are descriptive of the commissioning process, rather than explorations of commissioning practice. The approaches to commissioning discussed above are also records of policy driven directions to the task of commissioning. They are not research based evaluations of which approach may be better. Indeed, the very political nature of approaches to the NHS, and consequently commissioning within it, make such evaluations problematic.

The cases identified above, in addition to the earlier narrative on defining commissioning, beg a possibly fundamental question: what end is commissioning seeking to achieve? The grounding of commissioning for public services is that of assessed need. This in itself poses further questions. How is the need defined? Who defines it? Furthermore, there may be an assumption that 'need' can be defined objectively. The research tests whether the various influences do allow such objectivity, as the complexities of defining need will occur in context. The complexities in defining need include:

- Timing. Although commissioning organizations such as the CCG will have access to a Joint Strategic Needs Assessment (JSNA) for its area (produced in collaboration with the relevant Local Authority) the time required to produce such analysis may result in the assessment being considered no longer current. Although evidence it only becomes useful evidence if actually used by decision-makers.
- Subjectivity. Any needs assessment will involve a degree of subjectivity. Thus, a list of health needs will require prioritization and a degree of discretion. In some cases, such as assessment of mental health needs, the very assessment of a need itself may be seen as subjective.
- Context. Needs assessment will occur in a real-world context of competing priorities and attempts at objective assessment will necessitate recognition of wider influences. The influences on the decision-making process will shape what is considered by be the population needs.
- National versus local. With a corporate context of nationally directed policy, commissioning often needs to balance requirements to deliver initiatives to address perceived national need against a possibly divergent aspiration to address more locally focused needs. With a decision-making body, such as a CCG Governing Body, with a predominance of local clinicians make test the national to local balance.

Not only are there potential issues in needs assessment, but also the process of assessment, prioritization, and decision on what is to be done will not necessarily be straightforward.

Overall the process of commissioning at least by intention is relatively straightforward: attempting to satisfy identified needs through the allocation of available resources.

What is important for this study is to recognise that this process is not value or politically neutral. It occurs within a politically driven policy environment and issues such as how to use competition will influence local decision-making. Furthermore, just as the variability of evidence to support decision-making may vary so the subjective interpretation of those charged with commissioning will influence how it is implemented.

2.6 Frames and influences in the decision-making environment – Developing the conceptual framework

The moralization gap

What may make the 'living tapestry' of the people in organizations so rich and interesting is its diversity and complexity. Thus, this rich tapestry is not of individuals and groups who think the same: rather views of the same phenomena may elicit different opinions. Pinker (2011) describes the concept of the *moralization gap*: the difference in interpretation of events depending on the individual's role in an event, particularly where one was a perpetrator and one a victim. Thus, the difference in perspective provides a potentially major difference in narrative[22] (Pinker 2011).

The *perpetrator* sees an event as self-contained, relatively minor, an act that was largely necessary and determined, with few after effects and one that should be forgotten, with those involved moving on. So, 'it was really nothing, an accident I regretted but it was over soon, and I have already forgotten it'.

For the *victim* the event had a long pre-history, had a devastating impact, with effects lasting long into the future, being wilfully malignant by the perpetrator, and one that will never be forgotten by the victim. So, 'they have always hated me, this was the last in a long line of deliberate actions to harm me, it will haunt me forever'.

Based on psychological research Pinker (2011) suggests that these alternative views are sincerely held, and different groups will collect their own sources of facts and supporting information. This apparent discrepancy, as both cannot be objectively correct, may be in part due to position, experience, and thus how an individual or a group looks at an issue. They will see phenomena through ways of looking at the world: cognitive frames.

Introduction

Earlier in this review we encountered the concept of framing, which has been a central part of much of the analysis related to behavioural decision-making (Tversky and Kahneman 1981) and prospect theory (Kahneman and Tversky 1979). Furthermore, the previously discussed concept of bounded rationality may see the organizational boundaries identified as types of frame. The further use of framing may assist in describing not merely the 'who?' of decision-making (that is the constituencies of decision-makers) and the 'what?' of decision (what actions are taken with what effects) but also the 'how?' of decision. Thus, research complementary to that of negotiated order - into organizational framing - supports the project in defining how the different constituencies, decision-makers, and power groups communicate through the decision process. Frames and framing thus form part of the analysis of understanding how different influencing factors emerge and combine or compete in the process of strategic decision-making.

This chapter discusses:

- What is framing and different framing concepts and models
- The framing environment as evident to a CCG. The framing environment discussion summarises the major strategic influences from the literature that may affect decision-making in the CCG. The influences are described at three levels: the macro (high level, national, very large scale); the meso (middle level, at organizational scale); and micro level (individual and small group scale).
- The conceptual framework that emerges from the study of the literature and the framing influences in particular.

Framing

Frames have been defined as “schemata of interpretation” (Goffman 1974), which give meaning to events and information. The frames allow users to “organize experience and guide action” (Benford and Snow 2000). Benford and Snow (2000) further infer that frames are ‘action oriented’ sets of meaning and belief, which help to shape opinions and organize organizational support. For this definition, organizational framing is not merely a system of cognition (developing meaning) but also a system of organizational politics (developing power and influence). The framing concept used in this research is from Benford and Snow (2000): the *collective action frame*. In this form framing does involve helping to construct meaning but also aims to generate support for action and to engage with constituents and constituencies (Benford and Snow 2000, p. 614).

Cornelissen and Werner (2014) summarise framing concepts across a range of social science disciplines. This includes describing framing across three levels:

- Micro – the level of the individual or group, often as referred to in behavioural decision-making research (Kahneman and Tversky 1979).
- Meso – the level of the organization, as referred to in consideration of strategy making (for example, Kaplan 2008, and Kennedy and Fiss 2009).
- Macro – the level of broader corporate and cultural environments.

The separation across levels appears to align with the current research project’s consideration of external and internal influences and its relationships with structure and agency. The consideration of the level at which the frame emerges and impact on the decision may be important when researching strategic organizational decisions. This may be distinct from the decisions researched through behavioural decision-making, which have primarily studied the decisions of the individual, often outside of an organizational setting (for example Kahneman 2012). Thus, the varying influences of external and internal environments and the shifting and competing frames in the negotiated order may result in less predictability in the patterns of decision behaviour. Kaplan (2008) discusses ‘framing contests’ where differing frames compete for supremacy within a communication technology company.

A further dynamic is that between primary framing (priming) and secondary framing (Goffman 1974, Cornelissen and Werner 2014). Here priming is a form of framing but

represents the framing effect of pre-existing paradigms that create a frame (or frames) from cues in the operational setting. This is a form of primary frame: the social situation (in this case the negotiated order) has no impact on the frame. Thus, Goffman's statement, "It seems we can hardly glance at anything without applying a primary framework, thereby forming conjectures as to what occurred before and expectations of what is likely to happen now" (Goffman 1974, p.38) brings to mind Kahneman's (2012) regarding "intuition is remembering". However, although there may be similarities between the primary frame and the System1 – System 2 separation of behavioural decision-making (Stanovich and West 2000), the framing concept is developed at a deeper organizational level. This is not merely the individual's prior knowledge: the primary frame appears to provide an individual and group scene setting at the outset of a decision process.

In framing (as distinct from priming) the frames emerge through social interaction. The social interaction, therefore, creates a new frame, which may relate to pre-existing concepts (and thus, possible pre-existing frames), but which is not identifiable as a decision frame at the outset of the period.

Inter-subjectivity – framing as imagined order and the role of emotion

Harari (2014) considers the creation of order in human history, going well beyond the organizational concept of negotiated order, but with nevertheless some similarities. Harari's (2014) hypothesis is that human society has been possible in part due to its ability to cement cooperative relationships through 'imagined order': cultural phenomena such as religion and politics and belief systems more generally. This is consistent with the concept of negotiated order in organizations and, furthermore, provides a useful subtlety in its treatment of types of knowledge phenomena. Thus, Harari (2014) discusses three phenomena: the objective (that which is physically there); the subjective (that which is created in the mind of the individual); and thirdly the inter-subjective. The inter-subjective thus is created from individuals but exists as shared assumptions with its consequent power coming from its very mutual form. Inter-subjectivity may be seen as a form of framing process, where group frames are constructed. Potentially, at least following Harari (2014), this construction process works across micro, meso, and macro levels. Furthermore, the construction of any cultural order is not seen as being 'imagined': rather it "disavows its fictional origins and claims to be natural and inevitable" (Harari 2014, p.150). Therefore, the strength of the strongest frames and of the negotiated order itself lies not necessarily in its objective relation to empirical evidence but in its ability to develop and reinforce beliefs that are seen as inevitably correct. (In this case we may say 'correct' rather than 'true'.) Despite the probable benefits of evidential decision-making, frames in use may have uneven levels of empirical support. In some respects, this may be beneficial but not always necessary. Rationality in the case of the negotiated order: being the tail to the emotional dog (see Haidt 2001). The social intuitionist model (Haidt 2001) infers that

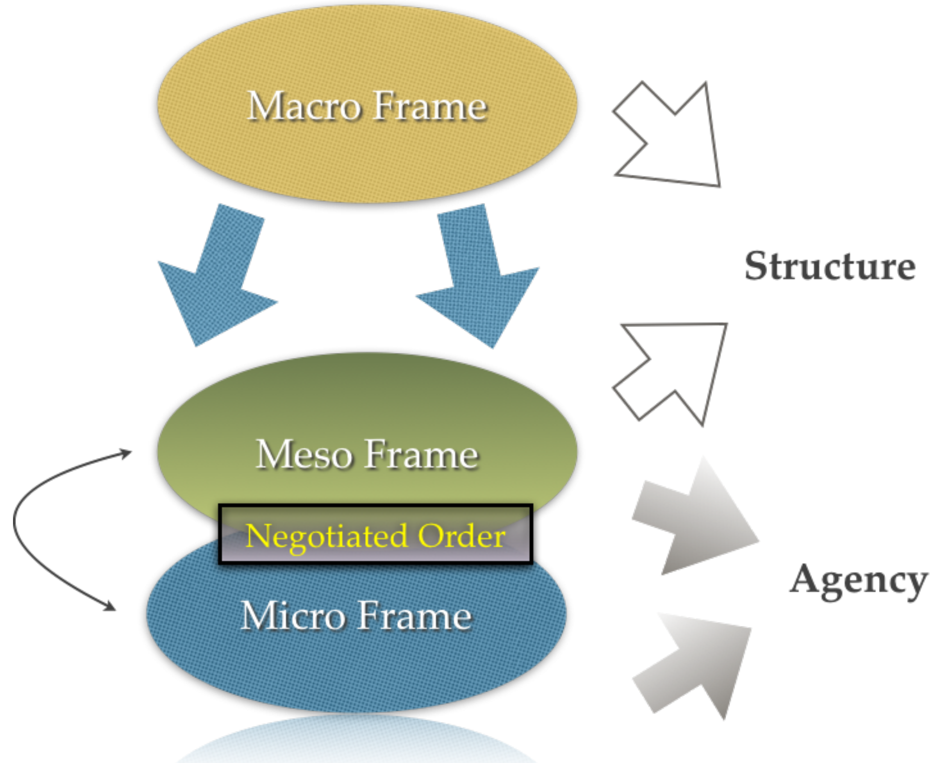
rational arguments used in support of decisions are primarily post hoc justifications, rather than pre-decisions considerations. This may suggest that in relation to framing the most important frames in a decision-making process are the priming frames: those that decision-makers have when they enter the process. This may result in a lesser importance for the social interaction frames. If this is the case, the negotiated order assumes greater importance for the use of power than lesser for the creation of interpretive frames. Pizarro and Bloom (2003) critique the social intuitionist model, referencing research inferring where “fast” positions are formed this is generally done based on previous reasoning. Furthermore, they assert that individuals do engage in active reasoning: the ‘dog’ thus not being entirely ‘emotional’. Pizarro and Bloom’s (2003) critique echoes Kahneman’s ‘intuition is remembering’: decisions evidently driven by ‘emotion’ or at least lacking obvious rational consideration may actually be using reason and learning from previous experience.

Haidt (2001) is concerned primarily with decision-making in the context of morality, and thus it may be debateable as to its strict application to organizational decision-making. More fundamentally, and in relation to the concept of emotion in decision-making more broadly, there are researchers who question a strict definition between reason and emotion in decision-making. This is demonstrated in the aforementioned concept of the somatic marker hypothesis (Damasio et al 1996, Bechara 1997), where neuroscientific studies suggest the more ‘emotional’ parts (and functions) of the brain complement, rather than undermine the rational elements. More fundamentally still, the recent development of the concept of the ‘theory of constructed emotion’ (Barrett 2017) infers a complex pattern of physiological, psychological, and cultural processes at work in the production of emotion. Thus, for Barrett (2017, p.31), “With concepts, your brain makes meaning of sensation, and sometimes that meaning is an emotion”. But the concepts in use will shape, frame, whether the response is emotional and what emotions will occur. This may be of great importance in exploring the role of individual behaviour within groups within a complex decision-making environment. This also recognises the multiple levels at which concepts and frames are applied.

The framing environment

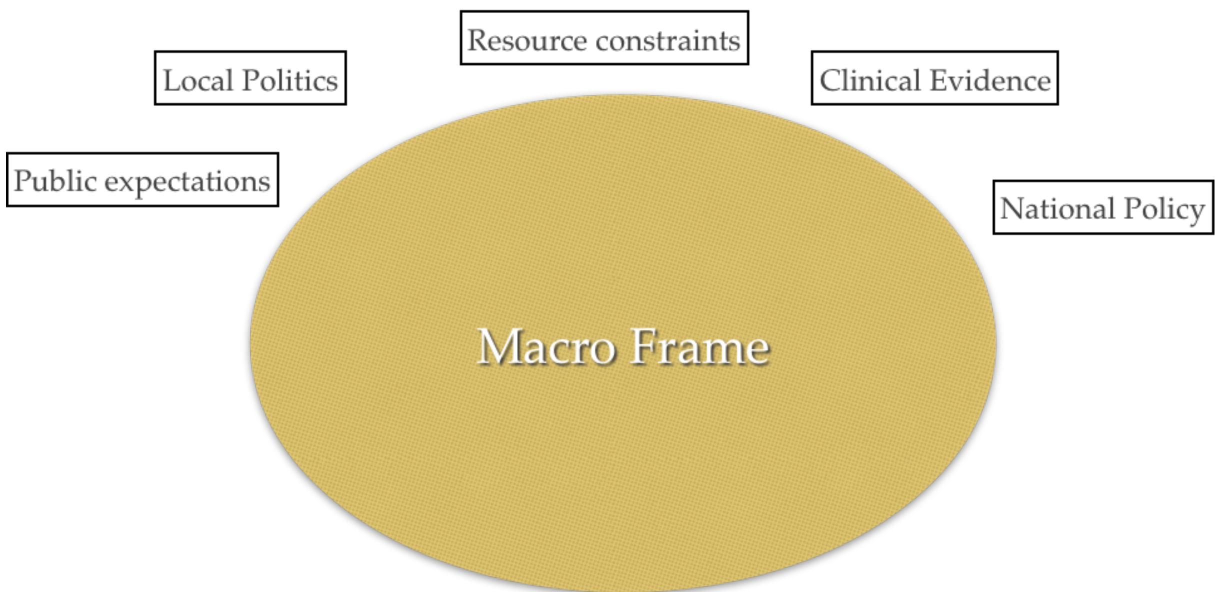
From the assessment of frame levels, it may be necessary to redraw the constituency maps according to not the two dimensions of external and internal, but of the three dimensions of Cornelissen and Werner (2014). Thus, the previously described influences are aligned to the three levels, where the influences drive the frame production and use. The synthesis of influences and frames, producing the environment within which the negotiated order develops is represented as:

Figure 10 - 3 Tier Frame Model of negotiated order construction



The Macro frame

Figure 11 - Tier 1 the Macro Frame



Public and stakeholder expectations

Gomes (2010) studying the influences on Local Government decision-making develops a 'five-sided' model of stakeholder influence. This provides a broad range of influences through the concept of the stakeholder. Gomes defines stakeholders as "people, categories of people – such as employees, managers, suppliers, owners and customers (service users for public organizations) – and organizations, which have a stake in the organization's objectives" (Gomes 2010, p.707). We may consider this description as to be so comprehensive as to ultimately lack definition and thus in the context of our research to be possibly too broad. Nevertheless, research on decision-making influences may help to identify which stakeholders do influence NHS decisions, including whether a model as developed by Gomes (2010) in relation to Local Government can be generalized to the NHS. The level of stakeholder influence described is considered so significant that, "satisfying the stakeholders' expectations is the main goal of public sector managers" (Gomes 2010, p. 707). It may be expected that the NHS may behave in a similar manner to Local Government, both in terms of the influences its experiences and how it conducts goal setting. However, it may be necessary to define the groups of stakeholders with greater specificity.

One of the almost inevitable consequences of the NHS being funded through general taxation is the view within the tax-paying community (in effect the whole adult population) that it has a sense (usually a strong sense) of ownership over the service. For Nutt (2005, p.294) “Everyone has an ownership stake in a public organization”. This includes views as to how services are delivered and prioritisation of how and where resources are used. The pressures this exerts of the commissioning process may be many and diverse, but we may identify three potential public expectation pressures. Firstly, ‘localist’ aspirations of improving patient experience. Secondly, perceived threats to service provision, which encourage opposition to service reconfigurations. Thirdly, populist views on publicly funded healthcare services that may be at odds with either needs assessments or published evidence.

Local politics

Whilst NHS strategy is in part driven by national politics and may thus reflect an element of political ideology, there is no necessary continuity of political views across the whole political spectrum. One area where this discontinuity may manifest itself is in the behaviour of local elected politicians. In extreme cases this has shown elected members of the political party of the sitting government vigorously opposing health policy that is considered to be locally unpopular.

Local political systems (primarily those part of the Local Government framework) provide processes for authorisation and scrutiny, which may often be a necessary part of the decision-making pathway for strategic decisions. For example, the upper-tier Local Authorities are statutorily obliged to provide Overview and Scrutiny of Health Committees (OSC). For a CCG seeking to implement a major strategic change it is quite likely there will need to be at least a discussion and consideration with the OSC (and by definition associated partners) if not indeed a process of formal public consultation. Although it may be argued that NHS commissioners should seek wide engagement and consultation before implementing major changes, the need to proceed through formal channels and to manage change processes within the gaze of public attention may influence the commissioning process. Thus, “The external environment of a public organization is littered with political considerations” (Nutt 2005, p.293).

Resource constraints

A national body, NHS England, determines CCG financial resources. NHS England itself is funded through the Department of Health, following inter-departmental negotiates within the financial management of the UK Treasury. In simple terms the resource allocations given to CCGs (as with previous NHS commissioning bodies) are centrally determined and there is very little flexibility for local variation. Funding formulas have been developed to allocate resources to different areas, and a new, ostensibly more age related, funding formula was introduced by NHS England in 2014-15. (As with previous examples, the introduction is implemented in a phased manner,

with movement towards target funding occurring through differential application of funding growth rather than absolute reductions to CCG allocations. In the case under scrutiny the CCG is within a group designated as furthest away from target allocation and thus received the lowest level of funding growth nationally.)

At one level the resource allocation is less an influence on commissioning than part of commissioning itself: it being a form of resource allocation to satisfy need. In this respect it is not so much an influence than a factor shaping the boundaries and framework of the commissioning process. On the other hand, however, the overall direction of funding and perceptions as to its likely development over time may influence decision-making. Thus, if we refer to the financial history of the NHS, we see periods of high and low growth. The level of current growth and expectations as to future growth may influence the approach to service development (do commissioners focus on getting best value from core services in times of austerity, or are they allowed to expand access and service provision in times of growth?). Certain services become centrally placed within this discussion one possible example being access to NHS funded In Vitro Fertilisation (IVF). IVF is considered a triumph of modern medical science and is thought 'evidence-based', with NICE supporting its use and considering it a cost-effective medical intervention. From an alternative standpoint, IVF does not directly address a primary health need (that is, it does not save lives, or improve the wellbeing of those with ongoing disease). Consequently, there may be differing schools of thought as to whether it should be funded through the NHS. On the one hand it is a proven medical technology that may enhance the lives of those who receive it; on the other, it may not be the most pressing demand on the scarce resources available. Here is the point where scarcity becomes a critical and context dependent commissioning variable. In 'times of plenty' there may still be a strand of opinion that does not support NHS funding of IVF, but with expanding resources many will see a logical sense of expanding access to services (such as IVF). In times of austerity, calls for expansion of service will be less readily heard and thus it may prove more difficult to develop novel services, particularly those that do not directly address a core health need. Paradoxically this may lead to commissioners funding relatively unproven services that may target a health need, whilst refusing to fund evidence-based interventions which are, nevertheless, considered marginal in terms of their overall health impact. (In 2014 some CCGs were commissioning IVF access well below that recommended by NICE, and in one case a CCG did not commission it at all (McVeigh 2014). At the same time CCGs were developing multi-million pound investment programmes under the title of the 'Better Care Fund' (LGA 2014), targeted at supporting elderly patients being managed more in their own homes. The evidence base for this programme was relatively uneven and at times appeared as an article of faith, compared to the 'hard' evidence of an intervention such as IVF.)

All of the above is not merely important in terms of relationships to specific issues. Rather it is also important in terms of creating an environment of perception as to resource availability and how planning should be focused in the medium and longer terms.

Clinical Evidence

Research and the evidence-based approach to medicine is often considered as both one of the major achievements of the discipline and a bedrock of a scientific approach to further development of healthcare (Gray 2009, Greenhalgh 2010). Despite this, there can be no automatic assumption that the clinical evidence base is either value free or objectively non-controversial. Reviews of the veracity of medical research have judged: “studies that report positive or significant results are more likely to be published” (Dwan et al. 2008, p.1); and “evidence for the existence of study publication bias and outcome reporting bias” (Dwan et al. 2008, p.1). Consequently, some authors conclude, “the medical literature therefore represents a selective and biased subset of study outcomes” (Chan and Altman 2005, p.1). It is important, therefore, as; it shapes the development of healthcare science; and it is a fundamental element in the decision-making resources of the commissioning process. It is not, however, something called ‘the truth’. Thus, in a similar vein we may quote Gould (1992), "Facts do not 'speak for themselves', they are read in the light of theory”. For theory, one may also substitute ‘ideology’ or any number of other relevant biases.

A further complexity in the analysis of evidence is not merely what *is* the evidence but *who* is using it. (Again, we do not consider it as inappropriate to see evidence in these terms. There is possibly no more than relative objectivity, if at all. Consequently, it does appear as if the evidence is being ‘used’, for good or ill.) The negotiated order describes a theatre of battle in the decision-making process within which participants will use evidence as one of a number of tools facilitating forms of negotiation and influence. Thus, we may re-phrase Gould’s statement in terms of evidence as an influence: ‘Evidence does not speak for itself: interest groups, within the organizational environment, present on its behalf’. The study from Lord et al. (1979) reinforces the possibility of evidence being used to support pre-existing positions. Although an experimental study that may have limited ecological validity, the research demonstrated participants using evidence to support pre-existing prejudices on the issue of the death penalty. Lord et al. (1979, p.2108) concluding “social scientists can not expect rationality, enlightenment, and consensus about policy to emerge from their attempts to furnish "objective" data about burning social issues”. Opinions on sensitive issues such as the death penalty may not necessarily reflect biases that appear in a complex decision-making environment such as the NHS. It may, however, question whether the emergence of evidence, of whatever quality, will necessarily provide balance into polarised debates[23].

National Policy

As with resource allocation there may be consideration of whether national policy is necessarily an influence on commissioning or just part of the commissioning process. Nevertheless, at the level of the decision-making body (of organizations that are created as statutorily independent) national policy may not be seen as something only to be followed, but rather as one of a number of competing influences and pressures

to be managed. This may be seen as another example of the Principal-Agent problem (Jensen 1976 and see earlier in the review) in that the central 'parents' of health policy produce directions and guidance to 'child' organizations, such as CCGs, with the intention of such bodies implementing the guidance. The organizations themselves may see things a little differently. Watson (2002) remarks that all organizations contain an (ultimately) irreconcilable tension: that between the need for control (one of the very points of having an organization in the first place) and the need to allow (and in some instances promote) autonomy for individuals and individual departments. Thus, successive NHS commissioning systems have sought to promote a sense of local ownership and autonomy. (Examples include GP fundholding, Practice Based Commissioning, and the very emergence of CCGs themselves, see Appendix 2.) This may, however, work against centrally determined planning guidance. Furthermore, there may be no automatic assumption that a local commissioner (such as a CCG Governing Body GP) will prioritize national priorities over local ones.

Further influencing factors of national policy are that directives may manifest themselves as capricious and impatient. The politically charged nature of tax-funded healthcare may encourage governments to change policy directions quickly, both in response to public pressure (and more probably) in relation to pressure for other political agencies (opposition parties or a variety of pressure groups and lobbyists). Nutt (2005) comments that the scrutiny placed on public bodies, compared to private companies, is 'intense' and the nature of the scrutiny often 'fickle'.

On its election the coalition government of David Cameron stated it was moving away from nationally driven targets and non-clinically driven performance measures, such as hospital patient waiting lists. By the mid-term of the administration there was evidence of extended waiting times compared to the previous government and the coalition's response was to instigate a new focus on reducing waiting times (backed by additional funding). The contradictory and possibly resource consuming messages may not be well received at a local organizational level. And such changes in policy often appear to emerge with an associated sense of haste (labeled 'urgency').

The Meso and Micro frames

The influencing factors on the meso and micro frames intertwine and present themselves at both levels.

Figure 12 - Tier 2 the Meso Frame

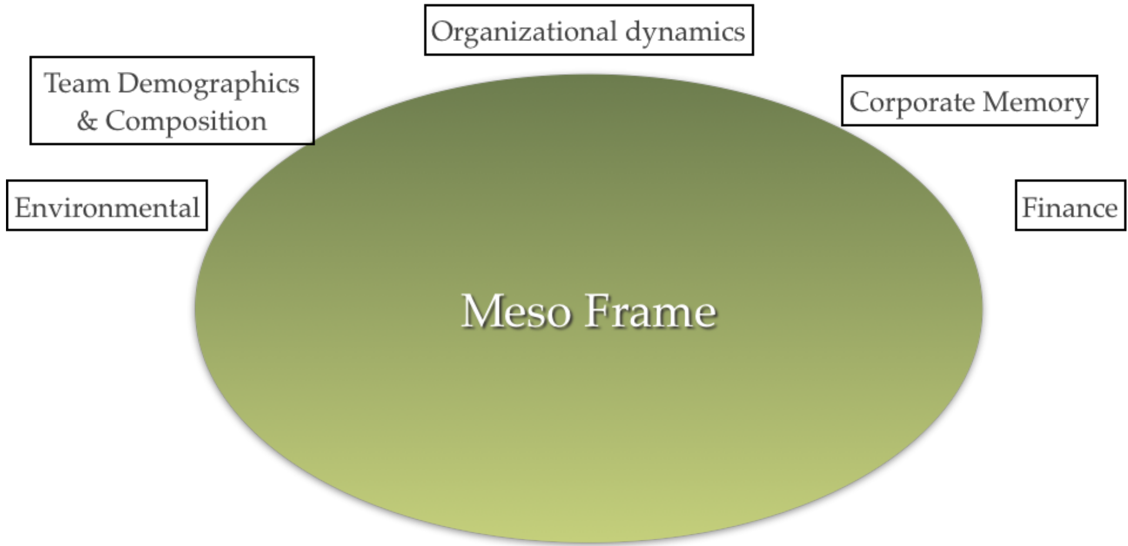
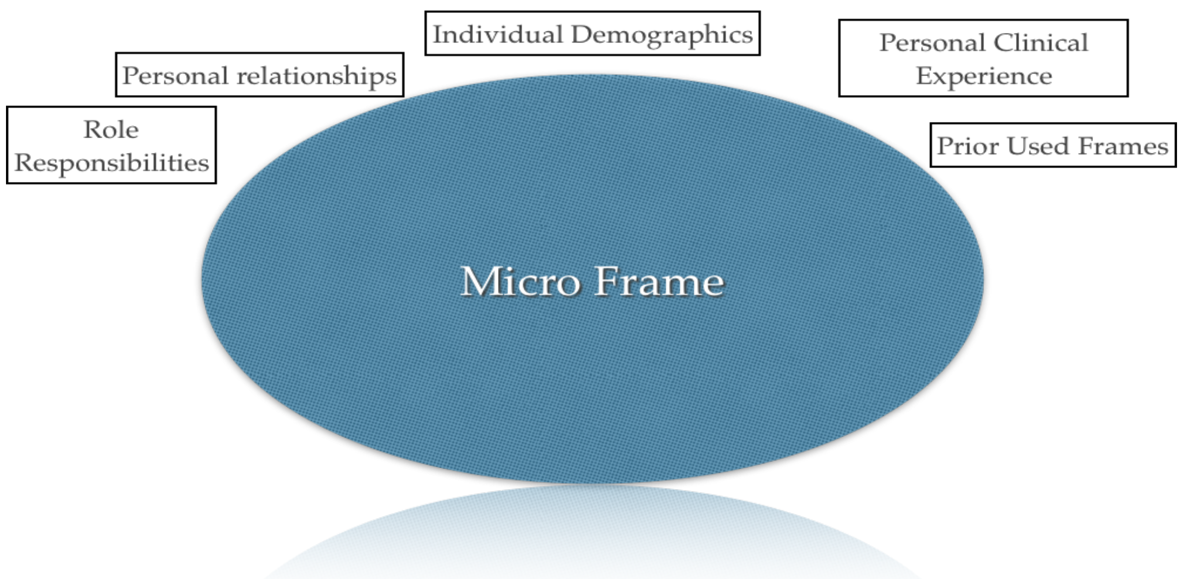


Figure 13 - Tier 3 the Micro Frame



Environmental

Parsons (2014) provides research showing the apparent local influences on corporate behaviour that are seen to explain differences between variations in corporate financial

misconduct. In simple terms, it appears firms (and those working in them) are more likely to exhibit financial misconduct if their neighbours behave in the same manner. This is provided as the most plausible explanation for the observed three-fold differences between misconduct across different areas of the USA (Parsons 2014). An earlier paper (Dougal et al. 2013) appears to provide a similar pattern but when applied to corporate investment. Thus, companies are more likely to provide investment if their neighbouring firms are doing the same. For both studies there is a perceived relationship not only at a corporate level of organizational influence, but also of influence at an individual level. Corporate Chief Executive Officers (CEOs) were more likely to be influenced by neighbouring CEOs of similar age.

It may be beyond the scope of the current research to explore the nationally driven cultural influences on decision-making (for example, using work from Trompenars (1993)). (Trompenars (1993) discusses the cultural differences between countries in their approach to decision-making; that between individualistic and collectivist approaches. It is unlikely such cultural differences will be apparent within this study.) It would be, however, within the scope of the current project to explore and assess potential influence from other local NHS bodies, particularly other CCGs, and the possible influence on decision-making of local peer groups. For the organization as a coalition the interest groups within the coalition may have similarly aligned peer networks that align to their own backgrounds. For example, across a region there may be a Chief Finance Officers group that meets and liaises both formally and informally. This may or may not provide significant influence on a decision-making process: but the research may seek to explore whether there are identified linkages between behaviours within the subject organization (and hence by its constituent decision-makers) and neighbouring comparative institutions. Comparisons may be made of similar decision types; their outcomes in the subject case study; and of equivalent decisions taken by organizations in other NHS regions.

This influence may have links to that of decision-maker demographics. One may speculate that where locally adjacent decision-makers of different NHS bodies are of similar age and socio-economic backgrounds they may be more likely to communicate (possibly through socialising) and may have similar points of reference (read the same journals or access the same mass media). Conversely where such senior figures (perhaps two locally adjacent CEOs) are demographically diverse (wide disparity in age, socio-economic class, etc.) their communication may be lower, with consequently reduced influence on decision-making.

Health Needs

There may be no other factor as commonly considered to be the foundation of commissioning as that of health needs. This may, therefore, be seen as another example of something that should not be treated as an influence but more as ‘part of the day job’. If commissioning is not seeking to address need, what is it doing? But the assumed consensus as to the place of ‘need’ may be misplaced. Competing different

needs will be presented and their prioritisation will vary. Outcome of corporate prioritisation may also be ultimately dependent on the dynamics of the negotiated order.

Briefly we may categorize types of need and their potential relation to parts of the organizational coalition.

- Clinical health outcomes. For some this may be considered the traditional approach to health need: a relatively empirical study of trends in disease, mortality, and morbidity. An example of such analysis is contained within a Joint Strategic Needs Assessment (JSNA), produced by all upper-tier Local Authorities, in collaboration with NHS partners.
- Demonstrated demand usage. This may be summarised as 'If we build it, they will come. If they keep coming, build it bigger'. The definition is less an assessment of an objective need and more a response to demonstrated behaviour (Wennberg 2010). Certain NHS interventions to 'improve access' may provide examples of addressing this need, by increasing capacity for patients to receive rapid assessment in primary care, even though such faster access has no evidence to support better health overall. It may, however, improve patient satisfaction.
- Opportunity for marginal health improvement. This may be summarised as 'Collecting lots of 1% improvements is the key to success'. In a number of clinical specialities research will discover opportunities for improved patient management. Individually such interventions are likely to provide marginal health improvement and consequently there may not always be a willing audience to consider such opportunities. The combined impact of a whole series of such initiatives may, on the other hand, provide the scale of improvement NHS commissioners may desire.

The concept of health need, therefore, is another area of struggle within the negotiated order. Negotiated goals may thus be a product of synthesizing the three elements of: objective health needs; subjective aspiration for services; and the improvements discovered through empirical research.

Team composition

In the early 1970s there was a debate between two influential political theorists Ralph Miliband and Nicos Poulantzas (Blackburn 1973). Miliband produced a volume (Miliband 1969) detailing the educational and socio-economic background of those in the UK establishment who were considered to hold most political and economic power. His conclusion was that political and economic power was concentrated within the hands of a small number of people most of whom shared a common background of class and education. Miliband suggested this, in part, explained the continued position of the ruling elites in UK society as those in power sought to extend the power and influence of their own 'class'. Nicos Poulantzas, from a different Marxist theoretical position, whilst congratulatory of Miliband's work was, nevertheless, critical of his analysis. For Poulantzas the origins of the individuals in power and whether they did or did not represent some form of class elite was less important than the function of

the state they were working in. Thus, for Miliband the proportion of the senior civil service that were educated in private schools and a narrow band of higher academic institutions ('Oxbridge') confirmed the state acting in the interests of those already in power. A narrow socio-economic elite was seen to maintain and reproduce socio-economic systems that maintained and reproduced power relations beneficial to itself. For Poulantzas, the origins and class of those running the state was of secondary importance: the state developed from an economic base of capitalism and its forms represented an effective way of delivering the functions required to maintain and reproduce the power relations of capitalism, including maintaining the position of its ruling elites.

Both of the authors described above are politically and theoretically Marxist. Consequently, their analysis reflects a theoretical position of class conflict within capitalism as an economic system. Nevertheless, the approach to understanding the relative influence between individual and structure further supports the approach of analytical dualism (see Research Methodology). We may contend that it is not necessary to subscribe to a Marxist position to learn lessons from the Miliband-Poulantzas debate. Foucault (discussed in Craib 1992) positions a debate less in terms of class and economic power and more that of *power* in general. Thus, the analysis may be seen not only as one of exploring the role of class relations, but of the impact of factors that may be grouped within a description of profile of the decision-makers. The exploration may support understanding the dynamics and mechanisms between structural factors (external influences) and agency factors (the negotiated order). The profile of the individual decision-maker in the process should not be ignored.

Corporate capacity and organizational process

All organizations require capacity (resources of people, building, and materials) to achieve its ends. Although CCGs are relatively small organizations in terms of people employed, they still require capacity to achieve their objectives. The number of staff in particular may present itself as a limiting factor in the decision-making process. Returning to Simon (1997) we may suspect that the bounded rationality features of satisficing and imperfect information may be linked to the availability of management capacity. Where capacity is greater a decision process may allow more time to consider options (rather than opting for the first plausible solution) and to generate information in support of a decision. When capacity is limited the converse may apply.

The constraints of organizational process and capacity are demonstrated at a number of levels: the simple number of staff available to support a decision-making process; the quality and performance of individuals; the processes and procedures in place in the organization.

Raw human capacity (physical human capital) is to some extent the easiest to assess, although recognising the volume available to support a particular decision may be complicated.

Individuals may have “a significant impact on the performance of large organizations, and even entire industries” (Mollick 2012, p. 1003). The Mollick (2012) paper suggests individual differences may have a more pronounced impact in ‘creative’ industries: but the research also examined the impact of ‘innovators’ (staff paid to be creative and entrepreneurial) and ‘managers’ (bureaucratic senior implementers). The “surprising” finding of Mollick (2012) was the importance of the manager role and the impact on firm organizational achievement from individual performance. Thus, “managers have significantly more impact on firm performance than individual innovators” (Mollick 2012, p. 1012). This is in part explained by the role of management in selection. Thus, the ‘innovators’ may produce a number of ideas: however, the idea that progresses to development will be ‘selected’ by a manager. This research may be comparable to a CCG decision-making process. Options may be developed. The quality of the options produced, and the supporting information will influence the decision-making process; but so will the ability of those making the decision to understand, analyse, and synthesise the options and information provided.

The feature of organizational process, if the process is well designed, should have a limited direct influence on a strategic decision. The need to progress through an organizational process, such as business case development, may inhibit the production of processes and obstruct issues moving towards a decision; however, once a CCG has begun a progress on a decision area, the organization process itself may not be a direct influence; however, the need to follow process and standard procedures may exacerbate capacity limitations and exhibit what may be termed ‘organizational inertia’.

For this study the role of both the senior managers in the CCG Governing Body and also the support management team that provide analysis and information to the decision-making process are examined to assess their influence.

Corporate history and memory

A challenging element of the research is that of establishing the influences on the decision-making process that are apparent but not actually evident in real-time. This is ontologically supported through Archer’s (1992) concept of morphogenesis that includes analysis identifying the need to include the impact of history and emergence. However, although theoretically supported, the attempt to establish the degree of historical influence remains problematic. The influence of history is contained within the analysis of decision-making biases (Tversky and Kahneman 1974) such as the availability heuristic (if it is remembered it has greater prominence). In the context of the current research the historical impact may be at both corporate and individual levels. The rapidly changing NHS environment may produce a lack of what is sometimes referred to as ‘corporate memory’: the ability of organizations to use their histories as evidence in support of future actions. The pace of NHS change at times seems so rapid (in organizational terms at least) that corporate memory seems an almost inevitable casualty.

Building on Archer's morphogenesis it may be possible to describe the dynamic relation between the agent and the environment across the three levels of framing. Firstly, at the individual/*micro* level that the compatibilist dynamic between the free-will of the individual at the point of action, within a largely determined environment (Dennett 2003). Secondly, at the internal organizational/*meso* level: between the individual decision-maker and the negotiated order of the decision-making environment. Thirdly, at the *macro* level of the organization's external environment: between the decision-making body and its corporate external world. Thus, within the individual the decision will be made in part from a pre-existing set of beliefs and knowledge, on the one hand, and aspirations and expectations on the other. The choice will be made, but from a series of largely pre-determined choices.

Within the group the decision may be made through the construction of a group consensus (a product of the negotiated order) influenced by the individual determinants, and the determining outcomes form the ordering negotiation. But the external focus of the project inevitably recognizes the impact of the commissioning environment. Consequently, we may describe the third level of determination as that of the external influencing factors. This may be seen as influences on the process or on individuals. In some cases, the combining factors may provide a set of pre-existing influencing factors that pre-determine the realistic options available. For example, the concept of the Overton Window (Russell 2006) suggests only certain political options will be achievable at any one time. Anything outside the window may not realisable, despite the relative quality or benefits of options laying outside the window. As a defined hypothesis the Overton Window appears to have limited empirical bases, but the concept may help to illuminate the external influencing factors. Thus, may there may be significance in the role of history. This may be a historical need to re-play events to secure an outcome not secured in the past; or it may be a reiteration of subjects within a frame of availability or realisability (within an Overton Window). A related factor is the concept of 'nothing new in the decision process' as highlighted by (Cohen et la 1972), linking the Overton Window hypothesis and that of the Garbage Can (Cohen et al. 1972) provides a plausible hypothesis that decision-makers will be presented not primarily with novel solutions but those that have been brought 'off the shelf' in some case after a lengthy gestation period or when considered long forgotten.

Arthur (1989) describes the impact of *path dependence* on the outcomes of certain technologies. Thus, the emergence of one technological solution over a competitor (Arthur's (1989) examples include the predominance of petrol over steam) may be as much decided by the influence of previous decisions taken and the present vested interests than the technical superiority of the technology itself. A form of path dependence may be seen in NHS decision-making, where previous decision may shape how decision-makers take similar decisions in future.

Despite the somewhat diverse evidences described above there may exist sufficient examples to conclude there are likely to be significant historical influences on strategic decisions. Thus, we may describe the historical deterministic influencing factors as:

- The overall determined environment in which commissioning occurs
- Historical obligations that shape the current strategic thinking of the CCG
- Known historical episodes that are present in the minds of decision-makers (including the availability heuristic)
- Perceived frames of opportunity that are considered to be what decisions may be 'allowable' at the point of decision
- Pre-developed policy options that emerge and re-emerge in response to defined commissioning needs.

Financial constraints

The role of finance in commissioning is considered as fundamental, resource allocation being a major component of its role in the healthcare system. It is, therefore, not surprising that we may consider it as both an external and internal influence. The postulated internal influences are: available resources, value for money analysis, and the competing investment priorities. The three influences work together in terms of not merely the effect of an overall resource envelope, but of how the envelope is allocated between different projects. In many respects this reflects many of the other decision influences but may provide an even starker demonstration of the work of negotiation within the organizational coalition. Coalition members will manoeuvre for position to access as much financial resource as they need (or as much as they can). The discussion thus may shift from whether a project in isolation is beneficial ('this mental health initiative delivers health improvement') to whether the clinical area under scrutiny has received sufficient resources ('mental health only receives X% of funding, it should have more'). In such debates the individual proposal in question may become a secondary issue and the decision is thus less as to the specific scheme and more as to the place of the scheme within a wider apportionment process.

Linked to the scramble to assert supremacy for competing interests is the struggle between different commissioning opportunities. They may seek to use the same resource, but relate to different clinical areas, and consequently comparisons may be difficult. The role of NICE in support of this process provides a form of the 'double-edged sword'. Defining interventions as 'cost-effective' against the available evidence base provides a clear statement for commissioners of what is seen to work and enables an objective reference point to support decision-making. The other edge of the sword, however, is that such assessments are made in isolation. For healthcare commissioning using resources across a wide spectrum of care, NICE assessments provide little support to help decide on how two 'cost effective' interventions compare against each other.

Synthesised Conceptual Framework

The conceptual framework for the project combines the previously analysed information and concepts. Thus, the analysis of the literature review provides a summary of the organizational concepts at play in the case study. The strategic

decision-making environment places the organization in an environmental context. The three level macro-meso-micro framing environment is the product of the literature review in that it: describes the strategic environment and in particular the role of strategy in the public sector; constructs a model of the decision-making context within which the case study occurs, recognising the influences on individual and group decision-making; and provides the conceptual framework within which the negotiated order dynamic is hypothesised to develop. All of this is seen to happen in the actual practical context of the case study: NHS commissioning.

Bordage (2009) in discussing conceptual frameworks suggests they have the purpose of both illumination and magnification: shining light on a problem and allowing the researcher to examine the problem in more detail. For Bordage (2009) frameworks are also a mechanism for the researcher to be explicit regarding their assumptions. In this project it is an opportunity to synthesise the conclusions emerging from the literature review and also to clearly identify the negotiated order concept as its analytical lens.

The use of the negotiated order as the analytical lens emerged from the literature review and particularly from studies of organizational behaviour, most importantly Cyert and March (1992) and the concept of the negotiated organization (for the researcher a precursor to the negotiated order). The review of group decision-making and board type (upper-echelon) behaviours confirmed the benefit to the researcher of conceptual approach that would allow such behaviours to be examined, but within a framework that supported exploring the research question and addressing the research objectives.

Although other approaches to group behaviour may have been used, it is considered that the negotiated order is the most appropriate for this case study, for the following:

- The literature on negotiated order (for example Strauss 1963, 1982) includes studies in healthcare settings.
- Other factors possibly at play in group dynamics, such as the use of power, are treated as falling within and the negotiated order concept and as constructing the order process.
- More recently developed organizational analytical concepts, such as institutional logics (Thornton and Ocasio 2008), may have been used as alternatives to the negotiated order, but are likely to cover very similar ground. Further research may test the validity of the lens in this study against alternatives.

The framework supports the research strategy of creating and producing research data. As described above the application of the literature review analysis and its methodological application is summarised in the Context-Mechanism-Outcome (CMO) approach (Pawson and Tilley 2004).

Figure 14 - Context-Mechanism-Outcome (CMO) Framework

Analytical framework of Critical Discourse Analysis

The analytical framework provides the means of analysing the produced research data consistent within the research methodology, in pursuit of answering the research objectives. The necessary task from the produced data was to establish a means of analysis that allowed scrutiny, analysis and synthesis of the produced data that delivered the research objectives yet was consistent with the requirements of research validity and reliability. As the primary produced data was that of text, the analysis required a means of textual analysis: but one directed by the research ontology. This was undertaken by the application of Critical Discourse Analysis (CDA) (Jorgensen 2002). The term discourse has been widely used and is subject to varied interpretation and definition, prompting some authors to suggest it has become 'vague' (Jorgensen 2002). As a general term, discourse has been defined as "a particular way of talking about and understanding the world" (Jorgensen 2002, p. 1). The project uses the definition of discourse provided by Jaynes (2015). This is more than discourse as a language event but as "language use, the communication of beliefs, and interaction in social situations" (Jaynes 2015, p. 98). Similarly, Clegg (1989, p.178) quotes Laclau as defining discourse as the phenomena through which the "social production of meaning takes place". For Jaynes (2015), quoting Van Dijk, an important element of

discourse studies is to describe how the three dimensions integrate. CDA provides an analytical framework that allows interrogation of the data produced (primarily textual) within the ontological and epistemological approach of critical realism. CDA is only one form of discourse analysis (Gee 2010). Gee (2010) suggests all discourse analysis should be *critical*, but for this project CDA is used as the main analytical typology adopted is the trinity of Fairclough as described below. Wodak (2001) understands the use of 'critical' as having "distance to the data, embedding the data in the social, taking a political stance explicitly, and a focus on self-reflection" (Wodak 2001, p.9). Elsewhere this is re-framed as CDA focusing on concepts of power, history and ideology (Wodak 2001, p.3). This project is considered to have maintained a distance to the data consistent with its realist methodology; focused on self-reflection of decision actors; assessed the use and presence of power; and analyzed texts within their corporate context and social history. There was, however, no explicit focus on political ideology and no political stance taken.

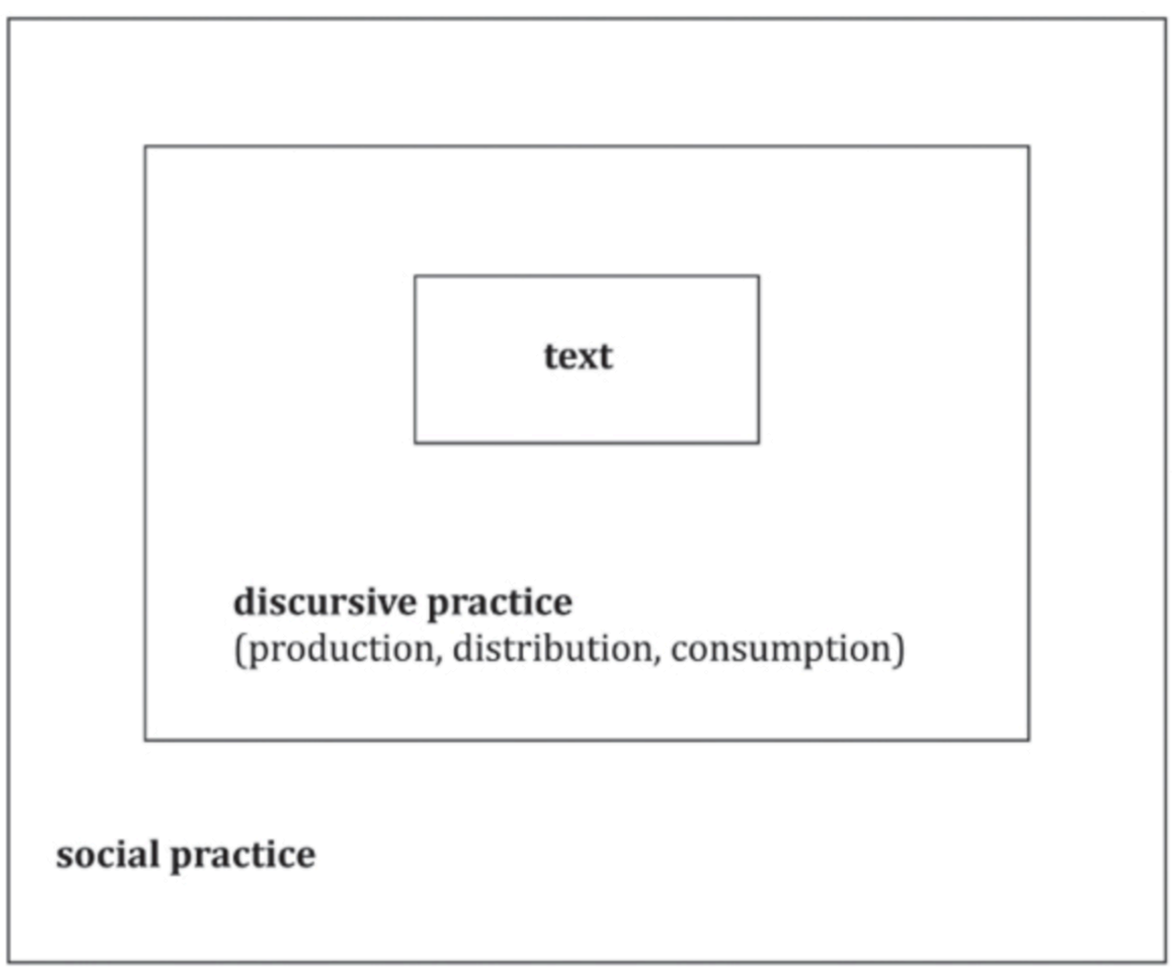
The use of CDA supported achieving the research objectives of the project and aligning closely to its realist methodology, as CDA includes the requirement to analyse language within its empirical context (Jorgensen 2002). This is facilitated by Fairclough's (2003) CDA approach, which avoids drawing a distinction between detailed textual analysis and social theoretical approaches. Rather there should not be an either/or distinction (Fairclough 2003). In this project the core data is primarily textual and there is a beneficial necessity to conduct detailed textual analysis: but such conducted with consideration of the wider social context. It may be considered that Fairclough's (2003) description of the 'order of discourse' is consistent with the concept of the negotiated order.

Fairclough's (2003) approach to CDA (Jorgensen 2002) describes a three-dimensional model: social practice; discursive practice; and text. Thus,

- Social practice – the case study occurs within its wider social context and the analysis of findings references this context and the role of social structure within management practice. This dimension places discourse within the creation and use of the macro frame level.
- Discursive practice. The practical observed levels of management activity are at the discursive level and use the meso (organizational) frame and the micro (individual) frame. This level recognises the wider social practice, structural influences, and analyses the production and use of language as a tool in decision-making and the development of the negotiated order.
- The text is the visible level of actual data collected in the study. Analysis of the data allows consideration of discursive practice: but without the actual data, consideration of discursive practice would be no more than speculation. Thus, the role of data in discourse analysis is reminiscent of Orna's (2005) description of information products as 'making knowledge visible'. In this case what is visible is the text. The analysis attempted to explore and discover the

mechanisms used in discursive practice. The study of actual data in practice provides the opportunity for social scientific study.

Figure 15 - Diagrammatic representation of Fairclough's CDA model (from Jorgensen 2002)



The relationship between the three levels is part of the analytical project. Furthermore, all texts are considered to overlap, described by Fairclough (2003) as *intertextuality*:

> We can begin by noting that for any particular text or type of text, there is a set of other texts and a set of voices which are potentially relevant, and potentially incorporated into the text. (Fairclough 2003, p.47)

As with the interplay between frames, it is evident of the interplay between texts used in the decision-making process. Yet again there is seen interaction across domains: intertextuality describing the interaction of language; interdiscursivity the interaction of language use; and multi-level frames the interaction of cognitive frames used and produced in the case study.

Thus, the conceptual framework of the research project synthesises the three elements of:

- Analysis of texts created and used through discursive practice (CDA), which then reveal;

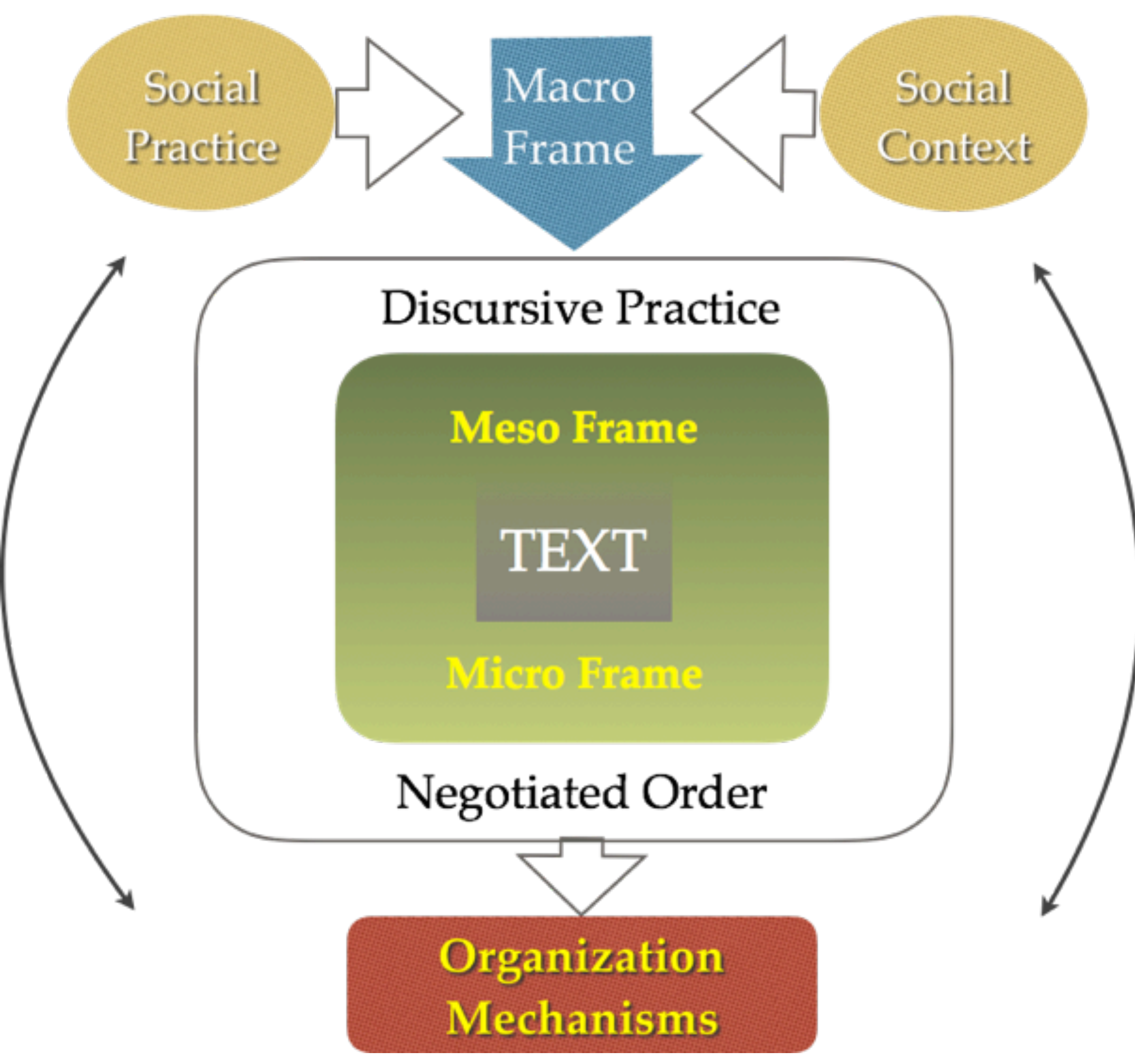
- The cognitive frames used in the environment of the created negotiated order, which then allows;
- Development of mechanisms at work in in the negotiated order creation and the behavioural relations implicit in the analysed text.

The discursive practices analysed in the case study occur within the broader corporate social context (for CDA its social discourse) and constitute the macro frames. Leitch and Palmer (2010) discuss the possible inadequate assessment of 'context' within discourse analysis. This may be addressed by applying the three-dimensional framework of Fairclough (Jorgensen 2002); furthermore, the explicit analysis and combination of discourse analysis with contextual framing may address the perceived inadequate treatment of context as considered by Leitch and Palmer (2010).

Discursive practice occurs primarily at the meso and micro levels and the theme of negotiation remained central to the analysis. Thus, ''texts discursive differences are negotiated; they are governed by differences in power" (Wodak (2001, p. 11). The visible reported feature of the negotiated order is the spoken and written text. Furthermore, the analysis of text explores the mechanisms that identify the spoken, written and *unspoken* and *unwritten* dimensions of power (Lukes 2005). For Foucault there is an inseparable link between knowledge and communication and discourse then becomes in itself an exercise of power: "No body of knowledge can be formed without a system of communications, records, accumulation and displacement which is in itself a form of power" (quoted in Gaventa 2003, p.4). Thus, CDA analyses the use of discourse in the power dimensions of the creation of the negotiated order.

The use of CDA in this project was aligned to the methodology of ethnography: the study of the decision case as a process not an event allowed longitudinal analysis of texts generated, used and reconstituted throughout the process. The diagram below summarises the conceptual framework and secondly with its relationship to the literature review with its relationship to the content of the literature review:

Figure 16 - Conceptual Framework of Discourse Framing



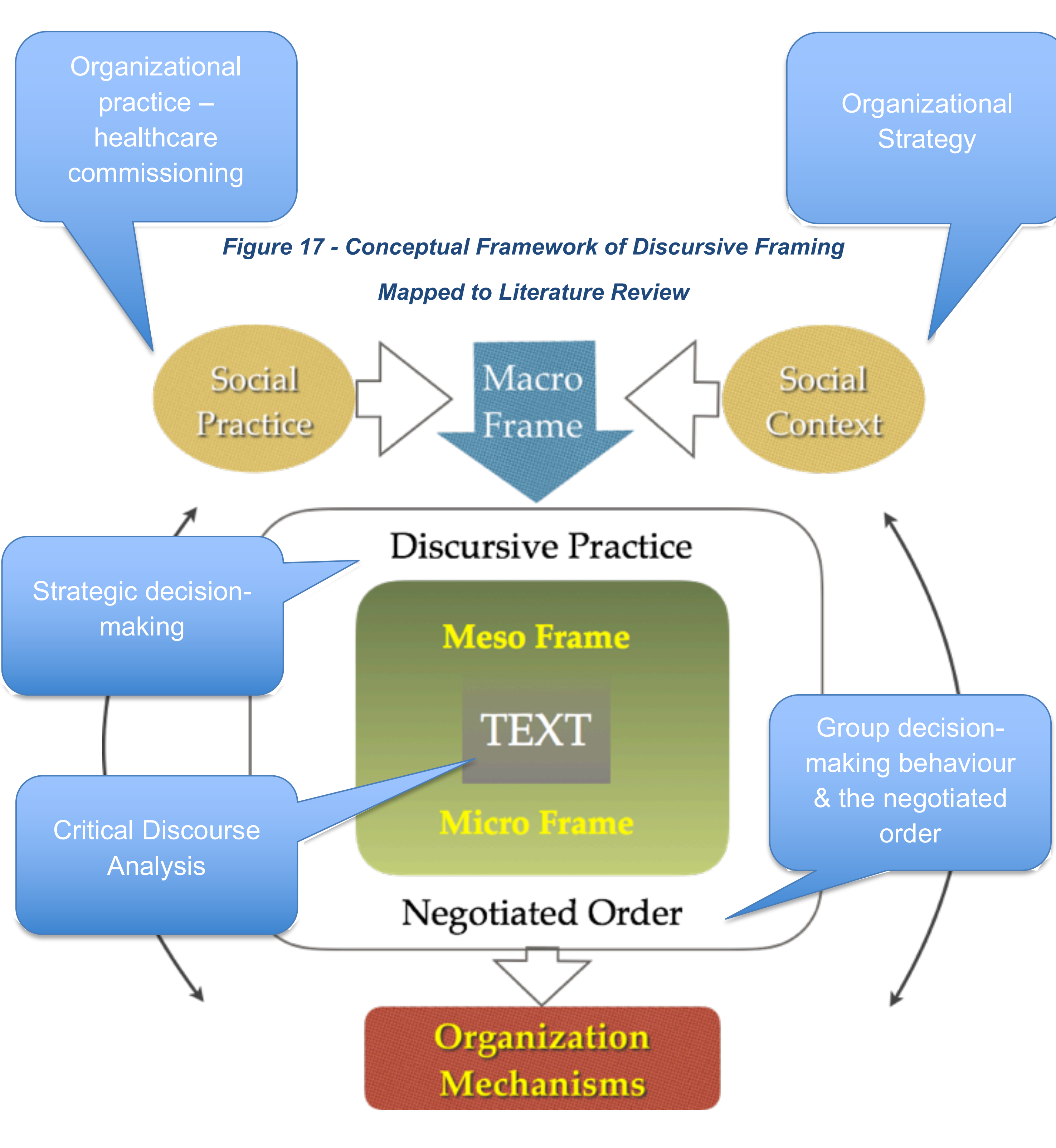


Figure 17 - Conceptual Framework of Discursive Framing Mapped to Literature Review

Chapter 3 – Research Strategy and Methodology

Shining a strange light

Returning to Kennedy's description of decision-making as "dark and tangled stretches" (Sorensen 1963, p.xiii) one of the purposes of the research is to illuminate the decision-making environment. Van Maanen (2011b, p.229) comments that, "Ethnography shines a light, sometimes a very strange one, on what people are up to and such doings are rarely if ever predictable or in line with what either 'current theory' or 'the experts' might say".

The task of the researcher in exploring the influences on commissioning is in part to explore the observed situation and the social factors at play, even if strange and unpredictable. This may not always be easy when confronted with competing cognitive frames and the risk of falling down the moralization gap (even if the wrong trees and wrong trains have been avoided thus far). The added complication for the researcher in this project was to deal with the evident complexities of the ontology facing the participant observer. The research strategy and methodology employed describes how the researcher addressed the challenge of achieving the research objectives and to bring the research subject into the light.

Introduction

This section describes the strategy employed in conducting the research and the method employed. The chapter details the different research methods employed and the timescales used in conducting the research. The chapter explains the supporting research methodology, critical realism, used in the project, and the approach of ethnographic case study as the preferred approach. This is then followed with specific description of the research undertaken and the analytical tools employed in processing the collected data. Finally, the chapter summarises the methodological framework developed to undertake analysis of the research data.

The chapter summarises the research method and methodology through discussion of:

- The underpinning methodology that supports the research and provided the theoretical basis to produce the research design
- The overall research strategy and methods used in collecting data
- The approach of ethnographic case study as the method employed
- How the project addressed issues of research validity and management of ethical considerations
- The approach to analysis of the research data through its various forms and stages
- The reflexive critique of the role and influence of the researcher in the project
- The resulting methodological framework arising from the literature review and the research methodology.

Research methodology

The approach of the social scientific research in the project has four dimensions:

- Ontology is the theory or study of being: what is existence and what it is to exist.
- Epistemology is the theory or study of knowledge: it produces theories of how we understand the world of existence.
- Methodology is the principles and systems for the methods used to explore, generate, and test knowledge
- Aetiology is the system of causes that explain the working of the world explored.

Thus, if ontology attempts to define and describe the world we experience; epistemology attempts to define and describe how we can establish such knowledge about the world. Consequently, ontology and epistemology are related, if separate, concepts. Furthermore, ontological positions often correspond to similar epistemological positions and arguably any theory of knowledge must correspond to a theory of being (even if implicitly so). The ontological positions will inform the methodology used in the research, and the applied methodology will provide the analytical tools to establish aetiology, the explanation of causality. The research methodology employed was that of critical realism.

Critical realism may be seen as an ontological position attempting to incorporate elements from the apparently oppositional theories of 'pure' realism and interpretive approaches such as phenomenology (Sayer 1992). A simplified continuum of objective realism and positivism (in various forms) to subjective interpretivism in research ontology is arguably an artificial polarity of positions on a continuum for research epistemology. The critical realist project is an attempt to reconcile elements of realist and subjective interpretivist approaches, with the emergence of an ontology that recognises necessary elements of multiple approaches (see Sayer 1992, Edwards et al. 2014, Fisher 2010). Critical realism, thus, includes an explicit recognition of pluralism and holds that an objective world exists independently of an individual's ability to interpret and understand it. Further, it recognises that how we do understand this objective reality is dependent on a subjective interpretation of this world as it is experienced. The real external world of 'intransitive objects' exists: but our means of understanding this world will always be in part socially constructed (as 'transitive objects') (Johnson and Duberley 2000). This duality is seen as making critical realism 'unique' within social science (Edwards et el 2014). The recognition of the duality is not primarily as an attempt to reconcile the objectivism of realism and the subjectivism of interpretive positions. More than this, it establishes a need to analyse both strands as equally important and at times dynamically conflicting, within its overall ontology[24]. The reconciliation of realist and idealist (anti-realist) ontologies and epistemologies into the critical realist synthesis is described in the diagram from Johnson and Duberley (2000)[25]:

	Thesis		Synthesis		Antithesis	
Epistemological realism		Metaphysical realism		Epistemological relativism		Metaphysical relativism
	Empirical realism		Critical realism		Superidealism	

Figure 18 - Bhaskar's Critical Realist Synthesis (Johnson and Duberley 2000)

Sousa (2010) summarises the differing positions of positivism, postmodernism, and critical realism across the four dimensions of ontology, epistemology, methodology, and aetiology. This has been modified as a summary table below:

Table 2 - Summary of different metatheoretical approaches (via Sousa 2010)

Theoretical Position	**Ontology**	**Epistemology**	**Methodology**	**Aetiology**
Positivism	A world existing independent of the mind	Knowledge gained through experimentation, the development of laws, allowing scientific prediction	Primarily quantitative methods, using deduction (falsifiability) and induction.	Deterministic cause and effect relationships in closed systems
Postmodernism	The view of the world is created through human experience and discourse	The world is known through discourse and the exploration of human interpretation	Qualitative research methods such as phenomenology and textual interpretation	Unclear if causation is a stable concept[26]
Critical Realism	Accepts the existence of a mind-independent world but observed and understood through human interpretation	Multiple approaches, including experimentation, social construction, description, and pragmatic explanation.	Mixed methods, using different qualitative and quantitative approaches to triangulate research; use of abduction and retroduction.	Causation as underlying complex mechanisms within interdependent open systems

The method applied to understanding the real world is to establish reality as *stratified* (Edwards et al. 2014, Fisher 2010). The stratification is at three levels, the *empirical*, the *actual,* and the *real* (Bhaskar 1978):

- Experiences. The ‘empirical’ level is that experienced by agents in practice. This level is subjective: including what individuals ‘see’; or indeed do not see.
- Events. The ‘actual’ level is that of events that happen in the world, which may be inconsistent with the subjective experience.
- Mechanisms. The ‘real’ level of mechanisms and structures that generate the actual world.

The strata interact not in a singular direction, but rather dynamically in directions top down (hierarchically) and bottom-up (emergently). Fleetwood (2005) further stratifies the ‘real’ into four modes of reality. Thus, things are considered real if they have ‘causal efficacy’: that is, they have a tangible effect or outcome, even if they are not materially existing. (Fleetwood (2005) uses the example of God, where the idea of God as a concept is real, even if God may or may not be actually existing.) Thus, the four strata are:

- Materially real – things that physically exist that exist independently of human
- Ideally real – concepts, ideas, and opinion, etc that form part of discourse. They are not material but have actual effects.
- Socially real – these are entities that are real by being depended on the social interaction of individuals and groups (for example markets and organizations)
- Artefactually real – things are a fusion of the materially real, the ideally real, and the socially real. Fleetwood’s (2005) example here include computers and violins, where their being is socially mediated beyond the mere physical.

The scientific methods employed are primarily abduction and retroduction. Abduction is an extension of the concept of inference to the best explanation (IBE Okasha 2002). This eschews the difficult debates regarding induction (see Okasha 2002) and rejects the evident simplicity of a reliance on deduction through falsification[27] (Sayer 1992). Instead it employs a pragmatic approach of abduction (literally ‘taking out’ the best explanation). Sayer (1992) discusses falsificationism and the deductive method suggesting that one of the problems with the approach is that it is rarely actually used in scientific research. Despite this rarity, many positivist authors reference Popper and the deductive method as ‘the’ scientific method, possibly misinterpreting the concept of induction (Greenland 1998). Hansson (2006) appears to justify Sayer’s assertion in a study of research published in the journal *Nature*. Of the 70 high-quality papers published in the year studied, only 2 employed a deductive approach consistent with falsificationism.

Abduction is a pragmatic approach, but with some similarity to induction, and is concerned with using IBE as a means of assessing the best and most useful explanation. For Sayer (1992, p.69) this involves replacing a search for ‘truth’ with a striving for “practical adequacy”. (Sayer’s version of critical realism is consistent with the position of philosophical pragmatism (Johnson and Duberley 2000).) Abduction is a method of combining observations and theories to provide the most plausible explanation establishing some form of causal relationship. The analysis of causality is

less a search for connections between discreet events (such as cause and effect) and more a striving to establish the aforementioned mechanisms (Sayer 1992, O'Mahoney and Vincent 2014).

Retroduction is similar in approach to abduction (for some authors (O'Mahoney and Vincent 2014) the two are conflated into one approach). The major difference in approach is that where abduction seeks to establish mechanisms, retroduction starts with identified mechanisms and then explores what causal forces would produce such mechanisms (and by extension which phenomena would not produce such mechanisms) (O'Mahoney and Vincent 2014). Thus, abduction may be seen as the more appropriate approach in the analysis of collected real-time and observational data, where mechanisms and outcomes may be uncertain. Retroduction is used where the outcomes are known but how the processes emerged leading to that point is less clear. Both abduction and retroduction appear consistent with the concept of IBE. The ultimate test for the validity of a text may be its practical adequacy. The strength of critical realism in organizational research may be its ability to incorporate elements of interpretivism, and thus interpretive research methods, within an overall realist framework. Placing of research within a realist framework provided a grounding that allowed interpretive exploration without moving into extreme relativism. Thus, the use and content of narrative discourse and the language games evident within interview data (and indeed observed conversation) provided rich research data exploring the decision-making process. Yet the framework avoided any over-emphasis on language.

Further exploration of the stratified approach can be considered with reference to the development of concepts of the different strata. Of particular relevance appears to be consideration into the roles and relationships of structure and agency. Central to this consideration in the methodology is the morphogenetic realist approach as described by Archer (1995). Archer (1995) develops the critical realist approach in an extensive exploration of structure and agency. In part the exploration is a reaction against, and a critique of, conflation theories (Archer, 1995). Conflation is seen as taking one of three forms: downwards conflation (structure and agency merging into one form dominated by the impact of social structure and the external world); upwards conflation (merging dominated by the perspective of the individual with social structure as secondary); and central conflation (structure and agency become merged into one with a perceived inability to separate the two). Against conflation, Archer infers an ontological perspective should maintain the ability and necessity to analyse structure and agency as separate (despite their obvious ultimate linkage).

The morphogenetic approach describes the relationship between structure and agency in terms of a dynamic process of change over time. Morphogenesis in biology is the biological process by which organisms change shape. In organizational theory the concept similarly explains how bodies or social systems evolve and change form. One of the major differences between morphogenesis and other theories critiqued by Archer is the acceptance of time as a factor that distinguishes structure and agency. Relating this to the research project provides an interesting dimension in the treatment

of decision. Much of the laboratory style experimental research provides no acceptance of a historical influence on the decision process. Although the history of the individual may influence decision-making, for example, through the effects of heuristics, there is no capacity for an assessment of a decision process before the decision-making under scrutiny. Much of the wider research does not attempt to frame decisions within an organizational historical context. So, in the case of Kovner (2009) decisions are studied within their decision-making timeframe, but do not provide detailed assessment of the historical decision-making context. Thus, the history is treated as important to understand why a decision is occurring ("why did we need to make that judgement at that time?"); but there may be an absence of the history of how decisions are made ("what did we do last time we made decisions that influences this decision?"). Therefore, the focus on the decision need may distract from a focus on the decision practice. If we accept Archer's concept of temporality, there may be a need to analyse not merely the current decision practice, but the historical development of the decision makers, decision-making bodies, and the associated organizational histories and organizational learning that shape the decision frame.

The morphogenetic approach may be associated with symbolic interactionism (Craib 1992) through its focus on temporality. As G.H. Mead is identified as an early influence of symbolic interactionism it may be no accident that he developed a novel assessment of time and thus its potential influence on social research. Maines (1983) discusses Mead's theory of time and infers a radical departure from traditional conceptions of the past and the future. Although the present implies the past and a future, "reality is always that of the present" (Maines 1983). The past arises through memory and exists in images contained within the present. Similarly, the future is always hypothetical: existing as a form of anticipation. For Mead, "We speak of the past as final and irrevocable. There is nothing that is less so . . ." (Mead, 1932, p. 95). Thus, the boundaries between past, present, and future are always uncertain. "There is a continuity of experience, which is a continuity of presents" (Mead 1929, p. 235). Thus, for Mead, the past has no status other than in its relation to the present.

The four dimensions of Mead's formulation of the past are:

- The symbolically reconstructed past: this is time as an ongoing process not measurement confined. "The present makes the past possible" (Maines, p.163). Also, "The symbolic reconstruction of the past thus involves redefining the meaning of past events in such a way that they have meaning in and utility for the present" (Maines 1983, p.163). "Each present, therefore, must reconstruct its past" (Maines 1983, p.163). The dimension sees the past as something that primarily supports sense-making of the present.
- The social structural past is not dealt with directly but is considered implied. The past structures and conditions, the experiences found in the present. The process is not entirely deterministic (according to Maines 1983) as unanticipated events require adjustment: the structural past thus provides probabilities for what will take place in the future.

- The implied objective past. Not explicitly described in Mead. The ‘what must have been’ dimensions. This relates to a situational ontology about events that have occurred in the past of which there is an established consensus. Thus, some events ‘must’ have to have occurred for certain things to be existent in the present. For the present to be like it is, the past must have been of a certain type.
- The mythical past. The dimension relates solely to symbolic creations used to manipulate social relations. These ‘pasts’ are creations and are not empirically grounded. But they have material effects and are thus may be empirically consequential. Such mythical creations are purposive and exist to provide advantages in social relations.

Thus, in using Mead’s formulation of temporality it may be seen that morphogenesis is a continuous, dynamic series of processes that not only link dialectically between structure and agency, but also across dimensions of time. Furthermore, da Silva (2007) draws an explicit link between the dialectical nature of temporality and structure-agency, and Strauss’s (1978) concept of the negotiated order.

The three steps in the morphogenetic cycle are identified as: structural conditioning; social interaction; and structural elaboration (Archer 1995).

- In structural conditioning properties are seen as being consequent on past actions and outcomes. Thus, these past events “have effects in their own rights later on, as constraining or facilitating influences upon actors, which are not attributable or reducible to the practices of other agents” (Archer 1995, p.90).
- Social interaction is considered to be structurally conditioned (influenced) but not structurally determined. The different relationships and interplay between actors will be influenced by structure but will produce effects from the interaction itself, partially independent from the influence of structure. The reconciliation of self-interest, itself promoted through structural conditioning, will occur through interaction and management of competing vested interests within a group, managed through negotiation and accommodation (Archer 1995, p. 90-91).
- The resultant interactions occurring within the conditioned structure then produce the process of *structural elaboration*. The elaboration is a process of change that affects the structure itself and those working within it. This product of group conflict, cooperation, and general interaction is seen by Archer (1995) as largely unintentional, although there seems no reason to assume some intentional outcomes may not be a product of structural elaboration.

This morphogenetic cycle avoids the conflations of moving straight from conditioning to elaboration (in effect a form of determinism); and from social interaction to elaboration (assuming no structural role). Archer’s (1995) approach to understanding the dynamic relationship between structure and agency as necessarily inter-linked, but analytically separate, concepts is labelled *analytical dualism*.

Archer (1995, 1996) identifies distinctions within the concept of agency. Thus, agency is not seen as equivalent to the individual. Rather agency may be of a collective or corporate body, *corporate* agency, or an individual, *primary* agency. The distinction is helpful within this project as the study is fundamentally associated with decision bodies. Thus, the research is both a study of the decision-making bodies in action and the decision-makers within these bodies in the decision process. The dynamic of creating the negotiated environment suggests a mutually influencing relationship between the primary and corporate agencies. The configuration of primary agents will in part shape the nature and behaviour of the corporate agency (primary to corporate morphogenesis). Conversely, the constructed corporate bodies will influence the decision-making behaviour of the primary agents themselves (corporate to primary morphogenesis).

Developing this distinction to support the research strategy and analytical framework it may be helpful to describe different temporal zones within the decision process. The area within the decision process, that is the time spent in and immediately before and after a major decision-making committee, may be described as *intra-decisional*. The period before the actual start of a decision process and the period after a nominal decision but before actual implementation, may be described a *peri-decisional*. The research may seek to explore whether the behaviour of agents is obviously different between the two zones, and how corporate and primary agents relate to each other, both within the socio-cultural structures.

Research design

Decision-making research is often described in three forms: experimental research, often within the field of behavioural psychology (for example studies included within Kahneman (2012)); analysis of political decisions utilising historical sources (such as Janis (1982)); and critical event case studies (for example as contained within Weick (2001)). The author's previous dissertation used case study and narrative research techniques. However, the approach was that of retrospective analysis: this was consistent with some of the three research designs described above. But previous retrospective research had often started from the outcomes of decision, reviewed the process, and constructed explanations. The analysis thus included an assessment of decision-maker behaviour: but not in real-time. Experimental studies were done in real-time, but not in a practical decision-making environment, questioning their ecological validity. Following Geertz (1973), to understand why people act requires studying what they do: the research studied in detail what decision-makers did and how they behave. Studies of management behaviour (for example, Mintzberg 1973, Tengblad 2006) that focus on the practice (or 'doing') of management provide a useful reference point.

Karlsson and Ackroyd (2014) discuss the options of intensive versus extensive research. It may be argued the critical realist approach is more consistent with the intensive approach and was used in this study. Furthermore, CR advocates suggest the use of a wide range of research collection methods (in this case, observation,

interviews, and historical documents) allowing the intensive approach, consistent with the CR ontology (see various chapters of Edwards et al. 2014). The intensity of the analysis is seen as helping to 'get under the skin' of the decision-making process.

To explore decision practice the research used three main methods:

- Ethnography (participant observation) of decision practice in decision-making committees.
- Narrative analysis of decision-makers recollections and retrospective assessment of the decision process.
- Analytical review of evidence used and developed in the decision process.

The conceptual framework required a method that allowed the generation of detailed textual research data of the decision-making process in action. Thus, the CDA approach to textual analysis requires text. The research textual data came from the observed meetings analysed within the ethnography. The triangulation of the meeting data with the approach of qualitative interview provided assessment of the levels of framing influences across the three levels of the framework. The deep study of behaviour was considered to be appropriate to the case study as the most appropriate method consistent with the conceptual framework.

Research strategy

The overall research strategy was one of case-study analysis (Yin 2009) during the decision-making processes occurring during one financial year. As the objective was research into strategic decisions, at the early part of the project appropriate decisions with a significant potential impact on corporate success were sought. The focus was on one major strategic decision process.

The research strategy had three arms: ethnographic study of real-time decision-making of the executive decision-making body; retrospective assessment of decisions through qualitative research interviews; and collection of the texts and resources used to support the decision processes. Yin (2009) discussed various approaches to the case study approach. The case study method was a single case design (Yin 2009, p. 46). Yin (2009, p.46-49) describes five rationales for using single case design. Of the five, the project is justified strongly by three of the rationales. The strong rationales for single case design are: that it was an extreme or unique case (such decisions are unusual and the combination of specific factors in the organization were unlikely to be repeated in the same combination in other areas); secondly, that it was representative of a type of complex strategic decision facing a CCG. (This combination of unique versus representative is paradoxical but enlightening: the decision is complex, multi-factorial, and at the time of decision-making provided a particular blend of internal and external influences; but such combinations, unique in their particular presentation, will, nevertheless, be typical of strategic decisions in this type of organization.) The third rationale was its revelatory nature, as the access of the researcher is considered unusual in terms of current NHS research, and untypical across corporate bodies more

generally. The rationale of critical test was not considered to apply in this case, due to its exploratory nature. A longitudinal rationale was also considered not to apply, as the research data was collected over a continuous, relatively short period. The case study design was considered to be holistic rather than embedded (Yin 2009, p.50). The three arms of data production could be considered as separate sub-units consistent with the embedded description: but the three arms were just that of data production and not separately identifiable semi-autonomous case study units. Consequently, the aim of the study was to produce a holistic case study.

Case Study

The case study approach is an appropriate strategy when research aims to ask 'why?' and 'how?' questions (Yin 2009, p. 4). A case study is defined as, "an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (Yin 2009, p. 18). Yin (2009) discusses perceived weaknesses to the case study approach: lack of research rigour; limited basis for generalisation; length of time; and weak ability to establish causality. The project addressed the perceived weaknesses through:

- An extended period of research data collection and reporting within a developed framework;
- Generalisation to theoretical proposition (Yin 2009);
- The ethnography was deliberately lengthy and detailed;
- The objective was to explore the mechanisms at work, more than assert causality.

The critical realist ontology and epistemology support the use of 'intensive' research methods (Edwards et al. 2014) such as case studies: an intensive dissection of a decision, using multiple research methods. The intensive research strategy supported the approach of seeking differing levels of research evidence. Thus, Yin (2009) suggests case study research may have three purposes: exploratory; explanatory; and descriptive. In this project the case study research aimed to: describe the detailed process of behaviour in the decision-making process; explore the relationship arising from the negotiated order; and attempt to explain the mechanisms at work in producing the outcomes from the decision process.

Ethnography

Ethnography may be defined as a form of social science research with the direct observation of subjects in their usual social environment (Watson 2003), over an extended period of time with the researcher actively participating with the subjects in the normal cultural setting (Hammersley and Atkinson 1995). Although participant observation may be conflated with ethnography, Hammersley and Atkinson (1995) suggest the ethnographer should use whatever data is available to inform cultural analysis. That said, it seems likely that much of what will be described as ethnography

is likely to include an element of participant observation. This may be an effective means of achieving "close observation of and involvement with people in a particular social setting" (Watson 2011, p.205).

Advocates of ethnography (Hammersley and Atkinson 1995) describe its relative merits compared to other research methods and in this case the specific reasons to use the technique being:

- Exploring actual behaviour of decision-makers in the process in real-time
- Exploring the decision process before the outcome of the decision and subsequent sequelae, thus reducing outcome bias
- Assessing how evidence is sourced and used through the process, rather than just assessing the quality of the evidence.

Hammersley (1992) discusses the relationship between ethnography and realism. This study used the methodology of critical realism and Hammersley's assessment of ethnography as supporting a realist position helps define the research framework for this project. Thus, the focus on decision-making in practice provides a perceived 'naturalistic' assessment of decision practice. The use of ethnographic techniques by an actor within the decision-making theatre is consistent with the role of complete participant within defined ethnographic typologies (Bryman and Bell 2003). But it may be necessary to go further in defining the approach as beyond general ethnography and closer to a definition of auto-ethnography (Bryman and Bell 2003) or participant ethnography (Hammersley 1992). The intention in this research was not only to look at the practice of individual managers, but that of the decision-making bodies.

One difficulty facing researchers using participant observational techniques in practice may be the complexity of placing such practical research into theoretical frameworks. As discussed above some definitions of ethnography (possibly Hammersley 1992) focuses on the approach as being its research method. Others (for example Watson 2011) instead emphasise the approach as being one fundamentally of sociological understanding rather than a research methodology *per se*.

Bryman and Bell (2003) discusses different typologies for participant observation. Typologies range from the most distanced observation ('complete' or 'total' researcher) to the most actively engaged in the community being studied ('complete' or 'total' participant). In this project the researcher played a maximally participating role consistent with that of complete or total participant except that the research was not covert (Bryman and Bell 2003) and the researcher would remain in the studied workplace after completion of the research. Bryman and Bell (2003) further discusses the level of involvement of the researcher in the process being studied: either active or passive. Clearly in this case study the researcher, as a senior figure in the organization under scrutiny and a major decision-maker in the decision-making process was heavily active. Bryman and Bell (2003) recognises that practitioners engaged in participant observation will need to demonstrate self-awareness of their

place and role in the organization. The use of the reflexive critique provided the explicit self-awareness and reflection of the individual researcher's position in the project.

The consistency of using a participant observer approach with a realist ontology is supported by using an approach described by Anderson (2006) as analytic autoethnography[28]. Anderson (2006) describes five features of this approach, all which were applied in the project: the researcher having the status of a full member of the social group; analytic reflexivity; the researcher being visible to the other participants; an open dialogue with the participants as part of the research; and a commitment to the development of theory. The last point being that the exercise is not merely to document an insider view of events, or a managerial autobiography: rather it is to explore organizational behaviour and generate theoretical understanding.

Although the use of retrospective qualitative interviews is obviously not participant observation, in this research it is considered to be an important part of the whole ethnography. Within the research strategy the interviews provided triangulation: the use of multiple methods of investigation to enrichen data generation and analysis (Bryman 2003, p.291). Thus, "ethnographers often check out their observations with interview questions to determine whether they might have misunderstood what they have seen" (Bryman 2003, p.291). In this project there was the use of interview data as cross-checking but also to "allow access to different levels of reality" (Bryman 2003, p.291). This was important to get access to individual decision-makers views of the process: not something that may be necessarily evident in the meeting data alone. This was considered to be possible due to two main reasons: firstly, certain more candid views of decision-makers may only be forthcoming in a confidential interview situation; and secondly, the wide variation in participant contributions (as demonstrated in table 20 and the graph in figure 28) demonstrates that assessing individual views from meeting data alone may be difficult. Thus, interviews provided not only triangulation but also allowed greater depth of research data and more comprehensive collection of decision-maker perspectives. Scandura (2000) suggests that triangulation by using multiple data sources may allow each data source to provide a unique perspective. Furthermore, Scandura (2000) infers research validity may be improved by the use of triangulation, and thus stronger conclusions may be drawn from analysis of data from multiple research methods.

Ethical considerations

The research methods employed provide a number of ethical challenges (Bryman and Bell 2003, Hammersley and Atkinson 1995). The ethical issues arising in the project were:

- Consent. The research confirmed individual consent from decision makers for both the scrutiny of documented decision-making meetings and semi-structured interviews. All consent was confirmed through signed consent forms in a format consistent with the requirements of the sponsoring academic body.

- Privacy and confidentiality. The potential professional conflicts were those relating to seeking honesty and openness from individual contributors without overdue concern for such honesty undermining working relationships. The project, through the consent process, confirmed the confidentiality of any interview comments. Observational data in the four management meetings were collected in formally recorded ('minuted') meetings where all contributions were documented for posterity. Although the meetings were recorded there remained a need for strict confidentiality as the subject matter included discussions as to whether to resolve commissioning issues through the use of open market tender. Consequently, some of the information may have been considered commercially confidential. Again, all documented information or data collected not already in the public domain was treated confidentiality.
- Consequences for future organizational decision-making. Beyond the need to protect individuals the project also considered the impact on future strategic decisions for the organization. The close attention to confidentiality provided protection from exposure of commercially confidential data that may compromise future decisions. The intention of the project was to improve learning about how decisions are made and thus help to improve future decisions. This was the positive side of the learning process. A potential negative was exposing any inappropriate behaviour by individuals or groups. In actuality no professionally inappropriate behaviour was observed.
- Data protection. The project did not include patient identifiable data. Furthermore, all participants were employed by the NHS; and thus, subject to data protection regulations and legislation. Nevertheless, all collected data required assessment for any mention of individual cases relating to patients or professionals.

Research validity and reliability

The adopted strategy sought to produce research that was both valid and reliable. Silverman (2011) describes the challenges to qualitative research of demonstrating both validity and reliability. Reliability, defined in terms of the consistency of results across different observers and differing occasions (Hammersley 1992), is inevitably difficult for case study research, as very often the type of case may be unique. Consequently, reliability requires techniques other than that of being merely easily replicable. Silverman (2011) discusses the feature of transparency as important for qualitative research. In this project transparency has been demonstrated through: a rigorous and explicit detailing of the research methods undertaken; verbatim transcriptions of interview data; and collection of verbatim-recorded meeting notes. Thus, all data sources were collected as verbatim information in the first instance and not just as researcher interpretation. Furthermore, the coding of qualitative data was conducted through a systematic process using qualitative analysis software (see below). Reliability of analytical concepts required linkage of developed codes and themes to the verbatim transcripts and organizational texts. Whilst an element of

subjective interpretation is a feature of all research analysis, qualitative and quantitative (Silverman 2010), transparency aimed to promote objectivity wherever possible.

Bryman and Bell (2003) describes validity as whether the researcher is observing, identifying, or measuring what they say they are. Three typical tests for research validity are: construct; internal; and external (Yin 2009). The validity of the project is maintained by:

- For construct validity using more than one data source providing triangulation. Triangulation is considered an effective approach in support of achieving validity in qualitative research (Silverman 2011). The use of multiple data sources was complemented by the use of consistent coding schemas across sources.
- The project was primarily exploratory there was not anticipated to be an identification of strict causal relationships, as indeed the project did not use a deductive methodology of hypothesis falsification. The Context-Mechanism-Outcome (CMO) framework sought to explore and construct mechanisms linking outcomes to context: causality more aligned to processes than to a series of events. Consequently, the project methodology provided no requirement to demonstrate the type of internal validity as described in purely quantitative research. The test of consistency was achieved by using a common coding scheme across all data sources and coding according to verbatim textual data for all sources.
- External validity, in terms of generalizability of findings and application to wider decision-making environments, provided the most significant challenge for the methodology. Yin (2009) however, states that case study research is generalizable to ‘theoretical propositions’ and ‘analytical generalizations’ (Yin 2009, p.43). This infers the research findings can be generalized not through a statistical frequency application to given populations (as in conventional quantitative research) but through the application of analytically developed theoretical propositions to equivalent management environments. The research findings and conclusions can be generalized to similar cases and apply more broadly through testing the theoretical positions in further research.
- A further test, that of ecological validity (Bryman and Bell 2003) is sometimes described as a sub-set of external validity, but distinct from population validity. Ecological validity tests how the research environment reflects a comparable real-world setting. It is confirmed by the nature of the real-world research of the project itself. Indeed, a major motivation for the project was to explore decision-making in its actual real-world environment, through an ethnographic approach.

Johnson (1997) discusses three types of validity pertinent to qualitative research, in addition to internal and external validity. Thus, the current project maintains validity via following approaches:

Table 3 - Johnson's (1997) research validities

Validity Type	Approach to ensure validity
Descriptive validity – the factual accuracy of accounted relayed by researchers	Data was verbatim transcripted and available wherever possible data used to highlight an observation in the analysis was illuminated by verbatim quotes.
Interpretive validity – the accuracy of portraying the views and meanings of participants	Observational data was triangulated with interview data to provide a check of authenticity in interpretation.
Theoretical validity – is the theoretical explanation provided credible from the data	The transparent data and coding schemes are provided and explained as base data for the claimed theoretical interpretation. Rival explanations are first developed and then a synthesised theory produced at the end.

Seale (1999) discussed various approaches to quality in qualitative research, including voices suggesting traditional approaches to validity and reliability, based on quantitative and natural science research may no longer be applicable. Such views appear to generate from non-realist conceptual standpoints, for example post-modernism. Such alternative approaches to research quality are not considered consistent with the generally realist ontology of this project. Seale's (1999) analysis of alternative positions may also be seen as suggesting postmodernist attempts to abandon traditional classifications of validity achieve limited success. Alternative classifications ("truth value, applicability, consistency, and neutrality" (Seale 1999, p. 467)) play roles in replacing their traditional antecedents: but may not undermine the need for classification itself. (Seale and Hammersley's 'subtle realism' (Seale 1999) appears consistent with the critical realist approach in the current project.) Thus, the approach to validity was taken consistent with the realist ontology. Wynn and Williams (2012) discuss the methodological approach used in critical realist research. The project is considered to have followed these principles as:

- Explication of events through 'thick description' – a detailed analysis of ethnographic data.
- Explication of structure and content – through elaboration of the different organizational and framing levels at work in the case study.
- Retroduction, explaining mechanisms and powers at work– by producing a theoretical model that aligned with the discovered data and research findings.
- Empirical corroboration that mechanisms described have greater causal credibility than alternatives – through the use of rival explanations and then a synthesized overall model.

- Triangulation of sources and methods – different data was collected from observation, interview, and documents.

The choice of decision

The CCG was necessarily selected as the subject of study as it was the organization of the researcher. The choice of decision was determined by the definitions relating to what is a strategic decision, as discussed in the earlier literature review. Thus, the chosen case-study decision was considered to:

- Support the achievement of a major corporate objective (in this case the development of stronger out of hospital community healthcare services).
- Involve or influence significant levels of healthcare commissioning (the case involved a range of community services providing healthcare across the whole CCG area).
- Be of a financial value above the delegated limits of any individual or committee of the organization under scrutiny, other than its main Governing Body/Board (in this case a value of approximately £12 million).

The subject for the case study also needed to reflect the practicalities of the research project and thus, in addition to the criteria relating to the strategic nature, it also complied with the following requirements:

- Being time limited within a defined period, in this case within one whole financial year of 2015-16;
- Involving a discreet collection of individuals to whom the researcher would have access (the CCG Governing Body and supporting officers);
- Having an ultimate decision-making committee to which the researcher would have access as a participant researcher (the CCG Governing Body).

The case study focussed on the path of the decision to the specific strategic decision during the financial year of 2015-16. The decision-making meetings occurred between the June and July of the year: preparation and early drafts of documents occurring slightly before this period. The project negotiated access by achieving agreement from the CCG leadership to the research.

Research methods employed

The research data generation was through the three routes of: participant observation of decision-making bodies; qualitative interviews with decision-making committee members; and collection of documents produced and referenced in the decision-making process.

Participant observation

The observational data collection was of four CCG meetings that were central to the decision-making process. The management meetings were the main decision-making

forums in the study and provided the observational data regarding the decision process.

The meetings were:

- Preparatory planning meeting.
- First CCG business committee.
- Second business committee.
- Governing Body in public where final decision was taken.

All of the meetings were audio recorded to support accurate minute taking by the CCG's note takers. The meetings lasted for 1-2 hours, with the time taken on the specific decision subject taking approximately an hour in each case. The researcher gained access to the meeting transcripts as part of the project, with explicit support from the organization and the meeting participants. Consent was gained from participants for transcript data to be used in the project.

Qualitative interviews and Interview sample

The aim was to interview the majority of the individuals directly involved in the decision-making process. This included the members of the Governing Body and a small number of senior CCG officers who led the work on the business case and presentations involved in the process. The qualitative interviews provided triangulation evidence in support of discovering the mechanisms at work in the decision process. The 18 decision-making participants involved in the process were split between Governing Body members, those with a vote at the eventual decision-making Governing Body meeting, and the professional employed officers of the CCG that were not voting decision-makers. The individual participant breakdown was as follows:

Table 4 - List of decision-making participants

Participant Title	Role	Pen picture
Clinical Chair	GP CCG Town Practice (Clinical Chair)	Very experienced male GP who has worked in the Ellerton area for nearly 40 years. Held similar lead commissioning roles for over 10 years.
GP Vice Chair	GP CCG Town Practice (Vice Chair)	Very experienced female GP worked in Ellerton for over 25 years as a GP. Long experience in commissioning type roles.
Ellerton GP	GP CCG Ellerton Practice	Young female GP, originally from the middle-east, who had been working in Ellerton for about 3 years.

Peripatetic GP	GP CCG Peripatetic	Male Ellerton GP, not a GP practice partner, but works with a number of different GP practices.
Notlam GP	GP CCG Notlam Practice	Very experienced male GP who had worked in the Nortondale area for over 30 years. Had a close affiliation with Notlam Hospital and senior GP partner at the large Notlam practice.
Nortondale GP	GP CCG Rural Nortondale Practice	Younger male GP from a very rural practice in the middle of Nortondale. Long experience in commissioning type roles with CCG and previous PCT.
Hospital Consultant	Hospital Doctor	A very experienced male former hospital consultant who had retired from working at Ellerton District Hospital several years beforehand.
Chief Nurse	Chief Nurse	Female Chief Nurse who had been in post since the creation of the CCG and had held various previous senior positions.
Practice Manager	GP Practice Manager	Experienced female GP practice manager from an Ellerton GP practice, the same practice as the CCG Chair.
Lay Patient Rep	Lay Member (Patient Engagement)	Recently retired male ex-Local Authority senior manager. At the time of the study part time CEO of a local charity.
Audit Chair	Lay Member (Audit and Governance)	Recently retired male ex NHS Finance Director who worked part time as a management consultant
CFO	Chief Finance Officer	Experienced male finance professional who had been working in Ellerton for only a few years.
CEO	Chief Executive Officer	Experienced male NHS CEO previously held board level posts in the former PCT.
Project Director	Project Director for the Project	Experienced female senior manager from a nursing background.
Project Manager	Project Manager reporting to the Project Director	Male manager recently appointed to the project role and had little experience of NHS commissioning

Deputy CFO	Deputy Chief Finance Officer	Experienced female finance professional with most of her experience in hospital trusts.
AD Commissioning	Assistant Director of Commissioning	Very experienced female manager with a long history of working in NHS commissioning
AD Primary care	Assistant Director of Primary Care	Experienced female manager but had most of her career in the private healthcare sector. Started in the NHS when the CCG was established.

Of the 18 individuals identified as centrally involved in the process, 16 were interviewed between January 2016 and July 2016. All interviewees were informed of the content of the research and completed a consent form prior to data collection. The initial timing of the interviews reflected both the practical issues of conducting the interviews after completion of the research proposal and ethical approval from the college authorisation processes. The period of data collection was a product of gaining access to the 16 individuals, bearing in mind also that the interviewer was working in the organization during this period. Although the timing of the interviews was relatively recent after the event, there was a risk that subsequent events may have distorted views of the decision. The actions resulting from the decision were only just coming into force when the interviews were conducted, and as such there may be a limited impact from outcome bias on decision-makers' views. It should, however, be noted that the ongoing presence of influences as described in the research data may also be felt after the event and needs to be recognised as an ongoing risk for research of this type. This could be further enrichened by a subsequent interview series at a later stage after the initial case study, possibly when some of the actions arising from the decision-making process have been implemented.

The format of the interviews was semi-structured with all interviews referencing the model interview questions as a base structure, with other themes or questions emerging from this base. The model questions are provided as Appendix 4. The aim of the interview questions was to encourage participants to explore items consistent with the research objectives within the conceptual framework. The questions were constructed to engage the interviewees (for example in questions 1 and 2) and to probe the interviewees within the frame of the conceptual framework. Thus:

- the role of empirical evidence as an influencer (Q3), as against the personal reflections on the decision-making subject (Q4);
- the impact of the decision-making process on the individual (Q5) and the expectations of the process against the eventual outcome (Q6);
- the range of influences felt by decision-makers in the process (Q7)
- the role of coalitions (Q8) and the importance of certain individuals within the process (Q9)

- the role of responsibility and governance in the eventual decision taken (Q10)

Lastly participants were asked about how decision-making could be improved within the CCG, as the project remained a practical study with the expectation of helping to shape future decision-making.

The questions were prompts in semi-structured interviews, and not merely questions requiring responses in a questionnaire. Consequently, the generated data from the interviews went beyond simply replying to the questions. The semi-formal and free-flowing nature of the interview discussion may be seen to be reflected in the volume of data created from the conversations. The interviews lasted between 35 minutes and 90 minutes. The duration dependent on the level of contributions of the interviewees.

Participant	Recorded words in interview
Clinical Chair	5,516
GP Vice Chair	2,471
Ellerton GP	5,549
Peripatetic GP	9,715
Notlam GP	6,597
Nortondale GP	*Not interviewed*
Hospital Consultant	2,739
Chief Nurse	11,627
Practice Manager	*Not interviewed*
Lay Patient Rep	3,972
Audit Chair	5,121
CFO	5,135
CEO	2,276
Project Director	6,792
Project Manager	10,415
Deputy CFO	5,479
AD Commissioning	5,262
AD Primary care	4,193

By the completion of interview 16, the two remaining interviewees were not available for interview until much later. Following transcription and analysis of the interview data, using coding triangulation with the observational data, the data appeared to support an assessment of theoretical saturation (Bryman and Bell 2003) in that: no significantly

new information appeared to emerge from the later data; the coding concepts appeared well developed and the interview data enhanced the understanding gained from the observational data; and the relationships across the data were considered to be well established (Bryman and Bell 2003, p.330). Interviewing of 88% of the decision-maker population was considered sufficient with the evidence of saturation. The two decision makers not interviewed (Nortondale GP and Practice Manager) were unavailable during the period of data collection and the researcher considered that theoretical saturation had been achieved and thus the absence of them from the data may not significantly change findings or conclusions. Their two spoken contributions to the meeting data (2,187 and 257 respectively) were included in the meeting data analysis and thus their participation was active if partial.

Documentary evidence

The documents used in the case study by the CCG itself were limited to:

- The draft business case (as presented to meeting 3)
- The final business case (as presented to meeting 4)
- PowerPoint presentations introducing the subject and partial content from the business case (as presented at meeting 2)
- Meeting minutes and agendas for the four observed meetings

Data analysis did not include specific analysis of the documents themselves, as they were referenced and discussed in the and interview data. It was considered more appropriate to consider the documents within their usage, that is how they were consumed and used as decision-making tools, rather than to evaluate them in their own right.

Research milestones and timeline
The research project progressed according to the following detail:

Milestone	Date
Preparatory Planning Meeting	17th June 2015
First Business Committee formal discussion	24th June 2015
Second Business Committee formal discussion	1st July 2015
Governing Body meeting with final decision	22nd July 2015
Semi-structured interviews with participants	January to May 2016

The methodological research framework and the development of the conceptual framework

This section explores the ontological and epistemological foundations for the research method. These critical realist foundations support the use of a realist analytical framework that also flows logically from the literature study. Pawson and Tilley (2004) describe a realist evaluation method with a Context-Mechanism-Outcome (CMO) framework. The morphogenetic approach aligns structural and cultural conditioning with Context; social interaction with mechanisms; and social elaboration with both outcomes and mechanisms. As described above in Archer's (1996) distinction between agency and structure the CMO framework applies across both dimensions consistent with analytical dualism. The CMO framework was usefully applied to the project as it aligned with the main literature review themes.

Context

The context of includes:

- Commissioning - the business of the organisation. This element of context is not merely the business itself but also the business environment, including policy directive and the external influences described above.
- Strategy - how the organisation delivers its business objectives. This also reflects elements of the business environment, but more specifically how the organization responds to that environment. Thus, this brings in both external and internal influences.
- Strategic decisions - how critical points are managed in assessing how to implement the organisational strategy. The decisions themselves appear in all three levels of the CMO framework. In the contextual level this is how the points arise and their importance to the achievement of corporate objectives.

Outcomes

The outcomes that emerge from the process included:

- Decisions made
- Actions taken
- Implications of the decisions and actions
- Intended and unintended consequences

Mechanisms

Finally, the framework sought to link the context of the process and its outcomes through the detected mechanisms. The research project sought to explore the phenomenon of the negotiated order and explored the:

- formation of coalitions & interest groups
- power struggles
- exchange and consumption of information
- creation and use of analytical frames

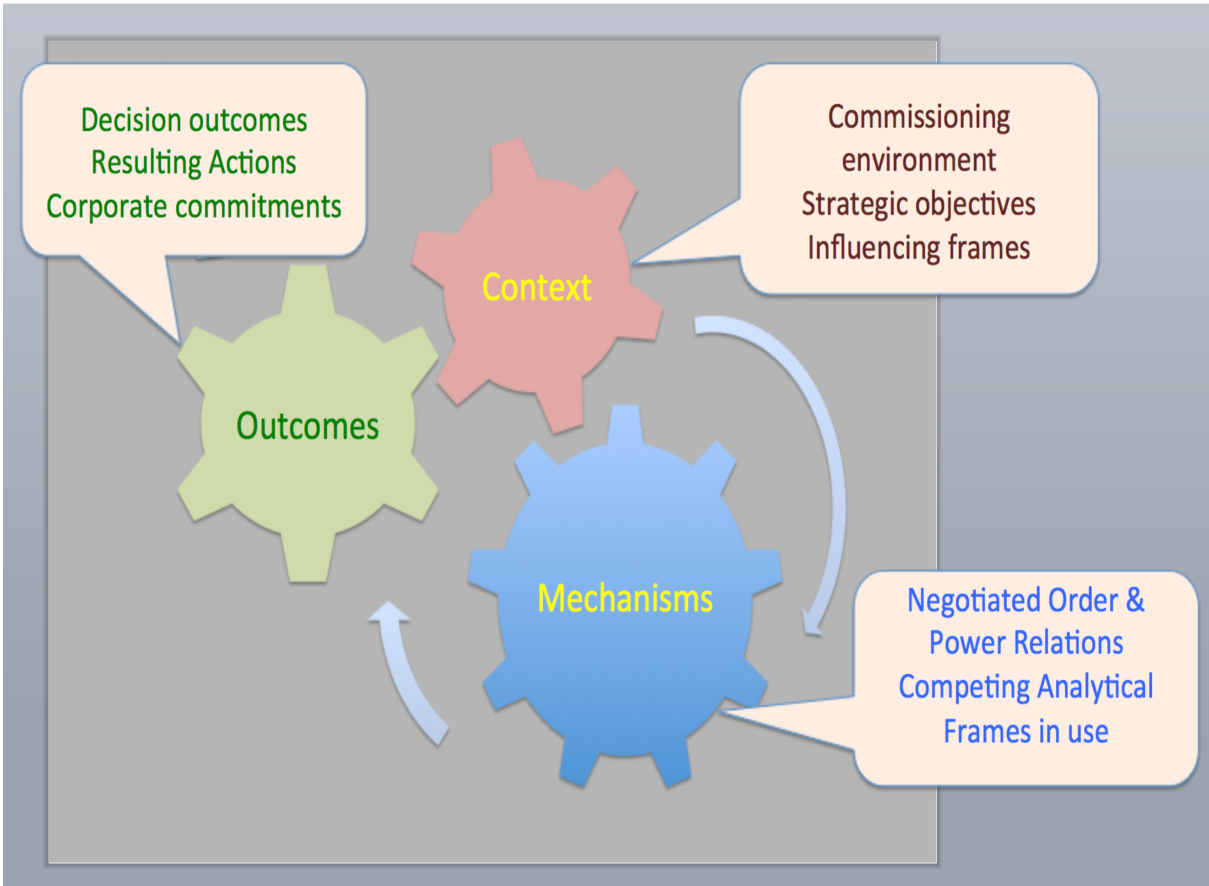


Figure 19 - Context-Mechanism-Outcome (CMO) Matrix

The framework supporting the analysis of the research findings aligns with the connected framework summarising the literature review themes and the hypothetical grounding of the research. Thus, the CMO framework above is considered to be within the conceptual framework identified in chapter 2.6 and shown in figures 16 and 17 and represents the method that underpins the research strategy of the conceptual framework.

From the research question to the research data analysis there may be described a consistent path of the research process in the project. Thus:

- The motivation for the research was that of understanding and then improving on the process of decision-making that occurs in NHS commissioning. This was the researcher's professional background and the case study occurred in changing environment of the NHS following the 2012 Health and Social Care Act, which introduced a greater involvement of clinicians (for the most part medical doctors) to decision-making bodies.
- The research question was "What are the factors that influence strategic decisions in healthcare commissioning: a negotiated order perspective?" Therefore, the research was just a general exploration of decision-making, but a more focussed study of the influences present in decision processes. The theoretical perspective used to frame the research was that of the negotiated order.

- The literature review provided the basis for the project by critically evaluating research into decision-making context and the subject area:
    - The management concept of strategy, as the decision subject is considered as strategic. Thus, the conceptual framework contains the macro level of organizational strategy. The literature reviewed was that which defined strategy and described its conceptual development and practice within both private and public sector organizations. The latter particularly informs the strategic context of the organization under study as a public sector healthcare body.
    - The subject under study is that of decision-making as seen through the case study of a strategic decision: thus, the review discussed general concepts of decision-making with a more specific focus on strategic and organizational decision-making models. The social practice researched was that of strategic decision-making practice and this appeared to fit within the meso framing level, the level of organizational praxis influenced by the macro environmental context.
    - The professional field of the case study was that of NHS commissioning and the review summarised the concepts of commissioning. The discipline of commissioning, however, is not represented in the conceptual framework, as this is the field of practice where the study occurs, rather than a conceptual element.
- Thus, the case study was of a commissioning organization, conducting a strategic decision. The decision-making practice was that of group behaviour which was also reviewed with the aim of assessing features of group decision-making behaviour. The recognised phenomena of the organizational coalition (Cyert and March 1992) and the negotiated order (Fine 1984) emerged from the survey of group behaviours within organizations and was selected as the most appropriate frame through which to conduct the study. The negotiated order is the level that social practice occurs and is the mechanism that may be revealed through the research (a testable hypothesis that the negotiated order may be demonstrated within NHS commissioning).
- The negotiated order is shaped by the framing environment at the macro level, which it itself then also shapes and frames at the meso (middle) and micro (lower) levels. Thus, the frames evident in the case study may be identified through the discourse shown in the textual data of the management meetings and the qualitative interviews.
- As the causal mechanisms may only be discovered through the analysis of texts the core of the conceptual framework is the method of analysing textual data: critical discourse analysis. Within the framework CDA provides the means to assess whether the three framing levels demonstrate the influences as descried in the literature review and, furthermore, what mechanisms drive the outcomes seen in the study.

Thus, the conceptual framework sits within it research context, that of strategic decision-making in NHS commissioning. The analytical lens is that of negotiated order as a description of group behaviour in the decision-making environment. The exploration of the negotiated order is assessed within the three framing levels that reference the range of influences that may be present in the decision-making process. Therefore, the research question was be addressed through the framework exploring the decision-making influences across the different levels, identified through the analysis of the decision discourse. From the generated data through to context we may describe:

- Data – what is visible, the textual narratives provided by group discussion and individual interview
- Group dynamics – the exploration of group behaviour and the hypothesised negotiated order as the pattern of how decision-makers behave in the decision environment
- Strategic context – the wider organizational context of the decision-making body reflecting the influences from the corporate environment.

The framework supported the generation and subsequent analysis of research in the case study.

Chapter 4 - Generation of data and coding development

Introduction

This section details the generation and collection of research data and its subsequent analytical coding within the conceptual framework as described in section 2.6 above. The audio meeting and interview data was analysed through qualitative methods. Analysis was conducted on the contributions from the observed meetings that provided numerical data on meeting contributions from participants. Qualitative analysis was performed on the verbal contributions in the meetings, of the interview data, and of the content of documentary evidence. Qualitative analysis whilst performed separately in each of the data areas, aimed to conduct consistent analysis, using common coding approaches, and seeking to identify themes across all of the collected data. The detailed discourse analysis of the codes against the data, particularly against discourse 'building tasks' (Gee 2010) is provided in Appendix 5.

Data analysis of meeting contributions

The transcripted meeting data was analysed to count the number of individual contributions and the word count for each contribution. From this data it was possible to calculate the number of contributions per participant and the total word counts for each participant, in each of the meetings. Together this then allowed assessment of the proportionate contributions of each participant within each meeting and within the four-meeting group as a whole. The method of analysis had similarities to that used by Bezemer (2014). The detailed analysis of meeting contributions and ranges of contributions made by each participant is provided in Chapter 5 and is summarised in table 20 and the graph summary below (repeated as figure 28 in Chapter 5).

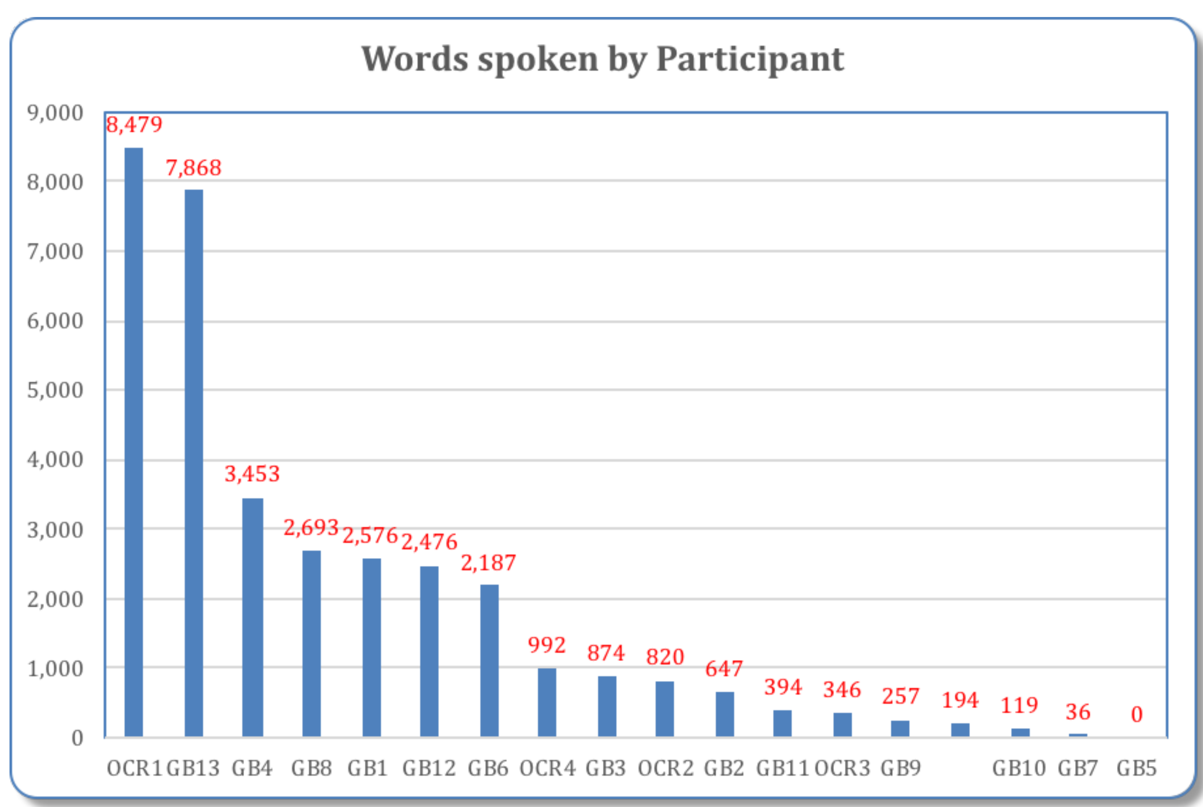


Figure 20 - Graph of words spoken by participants in management meetings

The graph demonstrates the range of word contributions from participants was very wide. The heavy word count seen by the CCG Chief Officer (GB13) and the project's Project Director (OCR1) may not be surprising, but the very low interventions by some participants may be more surprising. Although the number of words spoken may not reflect the relative influence individuals may have had in the process. For the actual formal decision-makers themselves, that is the voting Governing Body members, it is notable that each of them had the equivalent vote in the eventual decision meeting. But for some voting members, their explicit positions can be discerned (at least partially) through their verbal statements: for the less vocal, their reasons for their decision choice may be less obvious to external observers. This may be seen as problematic, both in terms of the quality of debate supporting effective decision-making, and in terms of the governance in a decision process, where an explicit record of individual positions may be seen as helpful.

Data analysis 1 – qualitative observational data

The transcripted data underwent analysis through a multi-layered coding approach. Coding of qualitative data is considered a standard approach to qualitative analysis (Saldana 2013).

The practical implementation of coding schema on the data used a modified and iterated version of the Silver and Woolf (2015) 'Five Level QDA' (Qualitative Data Analysis) approach. The original 5 level QDA as used in the project is represented as:

Table 5 - The use of Five-Level QDA (From Silver and Woolf 2015)

Five-Level Qualitative Data Analysis				
2 levels of strategy >> translates to >> 2 levels of tactics				
Level 1	Level 2	Level 3	Level 4	Level 5
Objectives	**Analytical plan**	**Translation**	**Tool selection**	**Constructed tools**
The purpose of the project expressed as the research question	The conceptual framework and analytical tasks	Translating the tasks to software tools and translating back	Specific software operations	Different software and analytical operations used for the project

Thus, in this project the five levels occurred as:

Table 6 - QDA coding level

Level	Research actions
1: Objective	Research objectives
2: Analytic plan	Conceptual framework emerging the literature review
3: Translation	The analytical framework of coding developed using the QDA tool (Nvivo)
4: Selected tools	Nvivo used to further analyse and facilitate second order coding and the discourse analytical framework analysing coding themes
5: Constructed tools	Synthesis of analysis emerging from software tools and wider analysis of data flowing into concluding research themes identifying mechanisms at work in the case study.

Data Analysis 2 - Initial coding development

The meetings sessions were digitally recorded; and after granting the project access to the recordings, all meeting contributions were verbatim transcripted. First cycle coding (Saldana 2013) followed an iterative process, following the steps of: simple word count analysis; initial verbatim coding; conceptual coding following re-analysis of meeting transcripts; synthesis of conceptual and verbatim coding.

The initial verbatim coding of observational data showed the top-ten word counts:

Table 7 - Simple word count coding of observational research data

Coded Word	Count of Use	Weighted %	Similar words included in code
Service	380	2.13%	Service, services,
Risk	327	1.83%	Risk, risks
Option	324	1.81%	Option, options
Tender	190	1.06%	Tender, tendered, tendering,
Need	181	1.01%	Need, needs, needed
May	181	1.01%	may
Model	166	0.93%	Model, modelled, models
Think	162	0.91%	Think, thinking, thinks
Change	156	0.87%	Change, changed, changes, changing
Want	148	0.83%	Want, wanted, wanting, wants

The simple word analysis provided limited insight into emerging themes but was a basis to develop first cycle codes for more developed coding concepts. The verbatim codes may be separated into simple descriptive codes, that document superficial processes occurring in the case study; and conceptual codes that hint at potential causal mechanisms. Thus, the frequent use of terms such as 'service' is reference to an oft-used professional term, but this may provide little information about the deeper dynamics of decision-making. Verbatim analysis did, however, allow the generation of conceptual codes.

The main emerging codes from the observational data, following second cycle coding (Saldana 2013), fell into a number of broad categories:

- **Improvement** codes relate to themes strong need to improve service beyond their current standards, often shown as emotions and feelings expressed in the process. Codes within this groups included:
  - Confusion
  - Frustration – "things have to get better"
  - Tension
  - Self-interest
- **Risk** codes relating to the potential downsides of particular choices.
  - Financial risk
  - Political risk
  - Clinical risk
  - Legal risk
  - Capacity risk

- **Corporate process** codes relating to the management of the decision-making process itself.
    - Governance – "how do we decide?"
    - Evaluation – "how do we choose?"
    - Procurement – "are we following a valid and legal process?"
- **Behaviour** codes describe how decision-makers and the wider communities act in the process. Specific codes included:
    - Openness
    - Closed and opaque.
    - Pragmatism
    - Nortondale (this became significant enough to become a higher level code)
- **Stakeholder** codes relating to how the decision options may be seen by wider partner agencies – "what do our communities expect". This tended to focus more on assumed expectations from partner agencies (GPs and NHS Trusts) than on patient groups.
- **Service design** codes cover discussion on how the services need to improve or be reconfigured.
    - The clinical model
    - Service information
    - Services at scale
    - Specification
    - Evidence

The initial coding analysis of meeting data was cross-referenced against the emerging themes from the interview data. This allowed the fuller exploration of themes.

Data Analysis 3 - Coding profile of the four meetings

The developed codes are summarised as:

- Improvement
- Risk
- Corporate process
- Behaviour (including the Nortondale sub-code)
- Stakeholder
- Service design

Each of the four meetings tended to show certain codes as dominant, reflecting the progress of the debate within the process, and possibly also the shifts in the dynamically generating negotiated order.

Table 8 - Summary of coding references in management meetings

Code	Meeting 1	Meeting 2	Meeting 3	Meeting 4	TOTAL
Improvement	36	35	31	13	115
Risk	62	187	290	56	595
Corporate	92	230	218	73	613
Behaviour	1	3	6	7	17
Stakeholder	0	20	32	14	66
Service design	51	57	88	41	237
TOTAL	242	532	665	204	1643

The range of coding references largely results from the relative length of the meetings (two long and intense, two much shorter). The final decision-making forum (meeting 4, the Governing Body) showed a relative balance across the codes, possibly reflecting its final decision-making status (that is as the ultimate decision-making meeting). The others tended to demonstrate an imbalance across the codes, reflecting the preoccupations in the meetings at the particular times.

Table 9 - Percentage allocation of codes across meetings

Code	Meeting 1	Meeting 2	Meeting 3	Meeting 4	TOTAL
Improvement	15%	6%	5%	7%	7%
Risk	25%	35%	43%	27%	36%
Corporate	38%	43%	33%	36%	37%
Behaviour	1%	1%	1%	3%	1%
Stakeholder	0%	4%	5%	7%	4%
Service design	21%	11%	13%	20%	15%
TOTAL	100%	100%	100%	100%	100%

This may be summarised in terms of meeting priority and as the place of each session in the overall process. Meeting 1 focussing mostly on: the improvement theme (justifying why there needed to be a change); the service design theme (what the changed service would need to look like); and the corporate process theme (how the CCG delivers its desired outcomes). Meeting 2 explored more heavily the corporate process theme, discussing issues such as legal process and procurement, possibly in part due to a need for the decision-makers to understand procurement routes and options to secure a new service. This session also included an increasing focus on

risks, spread across all of the risk categories. Risk was the largest single coding theme proportionately allocated for meeting 3. Meeting 4 spread attention across of the major groups (the stakeholder theme being small in coding references in al sessions), with the largest proportionate focus on the behaviour code (including the focus on Nortondale).

Each of the meetings tended to show a concept (or coding) rhythm: that is, certain subjects tended to dominate certain parts of each meeting. This may be considered as less so in the more structured (and public) Governing Body session (meeting 4). Thus, participants tended to engage in a back-and-forth discussion on the advantages and disadvantages of an issue and then move on the next one. Some concepts recurred through the meeting, and some had a discreet place in one part only. This raises questions as to meeting behaviours and etiquette (in the sense of individual and group cultural conduct). Discussion and the overall discourse may be influenced by how the group facilitates or obstructs consideration of differing subjects. For each session it was possible to identify structural and behavioural elements that shaped the discourses. The elements demonstrated in the meetings were:

- Agenda setting (2nd dimension power)
- Slide-deck/business case presentation (2nd dimension power)
- Chairing style (influencing 1st and 2nd dimension power)
- Participant opinion clustering on subjects (linking to coalition forming and polarisation)
- Group behaviour that allows considered attention to some subjects and quickly skims over others (2nd dimension power)
- Group consensus as to further exploratory work on information sourcing and document production informing future sessions and decision

Data Analysis 4 - Developed coding analysis of meeting data with interview data

The decision-makers were interviewed, and the verbatim transcribed interview data coded against the second cycle coding schemes developed from the coding of the observational meeting data. The coding references in the interview data against the same coding schema as the meeting data is shown below:

Table 10 - Summary of coded interview data

Code	Total References	% of References
Improvement	111	13.8%
Risk	82	10.2%
Corporate Process	221	27.6%
Behaviour	183	22.8%
Stakeholder	54	6.7%
Service design	151	18.8%
TOTAL	802	100.0%

Table 11 - Comparison of data codes between meetings and interviews

Code	Meeting Reference %	Interview Reference %
Improvement	7%	13.8%
Risk	36%	10.2%
Corporate Process	37%	27.6%
Behaviour	1%	22.8%
Stakeholder	4%	6.7%
Service design	15%	18.8%
TOTAL	100%	100.0%

From table 11 above it appears both the subject for discussion and the content of interviews included a stable level focussed on the improvement themes, but the proportion of coded data may not necessarily reflect the importance of the issue to all decision-makers. Furthermore, some of the ‘frustration’ elements of the improvement code may have been voiced more explicitly in interviews than the meetings. The degree of attention on corporate process codes in both data groups may be seen to reflect the need to discuss technical issues such as governance, procurement, and

option evaluation. Service design was an expected issue during a case study of a service redesign/service recommissioning subject, and the content proportion as relatively stable across both data groups. The stakeholder codes appeared limited within both data groups, but there may be seen to be some degree of cross-over between the stakeholder codes and the political risk code, which was primarily a political risk relating to the engagement of local, primarily NHS stakeholders. The preponderance of the behaviour codes in the interview data may be a reflection of two factors: firstly, that the questioning itself did address issues of participant behaviour; and secondly that in the meetings it would be unlikely that individuals would discuss in detail the behaviour of each other, or indeed the group as a whole. Conversely, in an interview setting such discussion would be much more likely.

The clinician Governing Body members (primarily GPs) from the textual analysis of the observed meetings and early interviews showed the greatest tendency towards the improvement code and the *frustration* theme, in large part driven by local experience of poor service delivery. Comments included: “I think the biggest influence was the exasperation with the Trust” (Peripatetic GP Interview); “I think the frustration of not making any improvements or not making any progress was felt by everybody” (GP Vice Chair Interview); and “I knew people were frustrated with current services and therefore they wanted to do something different” (Project Director).

The sense of experiential evidence of poor-quality services was possibly enhanced by the lack of objective empirical data produced by the service under scrutiny in the case study. Thus, one commented “it was hard to make an evidenced based assessment because of lack of data and comparisons with other areas were not that easy” (CEO). Similarly, another stated, “people’s memory of events and very subjective perspectives on part of the service, really, that was over-riding, I think for me, as a memory of those processes” (Clinical Chair). This may be seen as decision-making driven by emotion (Haidt 2001) or intuition appearing as emotion (Pizarro and Bloom 2003). Such personal clinical evidence does remain as evidence: “It’s not strictly evidence-based in what you term the scientific nature but it is evidence-based because it’s based on your own experience” (Clinical Chair); and ““you think it’s a gut instinct, but it’s based on 20 years of doing this day in and day out so it’s not really a gut instinct” (GP Vice Chair). The view of the Governing Body GPs, therefore, aligned with intuition being based on expert experience rather than emotion (thus Pizarro and Bloom 2003, rather than Haidt 2001).

Conversely, the CCG full-time non-clinical executive officers showed the greatest proclivity towards the *risk* and *governance* themes. The risk themes of:

- financial risk (an open tender option may produce a more expensive service) and
- political risk (relations with other stakeholders, particularly existing NHS organizations may deteriorate).

Financial risk was an obvious concern of the financial professionals: “my nervousness and I think a lot of other peoples was around the fact that we might not know enough

about the baseline position" (Deputy CFO); and "the lack of data that we are getting about the service as provided means that the potential for missing things I think is quite high" (CFO). The CO also recognised, "my pre-conceptions were that putting it out to the market would involve financial risks" (CEO).

The political risks were recognised by a broader range of decision-makers. One GP stating, ""the spectre of destabilising the Trust is always a thing that is in the background and that then came to play in the meeting [Meeting 2]" (Peripatetic GP). The CO's opinion was "my pre-conceptions were that putting it out to the market would involve financial risks, but also big risks in terms of our relations with the main stakeholders" (CEO).

Interestingly legal and procedural risks were identified in the meeting discussion: 11 references to legal risks or legal requirements. There was, however, less clarity whether procurement was or wasn't legally required: thus, "there is still a legal obligation to tender services" (Chief Nurse) and "We should do things because it is the right thing for patients not because we worry the lawyers might take us to court" (CEO). This equivocality on legal requirement appeared to result in the issue dissipating later as a decision factor and it featured less in interviewee responses, although one respondent suggesting the "NHS with this procurement is much more cautious than in local government" (Lay Patient Rep).

It appears that those charged with financial accountability may be more risk averse, in part due to their responsibilities in achieving financial targets (more pressing to accountable executive officers than part-time Governing Body members). One interviewee observing different approaches to risk: ""it comes down to appetite for risk… at the meeting I attended there was a fair bit of division around what people were looking to get out of it" (Deputy CFO).

In considering stakeholders, the groups of clinicians tended to prioritise the wider GP community as the most important stakeholders, possibly reflecting the nature of the CCG as a membership body. (The forum where the CCG engages with the membership practices was the Council of Members.) For example, "If we continue with the current service it is a big reputational risk with our current practices" (Nortondale GP, Meeting 3) and "the Council of Members… are very keen on a tendering option for that element of services that are in Lot 2" (Clinical Chair, Meeting 4). Executive officers appear to focus more on the relationships with other public sector agencies. This tended to overlap with the code of political risk. For example, see the comment regarding "the Trust" (above), and the statement by CEO "the biggest strategic risk is the first one in terms of the overall strategic programme with the health economy. There is a risk of bringing in another provider to that programme" (CEO Meeting 3). This referenced the concern that wider stakeholder engagement maybe threatened by the impact of a change on the discreet services in the case study. But as with the overall discussion of tender or not the impact on stakeholders was debated. Thus, a contrary view expressed by Nortondale GP was, "on the one hand they may be a bit upset. On the other hand, you may say what has our relationship with [the

Trust] given us so far?" (Nortondale GP, Meeting 3). Reference was made to patients and patients experience (Meeting 4), but this appeared to support multiple arguments.

The service design codes focussed on the development of clinical models and what the process may achieve in terms of services delivered to patients. Such discussion would be anticipated in a strategic decision of this type, but the overall decision concerning the route to delivery appeared to focus more on the way to achieve the right provider model rather than the specification for delivery. The relative lack of discussion may also reflect the volume of consideration on service design included in the circulated business case and associated management presentations. Summaries of the intended design included: "Deliver a more streamlined and integrated community service that patients receive the right care at the right time in the right setting" (business case content quoted in Meeting 3). Although a clinical model was described in the business case, various details of the potential services were discussed in all of the meetings, suggesting that there was a parallel process of decision-makers establishing what they wanted to commission.

The behaviour codes described decision-makers experience of how the other members acted. These included assessments that the process was relatively open, and in other's views that it was opaque and confusing. Thus, for Lay Patient Rep, "you can sometimes recognise when deals have been done over the table and around the committee room, you vote for me and I will vote for you. There was none of that and has never been a hint of that". Contrary to this, one described a sense or pre-determination: "what [Project Director] did was she did the risk analysis, one of those template things, and that was just a complete set up" (Peripatetic GP). Similarly, another commenting "to some degree yes I think there is a pre-constructive plan to do this, this and this" (Notlam GP). Other perspectives, from two officers outside the decision-making body reflected less on the closed-opaque debate and more on the wider engagement of individuals and perspectives throughout the process. Thus, "I don't think we crystallise people's views" (AD Primary Care) and "The initial involvement from my perspective, [of] finance and contracting, was really minimal" (Deputy CFO). This tended to suggest power and influence as applied at the second and third dimensions of power (Lukes 2005). Perhaps most significantly in terms of the eventual outcome this thematic group of behaviour codes also included the Nortondale code. This shaped the outcome sufficiently to be treated almost as a concept in itself, although its importance lays in the wider examination of the negotiated order. This will be explored further in the consideration of negotiated order.

Evidence emerged supporting the hypothesis of the negotiated order concept. Some interviewees did recognise the presence of internal coalitions consistent with the idea of negotiated organization (Cyert and March 1962). What was evident was the different roles and backgrounds of decision-makers appears to influence their behaviour. The structure of corporate boards (the CCG Governing Body in this case) often reflects a desire to establish diversity amongst the senior group to provide balance and an appropriate level of challenge. (One author suggesting elements required for a

successful board include "high challenge, high trust and high engagement" (Chambers et al. 2013, p.8).) Although this diversity appears to be demonstrated in the case study, the need to arrive at some form of decision-making consensus suggests some form of negotiated settlement may be necessarily required. Thus, the group diversity involves not merely trust and challenge but continual negotiation between competing priorities and positions.

The CCG Governing Body had the following composition at the time of the study:

- Full-time executive management officers (Chief Officer and Chief Finance Officer)
- Full-time clinical management officers (Chief Nurse)
- Part-time primary care leads (6 GPs including the Chair and 1 GP practice manager)
- Lay member as secondary care (hospital) clinical lead
- Lay member with responsibility for patient and public involvement
- Lay member with responsibility for audit and governance
- Other co-opted, non-voting, members from partner organizations (Local Authority, Public Health, and Local Medical Committee)

The sense of 'deal-making' and compromise within the process was referenced by all interviewees in differing ways. This will be explored in the later sections considering influences, frames, and the negotiated order. From the analysis above we may align the coding groups to an evident framing level. Thus:

Table 12 - Data codes aligned to framing levels

Framing Level	Research Codes
Micro	Improvement Service redesign Behaviour
Meso	Stakeholder Corporate process Risk
Macro	Risk Corporate process Stakeholder

Reflexive critique

Reflexivity has been described as the viewpoint of the researcher being 'bent back' towards the researcher themselves (Winter 1989). For Finlay (2002, p.532) reflexivity is "thoughtful, conscious self-awareness" and the reflexive research analysis involves, "evaluation of subjective responses, intersubjective dynamics, and the research process itself". Similarly, interview data has been described as "co-authored by the interviewer" (Kvale and Brinkman 1992, p. 192). For this project the role of the researcher within the organization placed significance on the concept of reflexivity.

The project uses as its reference point the theoretical framework of Archer (2003). This confirms that reflexive analysis and the acceptance of the valid role of the individual voice within research and social exploration is consistent with a realist ontology and epistemology (Finlay 2002).

The nature of the research and its potential implications may have importance for organizations of the type under scrutiny. In which case the senior members of such organization may interrogate the research conclusions from a similar position to the main researcher. As such the reflexive position is not merely an acknowledgement of a research position, or indeed an interesting academic curio, but actually a potentially fundamental requirement to assess the potential impact of the research to wider management praxis. In some respects, we may talk about a *reflexive imperative*. The imperative to acknowledge the reflexive element of the study is necessary due to the perceived originality of the project. Thus, the place of the researcher as in the centre of the organization under scrutiny is unusual: but this places further challenges to the research, in particular maintain a sense of objectivity to the analysis.

The reflexive critique may assume greater importance when placed in the context of practical research with the aim, not merely of exploring organizations, but of developing practice within them. Thus, Winter (1989, p.11) states, "The agenda is not determined by an outside agency (an 'academic' researcher or an institutional superior) but by those whose practices are to change as a result". The reflexive element of the analysis in the study, thus references learning from action research (Winter 1989).

The presence of the researcher as a leading member of the organization under study demanded a need to consider how the reflexive approach would be used and as to how the objectivity of the research process could be maintained. It was considered that the challenges to research validity remain the same but that the researcher position needed to be clearly identified from the outset. Furthermore, the concept of discourse as 'language events that provide the social construction of meaning' implies that the researcher themselves are a necessary part of that construction. The use of reflexive analysis, moreover, provides one of the methodological 'layers' within a multi-layered critical realist approach, recognising the dynamic interplay between agents to agents, and agents to structure. This concept of layering may indeed apply to the perspectives of the researcher themselves. In her discussion on the 'internal

conversation' Archer (2003) proposes three elements that are part of the human inner mental state:

- That a domain of internal mental privacy exists in any conscious individual;
- The private mental states are inaccessible to external inspection; and
- Accessing the internal state is not a passive process of observing the internal mental world, rather it is an active conversation of the self with the self.

For Archer (2003, p.34) this active process helps us to, "define what we do believe, do desire and do intend to do". Thus, for the reflexive researcher it is the conversation of the researcher with themselves that ultimately produces the research product. Not a two-way interaction between the researcher and data: but a multi-layered interaction of researcher with data, and researcher with researcher.

Reflexivity is considered to be a useful tool in social science research (Winter 1989). Furthermore, Archer (2003, p.19) describes the fundamental role of reflexivity and the 'internal conversation' in human society:

> Were we humans not reflexive beings there could be no such thing as society. This is because any form of social interaction, from the dyad to the global system, requires that subjects know themselves to be themselves.

The reflexive critique is taken from the perspective of the research as an individual actor within the process and consequently the first person will be used throughout these sections. The sections review the reflexive view of the research objectives, the impact of the self-reflection on researcher themselves, and the conclusions from the research project on future management research.

Chapter 5 – Management meeting observation findings

Introduction

This chapter describes detailed the findings from the collected research data of the four observed decision-making meetings in the case study, collected through participant observation. The management meetings were the main decision-making forums in the study and provided the observational data regarding the decision process. The qualitative interviews provided triangulation evidence in support of discovering the mechanisms at work. The core data of the ethnography was this observation data and a significant level of extracts from the data are provided which demonstrate the behaviours and the dynamics of the decision-making process.

The 18 decision-making participants involved in the process were split between Governing Body members, those with a vote at the eventual decision-making Governing Body meeting, (with a 'GB' prefix) and the professional employed officers of the CCG that were not voting decision-makers (with a 'OCR' prefix). The individual participant breakdown was as follows:

Table 13 - List of decision-making participants

Participant Index	Title	Role
GB1	Clinical Chair	GP CCG Town Practice (Clinical Chair)
GB2	GP Vice Chair	GP CCG Town Practice (Vice Chair)
GB3	Ellerton GP	GP CCG Ellerton Practice
GB4	Peripatetic GP	GP CCG Peripatetic
GB5	Notlam GP	GP CCG Notlam Practice
GB6	Nortondale GP	GP CCG Rural Nortondale Practice
GB7	Hospital Consultant	Hospital Doctor
GB8	Chief Nurse	Chief Nurse
GB9	Practice Manager	GP Practice Manager
GB10	Lay Patient Rep	Lay Member (Patient Engagement)
GB11	Audit Chair	Lay Member (Audit and Governance)
GB12	CFO	Chief Finance Officer
GB13	CEO	Chief Executive Officer
OCR1	Project Director	Project Director for the Project
OCR2	Project Manager	Project Manager
OCR3	Deputy CFO	Deputy Chief Finance Officer

OCR4	AD Commissioning	Assistant Director of Commissioning
OCR5	AD Primary care	Assistant Director of Primary Care

Meeting 1

Attendees: ELLERTON GP, PERIPATETIC GP, CHIEF NURSE, CEO, PROJECT DIRECTOR, AD COMMISSIONING (6 people).

The meeting was held mid-June 2015. It was a preparatory planning meeting to prepare production of the business case and agree the timescales for the decision process. The meeting involved seven participants making 243 separate verbal contributions totalling 5,125 spoken words. The contributions ranged from the highest contribution level of 41% to 2.6%.

This felt to be the start of a decision-making process that had a long gestation in the CCG and indeed before that in the local health community: ELLERTON GP stating, "I have had my fingers burnt too many times". This planning meeting was relatively informal and was a pre-meeting to the more formal discussions that would eventually end in a decision taken at the Governing Body. This was also somewhat smaller than the formal committees. It had a relaxed atmosphere with light-hearted comments ("As a Scorpio my memory is long", CHIEF NURSE) and there was much jocularity and amusement throughout. The meeting had no formal chair and did not produce formal written minutes to record the session. The attendees at the session had been agreed by a previous CCG business committee and reflected a smaller sub-set of 4 of the CCG Governing Body and 2 senior officers. PROJECT DIRECTOR had already been identified as the lead for the programme of work involved in the case study. They had played in a similar role in a recently managed procurement for an integrated urgent care service, a service that had started in the April of the same year.

At the time of the meeting there was not a fully developed business case outlining the options under consideration, as this meeting was largely concerned with sketching out the process for how this case would be subsequently developed. It did reflect on the wider patient and stakeholder engagement that had occurred in support of establishing the best care models for community care. The PROJECT DIRECTOR has a significant input into this meeting, as indeed they would throughout the other meetings and the process in general. This would include PROJECT DIRECTOR being the main author and editor of the business case that was eventually presented to the CCG Governing Body later that July. The meeting began with an assessment that the clinical model for a new service had already been largely agreed:

> We had discussion last week about the model of delivery: the model has been agreed around the four clusters of community teams and this is within the CCG strategic plan (PROJECT DIRECTOR).

The discussion moved on to whether there was agreement to the composition of the clusters, a factor that did not seem to be clear from the CCG strategy. This debate represented a significant part of the meeting discussion and in retrospect may be seen

as the part of the meetings that discussed the clinical model the most. This debate tended towards the forensic in its level of detail, but possibly reflected the sense of overall agreement to the model and thus a desire to get to implement the theoretical model. The model was considered as largely agreed and consistent with the CCG strategy but, interestingly, "We never really got the configuration signed off" (CEO). The ensuing discussion included GP practice level debate as to the composition of the 'clusters'. This became quite detailed:

> PROJECT MANAGER - I can draw the geography and look at different options.
>
> CEO and PROJECT DIRECTOR – Yes that would be a good idea.
>
> PERIPATETIC GP – The problem I can seeing that is worth flagging now is that if the LMC wants to build a super-practice it would have Provenance Terrace joining Enderby Gardens.
>
> PROJECT MANAGER – But this reinforces the point that we don't base it around specific practices.
>
> PROJECT DIRECTOR – We may have to move the shape of the clusters with different scenarios.

From the discussion as to the specific configuration of the model and its geographical alignment the meeting then moved on to consider the content of a business case, and the likely option appraisal. PROJECT DIRECTOR then provided the first site of a range of options in the process:

> The 5 options are:
>
> I. Don't do anything stay with the current service specification with the current provider
> II. Stay with the current provider and try to achieve the model specification through a managed change
> III. Procure through the open market through a single open tender
> IV. Procure through the open market with a staged approach following a pre-qualification stage.
> V. Procure through the open market with a process of competitive dialogue (PROJECT DIRECTOR Meeting1)

From this introduction of options, the meeting did not then discuss the benefits of each option but deliberated the evaluation criteria in assessing the options. Although this discussion was relatively brief, there was no explicit reference to the wider CCG strategy or 5YFV in developing assessment criteria. It may have been helpful to consider how the process related to wider corporate objectives, as the discussion at this point seemed to lack focus, and the group was struggling to decide how it should arrive at evaluation criteria. For example:

> CEO – Is integration important as a criterion for deciding which procurement route we choose?
>
> ELLERTON GP/CHIEF NURSE – No

ELLERTON GP – The question is probably are we going to buy this suit off the rack or are we going to get someone to design it bespoke?

CEO – In which case integration isn't a criteria (sic) for deciding the procurement route.

ELLERTON GP – It is a criteria (sic) in the model but not for choosing the procurement route.

PROJECT DIRECTOR – Whether it aligns with other services is not a criterion. Is the criteria about going out to market to secure the outcomes we want?

There was a recurrent theme of discontent with the current service and service provider, although differing levels of strength of feeling. This may be seen as where there was a conflict between the need to objectively develop a proposal against the feelings of frustration from personal experience.

CHIEF NURSE - But how will you decide what is the best way to achieve the model. That is what we should be asking.

CEO – How are we going to judge it?

AD COMMISSIONING – Past performance?

PERIPATETIC GP – Below the belt!

CHIEF NURSE – Why is that below the belt?

PERIPATETIC GP – Because that would mean we have to get rid of our incumbent.

PROJECT DIRECTOR – That is one of the things we should look at.

ELLERTON GP – What is the big deal if you do?

CEO – It probably needs to be more objective than that.

PROJECT DIRECTOR – Remember we have to score it.

CEO – What the Trust will say is the service that they deliver is largely the same one as they inherited.

CHIEF NURSE – 3 years down the line!?

CEO – It takes at least 6 months to consult with staff.

CHIEF NURSE – What about the other 2 and a half years then!

ELLERTON GP – Surely that is not acceptable.

CHIEF NURSE – Our response may be that we want them to focus on acute care and not bother with community services.

CEO – Not having the Trust as a provider is not a reason to choose a procurement route.

PROJECT DIRECTOR – We have to be able to score that against each route.

> CHIEF NURSE – But if you have a current failing provider who are failing at many levels.
>
> CEO – There are other services such as A&E that are failing to deliver and we aren't planning to put all of them out to tender.

There appeared, therefore, a strong voice, of a group of attendees, supporting the move to open market tender, including discussion as to the legal requirements: "I don't know why we don't just say we are tendering because of the legal obligations?" (CHIEF NURSE). This appeared to be borne out of the frustration experienced from the current community services, the ELLERTON GP, commenting, "The only way to hold them to account is to scrap everything and start from scratch". This had two main elements. Firstly, the GP experience of poor integration between primary care and community services, combined with an increasing feeling of dislocation. Secondly, the experience of CCG officers trying to redesign services: where engagement from the community services provider had been perceived as very difficult ("We have an improvement trajectory for A&E and it is going backwards", AD COMMISSIONING). In this meeting the views of the ELLERTON GP, the CHIEF NURSE and the AD COMMISSIONING (officers previously involved in difficult redesign) were very strongly in favour of creating a new, different service, possibly through the tender route. The PROJECT DIRECTOR and PROJECT MANAGER as the project leads were trying to keep a balanced position, but the PROJECT DIRECTOR in particular had run successful procurements in the past and was not averse to using market mechanisms. The PROJECT MANAGER was less senior and relatively new to the CCG, and consequently had a less strident voice. For the PERIPATETIC GP and CEO there were possibly different reasons for being more critical of tendering. The PERIPATETIC GP was the GB member most supportive of maintaining local services and saw the fact of the community and hospital services being provided by the same Trust as significant: he may have been concerned that affecting one may undermine the other. Thus, the PERIPATETIC GP stated a preference for continued working, "I think we need to go back to saying where we all are in terms of do we think we should give the Trust another chance or are we floating voters? Do the Trust get another go?". For the CEO, there was one big concern, that like PERIPATETIC GP, the introduction of new providers into the community may further disintegrate services and weaken the overall healthcare system. This also recognised the political impact on relations with the main acute provider, "it is a difficult position to hold to say, 'we want to get a new provider because we don't like the current one'" (CEO). A smaller concern was that of the risks of tendering itself and the uncertainty of outcome from an open market process ("if you bring in new providers, they may be able to make more radical changes, but it will bring risks on instability" (CEO). The latter felt to be a bigger risk to CEO in their role as the Accountable Officer (AO) position in the CCG where they are accountable to NHS England (NHSE) and the Department of Health (DoH) for decisions taken by the CCG. Thus, if the tender process collapsed or a successful bidder subsequently withdrew from provision, the responsibility for problem solving would rest with CEO. Although the whole officer team would be involved in problem

solving, it may have been a bigger risk for the CO (CEO), and possibly also for CFO (although not present in this meeting) due to the financial risks contained in tendering. The strategic risk of disintegration and negative relationships with the current community providers (one also the locality's main acute hospital provider) were significant, but more manageable. CEO later reflected that in this session he and PERIPATETIC GP had a more positive view of the incumbent provider as a healthcare partner than the others in the meeting.

The latter part of the meeting saw the emergence of the differing treatments of risk through the process. The risk averse approach (representative of the latterly coded risk theme) is shown as, "In terms of the 2 options we need to be clear that they bring with them a set of opportunities and a set of risks. Broadly the areas of opportunities are also the areas of risk. So, in terms of workforce the least risk approach is to do as little as possible" (CEO, Meeting 1). Exemplification of the alternative treatment of risk was, "The biggest risk is to do nothing" (CHIEF NURSE, Meeting 1). The risk assessments also demonstrated a different interpretation of the workforce risks associated with change[29].

> CHIEF NURSE – The biggest risk is to do nothing.
> CEO –That seems like it now, but after a major change it may look different.
> CHIEF NURSE – Yes but we are already seeing lots of staff leaving community services and going to work for GP practices.
> PERIPATETIC GP – We are not losing staff from the heath community.
> PROJECT MANAGER – I am less concerned people don't want to change. The staff engagement exercise showed the staff did want things to change.

The degree of polarisation across the meeting may be seen to present a challenge to the concept of clinically led commissioning. Facilitating clinical commissioning involves creating an environment where clinical leaders can shape healthcare policy: but ideally a *safe* environment. Making space for clinicians requires providing opportunities and capacity to make the necessary decisions: ultimately allowing clinicians to decide on policy according to their objectives for improving healthcare delivery. The safety requires ensuring that this space excludes opportunities that take the CCG and its leaders into dangerous places: potentially steering a decision-making process away from areas that may breach statutory guidance, allow bodies to mount a legal challenge the CCG, or take financial decisions that will undermine the corporate sustainability. This decision involved forces driving simultaneously in opposite directions. Thus, the frustration with both current service delivery and the sense of inertia when attempting to improve it, suggested a drive towards tender and more radical changes. But the more radical the changes, the greater the risks; and, thus, the more the safety of the organization could be threatened. The discussion appeared balanced and may have avoided groupthink (Janis 1982). Others in the meeting appeared to consider CEO as generally more supportive of the current provider. There was an obvious struggle between CEO and PERIPATETIC GP wanting to achieve balance across options and the desire, particularly from the CHIEF NURSE-AD

COMMISSIONING-ELLERTON GP group, to move more quickly to affect service change. The following dialogue is an example of the struggle is shown in the meeting:

> CEO – It would be wrong to make the decision based… on 'Well last year we tried to redesign the services and it was a real pain in the arse and we don't want to do that again'.
>
> CHIEF NURSE – But every pathway we have tried to redesign
>
> PERIPATETIC GP – This is a lot bigger than the pathways we have done before. I am glad I had my 1:1 with the Trust Director Finance last week… We both know what we want to deliver, but we need to see how we get there from where we are now. When we realise we may not be getting where we want to be, then we tender. We have not tried this with this service.
>
> ELLERTON GP – Not with this service but with many others. We have tried that, and it didn't work.
>
> AD COMMISSIONING – We have an improvement trajectory for A&E, and it is going backwards.
>
> CEO – But we need to measure the options against the criteria. It may be some of us have complete faith in the YFT management.
>
> PERIPATETIC GP – Now I didn't say that!

The last statement produced laughter throughout the room, implying that although the PERIPATETIC GP and the CEO had some confidence in the FT, the confidence had limits!

Meeting 2

Attendees: CLINICAL CHAIR, ELLERTON GP, PERIPATETIC GP, NORTONDALE GP (meeting Chair), CHIEF NURSE, AUDIT CHAIR, CFO, CEO, PROJECT DIRECTOR, PROJECT MANAGER, DEPUTY CFO, AD COMMISSIONING (12 people)

This discussion was held as part of a formal CCG committee meeting, its Business Committee, in late June 2015. There were 12 participants involved making 474 contributions with 10,725 words. The biggest contributor making 26.8% of intervention; one participant making no verbal contribution. The meeting was introduced by a management presentation summarising a circulated supporting paper. The presentation and paper were developed after Meeting 1 and reflected some of the debate that occurred in the first session.

The general 'feel' of this meeting to the observer was different to that of the first one. It was a much bigger group; was outside of the CCG headquarters in a large community hall in the CCG's main population centre; it had followed a prior meeting with a full agenda; and it was more obviously structured and run according to a project plan. Consequently, a level of intimacy and therefore, humour were less evident. The

room size and layout made it difficult, at times, for members of the meeting to hear all that was said. (Furthermore, such meetings can encourage smaller sub-conversations and whispered comments.) The NORTONDALE GP chaired the meeting as the regular chair of this committee.

The use of business cases and presentation software in such situations may be worth reflection. On screen slide-share presentations, particularly using software such as Microsoft PowerPoint (PwP), have become increasingly common through in modern management. Despite comments regarding 'death by PowerPoint' it is still a very commonly used tool. The differences between Meeting 1 and Meeting 2 show possible reasons for its increasing use. On this occasion (Meeting 2) the initial period of the session was shaped and dominated by the PROJECT DIRECTOR (supported by PROJECT MANAGER). There was no explicit requirement for others not to comment or for clarifying questions to be avoided. However, the ability to hold the meeting's attention for the first 10-15 minutes, without alternate contributions of any length, created an environment where the subject matter for the subsequent discussion was largely formed. At one level this is merely developing the theme of the meeting and providing the requested information for participants to discuss. At another, however, this may be in accordance with Lukes' (2005) 3 dimensions of power: creating and managing agendas for decision. Furthermore, if participants are only able to hold a limited amount of information at any one time, then an early play to fill the information capacity may restrict certain other information or issues being discussed, at least as a priority.[30] Therefore, devices such as slide-share presentations and business cases may allow enforcement of particular frames: possibly at the expense of other, competing frames. In this case, there were elements of the presentation and supporting papers that were close to the 'go to tender' position; more so than the contrary view. One example was the risk associated with legal challenge if the services were not put to the market, expressed during the presentation as "If there are other suppliers how aggressive will they be and how likely will they challenge and what is the level of risk from challenge" (PROJECT DIRECTOR Meeting 2). This was a risk that the CEO suggested was relatively small ("I think it is a risk to challenge. But the regulations on integration are sufficiently ambiguous that you may interpret it as not a breach" (CEO)): but the presented material indicated this could be a major corporate risk. This may be less important if the meeting participants considered all information equal. If, however, the information produced in meeting papers and presentations has higher status, this may enforce certain viewpoints, and strengthen the coalitions linked to such views. The assertions regarding the risk of challenge due to anti-competitive behaviour were challenged in the meeting, but the anchoring of the discussion (as for Tversky 1974) was with the stated position regarding legal challenge.

> PROJECT DIRECTOR – if you don't put it out to the market and a provider thinks that we have acted in an anti-competitive way they can challenge that they have not had the opportunity to bid for a contract… Now what we are doing is commissioning a different model and awarding a new contract. A provider

may see it as a Contract opportunity… You may decide you want to take the Risk.

PERIPATETIC GP – Hang-on! That is huge! If we were in Nottingham 3 years ago and we involved in the Dermatology tender, that decision would have a bigger impact on us than any of the things you have spent 10 minutes scaring us about.

PROJECT DIRECTOR – No I am not trying to scare you and it is not down to me to decide.

A further complexity, as demonstrated here, may be that information was presented but in a form that was difficult to understand. On this occasion some of the presentation slides were difficult to see ("I knew I should have used different colours" PROJECT MANAGER, Meeting 2). This may have been inconsequential: or have hidden potentially important information that was alluded to but not in a form where it could be appropriately critiqued.

The discussion on the presentation content was intended to inform the production of the business case that would be provided to a CCG business committee. The discussion then shaped the options that constituted the emerging option appraisal. The scope of services in the developing case was outlined and their relationship to current healthcare providers. The presentation covered the genesis of the programme of work and the development of the conceptual model in the wider CCG strategy. The main principles of the desired model for community services were described by the PROJECT DIRECTOR as:

- Providing easy access to primary care;
- GPs at the centre of coordinating out of Hospital care;
- Greater focus on prevention of ill-health;
- An understanding of planned care pathways to ensure out of hospital care is delivered effectively;
- Alternative out of hospital care settings will be developed with services outside of hospital developed to provide Patients with the right care;
- Rapid access to Urgent Care;
- Health and Social Care providers working together with active management of Long-Term Conditions and the care of the Frail Elderly;
- Patients having a named coordinator; and
- GPs rapidly accessing specialist skills for patients closer to home.

The points included referenced both the CCG strategy and engagement with patients and stakeholders ("these were some of things that came out of the engagement process as being important to people about the service should look like" PROJECT DIRECTOR). The model was summarised in an overview graphic displayed in the on-screen slide-pack. The presentation stressed that the clinical model underpinning the proposal was part of the established CCG strategy and was, to some degree, promulgated as an agreed 'given': "The model is built on the vision of community

services that is within the CCG strategic plan. It is vision that is already supported by the CCG" (PROJECT DIRECTOR, Meeting 2). Although this was described as an already established model, discussion did, nevertheless, ensue as to the content of the model and some of its assumptions. However, this was moved on by a clear view from PROJECT DIRECTOR as to the need for the decision: "The key thing today is the options appraisal to decide how we procure the service going forward. So, we need to focus on the procurement options." (PROJECT DIRECTOR, Meeting 2).

The presentation then proposed three options for how to achieve the model service:

- Option 1 – Work with the current range of providers to change services to reflect the aspirations of the model.
- Option 2 – Re-procure all the services within scope through an open market competitive tender process
- Option 3 – Re-procure some service elements through competitive tendering and work with existing providers for those not tendered.

After the description of options, debate ensued as whether the main issue at that stage of the process was that of a discussion of which option, or rather whether to continue with the current service or not: "I think there is some confusion here. The fundamental question here is do we want to continue with the current service or change it." (CLINICAL CHAIR). This point was debated, and the consensus seemed to be that as the model had been previously developed and agreed the question was how to secure delivery of the model. The CEO suggested the options needed an "option 0": that of the status quo with minimal change.

The discussion on dissatisfaction with the current service quickly shifted to whether or not the service change would be delivered by the competitive tender route:

> CLINICAL CHAIR - Because the decision about whether we continue with the current provider determines whether you go out to tender.
>
> AD COMMISSIONING – We have already…
>
> PROJECT DIRECTOR – The decision has been made that the design of community services needs to change and that is contained within the CCG strategic plan.
>
> CLINICAL CHAIR – In which case option 1 of working with the current provider is to deliver the new model.
>
> CEO – I think that is right but personally, particularly when the business case goes into the public domain, I think it probably should have an Option 0 that documents the continuation of the status quo.
>
> PROJECT DIRECTOR – Yes for the business case but for the exercise today we are discussing do we tender or not tender. These are the 3 things we need to consider.

Such exchanges suggested some participants (here AD COMMISSIONING) had, perhaps, already assumed the likely outcome would be to tender and probably to find a new provider (or at least significantly change the nature of the relationship with the existing provider). Late in the meeting a seemingly resigned comment on a similar theme, “that is the worry for me is that most people are fed up with the Trust and that will influence the decision” (PERIPATETIC GP).

The meeting then moved on to consider how options would be evaluated against which criteria, and wider contextual issues such as legal issues and NHS regulatory frameworks. There were four criteria identified in the presentation:

- Value for money
- Patient satisfaction
- Service delivery (model of care/integration)
- Demonstrable outcomes

Interestingly this discussion of evaluation criteria quickly shifted to one of considering legal challenge on the grounds of non-competition. In this meeting explicit reference was made to legal advice, “This is the advice we have received from the legal team” (PROJECT DIRECTOR, Meeting 2) but no actual evidence of this advice was ever presented at any of the meetings (or, as far as can be ascertained, circulated to Governing Body members). Reference was also made to the then provider regulatory body, Monitor, who were seen as a potential arbitrator in a dispute, but the role and authority of Monitor in the process was not clarified. This may be seen as a means of asserting one of Mintzberg’s (1983) power systems: that of expertise. In this case expertise was referenced but not demonstrated. Whether the lack of evidence undermined the statement or left an extant oblique reference to legal expertise is questionable.

The debate returned to how to evaluate an option appraisal, peppered with comments regarding the dissatisfaction with the current services, and how a tender process may be managed. Thus, with limited discussion as to the clinical model (a general sense that there was agreement to the need for change and some agreement to the clinical mode) the debate shifted to how to secure the model and the advantages and disadvantages of the procurement option. The meeting on several occasions agreed it needed to confirm the evaluation criteria but seem to struggle to actually focus on this task:

> NORTONDALE GP – We are still at the stage of sorting out the criteria.
>
> PROJECT DIRECTOR – We have to sort the criteria and then go through each option.
>
> CEO – Can I just be clear in terms of what we are proposing in terms of Evaluation. There are 4 criteria, they are there and what are to some degree risks on the following slide.
>
> PROJECT DIRECTOR – We need to ask the questions as we go through it.

CEO – Are you suggesting we evaluate against the 4 criteria and those on the Following slide? So, is it 8 criteria or the four plus the following slide points as a criteria of risk?

PROJECT DIRECTOR – It is however you want to do it?

NORTONDALE GP – Do we need to put something down about quality?

PERIPATETIC GP – I will use a new word: Value. Quality is last year's word.

AUDIT CHAIR – These 4 seem very important the later ones seem part of how you achieve them

AD COMMISSIONING – Can we not look at each option against those as criteria and then assess the risk?

Discussion went on to the potential impact of staff currently involved in the service (who may transfer to other providers under the TUPE conventions). This varied from a sense that staff were as dissatisfied as local GPs ("staff and leaving with the current provider and it is already falling apart" AD COMMISSIONING) to a view that despite the service model staff wanted stability ("They want to be paid by the same people and receive the same pension" PERIPATETIC GP). The impact on staff was disputed with no obvious consensus in the meeting, including whether it was necessarily even a significant issue, "The average man in the street won't know or care who employs District Nurses" (CLINICAL CHAIR). As in Meeting 1 there was some time spent on the opinions of the current service provider.

Risk also emerged as a concept in the discussion, although this was mainly around the risk of service "destabilisation" and "disintegration", with consideration as to the impact on current NHS relationships:

CLINICAL CHAIR – One of the main risks for me is the relationship with our current provider.

PROJECT DIRECTOR – It may affect the levels of negotiation.

CHIEF NURSE – You could argue it will strengthen our relationship with our current provider. Because at least they will know we are prepared to go to the market, whilst at the moment they don't.

CEO – I do think it will negatively affect our relationship. I do think it potentially undermines the wider strategic programme.

The financial risk, when mentioned, was mentioned in terms of resources lost to community services than any potential increase to CCG financial pressures, "Or there is a £1m coming out of community services and filling the black hole from secondary care" (PERIPATETIC GP, M2). Risk was also identified in terms of the impact on Notlam Community Hospital if the services were tendered and the Trust, who ran the Hospital, lost the contract, potentially providing a financial deficit to one or other part of the local NHS.

The financial discussion moved on to the subject of Value for Money (VFM), previously identified as one of the evaluation criteria. This involved a debate on how VFM was assessed by the value of services delivered, or by a market mechanism that showed the respective value and efficiency provided by different providers in the market. The CLINICAL CHAIR commenting, “Are you likely to get VFM by working with the current provider to develop the service or are you going to get VFM through going to the market”. This financial discussion raised the lack of information available on the current services, including both activity data and more detailed financial information. The CFO commenting, “We have a model of care at the moment that we don’t want but if we move to a new model of care with the same provider Even if we say it is the same amount of money, how will we know we are getting value. If we can’t value it at the moment, how will we know the amount we have picked to pay if we haven’t assessed against some other test” (CFO, Meeting 2).

Throughout the meeting the issue of how to procure the service, with frequent references to “tender” or “tendering”. According to the coding scheme, there were 89 references to the procurement code (a sub-code of the corporate behaviour code), greater than any of the other meetings and 40% of references across the four meetings. This focus on whether to use the tender route or not was a large part of the session and much of the discussion appeared to present a binary choice between all tender and not, with organizational coalitions emerging in the meeting.

The meeting ended with an agreement to produce a business case for the forthcoming CCG business committee.

Meeting 3

Attendees: CLINICAL CHAIR, GP VICE CHAIR, ELLERTON GP, PERIPATETIC GP, NORTONDALE GP (meeting Chair), HOSPITAL DCOTOR, CHIEF NURSE, PRACICE MANAGER, AUDIT CHAIR, CFO, CEO, PROJECT DIRECTOR, PROJECT MANAGER, DEPUTY CFO, AD COMMISSIONING (14 people plus one other officer not centrally involved in the process).

The meeting was the Business Committee occurring before the subject’s appearance at the decision-making Governing Body. The session was held in early July in advance of the subsequent Governing Body in late July 2015. This session had 16 participants with a range of contributions of 91 to 1, spanning a word contribution range of 23.3% to 0.3%. Again, there was a presentation and supporting paper.

This meeting was the final significant decision-making meeting of the process before the finally planned formal decision at the Governing Body and various times people seemed to discuss whether this was the time to make the decision. The chair (NORTONDALE GP) had to remind participants that the eventual ‘final’ decision would be taken by the Governing Body later in July. That said, it was clear this discussion would be important in shaping the eventual outcome and by this stage positions would be taken that may not change too much before the Governing Body meeting itself.

The meeting discussed the circulated business case (titled ‘Business Case for Out of Hospital Care’ dated June 30, 2015), presented to the forum by the PROJECT DIRECTOR. The document had evidently appeared as a late paper and NORTONDALE GP commented, “I’m afraid we haven’t seen this document beforehand”, suggesting at least some members would have benefited from more time to consider the content. The information was presented, however, as largely known to the audience: “Some of you may have seen a lot of the information before” (PROJECT DIRECTOR). The PROJECT DIRECTOR’s introduction referenced engagement with groups of stakeholders, including the CCG’s wider GP community and some of the community staff themselves. The PROJECT DIRECTOR also confirmed the likely value of the services under consideration as “more than £9.8 million”, which was then clarified as £9.8 million plus a further £1.7 million from a smaller provider, giving a total value approaching £12 million. The combination of different contract values appeared to provide a level of complexity: the discussion as to the financial values showing that at this stage of the process some of the underpinning information relating to the project was still uncertain to the decision-makers.

As in the previous meetings there was a discussion as to the status of the clinical model. This was accepted as ‘agreed’ to a point:

> NORTONDALE GP – In terms of this afternoon we are not thrashing out the model.
>
> PROJECT DIRECTOR – No we are not.
>
> NORTONDALE GP – We have got a high-level agreement of what the model is.
>
> PROJECT DIRECTOR – The detail will come in the next phase of developing the specification.
>
> NORTONDALE GP – You make me nervous every time you say the model is agreed.
>
> PROJECT DIRECTOR – The model that is in here is the same as that in the CCG strategy. It depends on the future progress as to how we shape the model.

The presented document summarised:

- The background to the case and its context for the CCG
- The services under consideration and the financial values
- The developed clinical model for how community would work
- The case for change to the new model
- Information on stakeholder engagement and stakeholder feedback
- The options presented for how to get to the new model
- The option appraisal
- Recommendations and next steps
- Equality impact assessment of the changes

Although the document covered all of the above the main point of discussion in the meeting was on the option appraisal to achieve the model service. The services included in the scope of the business case were: community District Nursing and Therapy services; community equipment and wheelchair services; intermediate care; and Podiatry. Community paediatrics included in the overall services listed at Meeting 2 had now been excluded from the scope.

The options presented were:

a) Recommission the current service/leave as the status quo;
b) Managed change[31] process with the current NHS provider without tender for all services;
c) Competitive open market procurement for all services;
d) Combination of b) and c) where some services would be tendered, and others taken through a non-competitive managed change.

The business case provided an initial assessment of the options and evaluated them against four criteria:

- Value for money – how options would achieve the best price for service;
- Patient experience – how patient experience would be improved;
- Service delivery – how the service improvements could actually be delivered;
- Demonstrable outcomes – how options would ensure delivery of improved patient clinical outcomes.

The options were then further assessed against the risks they presented to the CCG. These were the three risks of:

- Strategic risk – how the delivery option may impact on the wider healthcare commissioning and work of the CCG;
- Reputational risk – how a decision may affect the status of the CCG in its health community
- Financial risk – what level of financial uncertainty an option provided to the CCG.

The intention being firstly, to evaluate options against their ability to deliver desired care model against the identified criteria. Secondly, to assess the options against their assessed risk.

The option scoring and scoring methodology was recorded as follows:

Table 14 - First business case scoring methodology

Score	Rating	Description
0	Not adequate	*Does not meet requirement*
1	Adequate	*Would meet minimum requirements*
2	Good	*Meets most of CCG strategic vision to enable transform of health care provision*
3	Excellent	*Meets all strategic vision to enable transform of health care provision*

Table 15 - First business case option scoring

Option	Value for Money	Patient Experience	Service Delivery	Demonstrable Outcomes	**Total**
a)	**0**	**0.5**	**0**	**0**	**0.5**
b)	**0.5**	**2.0**	**1.5**	**2.0**	**7**
c)	**2.5**	**2.5**	**2.5**	**2.0**	**9.5**
d)	**1.5**	**2.0**	**2.0**	**2.0**	**7.5**

This made option c), for all services to be tendered, as the preferred option. The case stated that there wasn't a differential assessment of the financial impact of each option as, "care will be based on redirecting resources that are currently committed to the existing community services contract to provide funding for the provision of the new model" (1st Business Case, p.13). Thus, the financial assessment was not of the ability of an option to provide a direct financial benefit (that is lower cost) but rather assessment of the financial risks of each option: that is an option's assessed likelihood of providing financial uncertainty and potential financial deterioration.

In the document presented to the committee the scoring table of options was included in the main body of the business case: however, the risk assessments were only documented in the supporting appendices (although all appendices were circulated as attached to the document that went to the committee). The risk assessment approach followed that consistently used in the NHS at the time with a combined assessment of *likelihood* (scored 1-5 with 1 unlikely to 5 almost certain) and *impact* (scored 1-5 with 1 minimal impact to 5 very significant), with both scores multiplied together to provide a final risk score in each risk domain. The scores are summarised below.

Table 16 - First business case options scoring

Option	Strategic risk	Reputational Risk	Financial risk	**Total**
a)	**16**	**15**	**12**	**43**
b)	**12**	**12**	**12**	**36**
c)	**14**	**12**	**12**	**38**
d)	**9**	**12**	**14**	**35**

The risk scoring was queried in the meeting as different approaches were used for different options and there may have been inconsistency in the risk assessments: "the approach of the team… is that you identify the risks that apply to each option. Personally, I would apply the same risks to all options" (CEO, Meeting 3). The meeting did not describe a need to produce alternative options and the assumption appeared to be some variant of the options provided would be presented to the eventual decision-making Governing Body meeting.

The meeting did identify problems with finding supporting information to analyse the services under consideration, as stated by the Project Director, "We don't have a great deal of information on the services and these are essentially contract value lines" (PROJECT DIRECTOR, Meeting 3). The following exchange was illustrative of the issue:

> PROJECT DIRECTOR – It is probably worth saying we are working to get some more activity information and some more detail, so we can do a proper analysis.
> NORTONDALE GP – Is there not a duty for them to provide the information?
> DEPUTY CFO – We are not sure what information is supposed to be provided within the community MDS [Minimum Data Set].
> CHIEF NURSE – It has been delayed.
> PROJECT DIRECTOR – There was some national work on community services benchmarking. At the moment we haven't seen anything from that.

In this meeting and the previous two, the decision actors appeared to accept the quality of information available and did not articulate a desire to gain more information in support of a decision. This may reflect a belief that further information was either unavailable or wouldn't add clarity.

The discussion on options quickly resulted in the meeting discounting option a), as this was not even seen as a 'serious' option:

> NORTONDALE GP (Meeting chair) – You [to PERIPATETIC GP] are not seriously saying that we should keep the same service are you.
>
> PERIPATETIC GP – No.

NORTONDALE GP – So we can discount that option.

There followed a detailed discussion of how the other options were assessed and scored. NORTONDALE GP, the chair of the meeting, after discussion of the case and at the point the meeting assessed the outcome of the initial score stated “Surprise, surprise the outcome is…”, which may be seen as a slightly ironic comment as to the strong likelihood that the highest scoring option may have been a strong favourite to be the highest score from the outset. This was supported by another comment, “It is obvious that the tender option will score higher” (PERIPATETIC GP). At this point in the meeting there is recorded general chatter on whether the scoring calculations had been produced and whether they were correct. This highlights what may be a common feature of such scores in business cases: that they are taken quite seriously and as semi-scientific means of evaluating options. This approach occurs within a scoring system that is to some degree artificial, internally generated by the process itself, and subjectively scored by the authors of the paper. The presentation of a score for options may have a significant influence on the eventual decision outcome through the anchoring heuristic (Tversky 1974). Thus, subsequent scores and numerical assessment may be influenced by the size of the initial score. Alternatively, the score may be seen as a means to rationalise a decision in hindsight and thus is not a true appraisal tool, but a means of justification. Thus, the NORTONDALE GP commented, “Have we got, or not got, to the answer we wanted so we are trying to change the score?”. Although this comment as challenged, it may represent that some decision-makers interpret the process to be primarily one of justification for a preference.

If meeting 2 had the largest focus of the four sessions on corporate process (particularly the *procurement* code and the focus on tendering), this meeting was the dominant session discussing subjects of risk. Across the coding categories of capacity, clinical, financial, and political risk the coding analysis recorded 290 references. Certain attendees appeared more concerned with risk and this tended to be a small group (see the coalition descriptions below). The meeting may have been the most obvious point of the juxtaposition of the improvement and risk themes, summed up in a comment from the CCG Clinical Chair:

> The bottom line for me, is there a benefit from tendering the whole lot worth the higher risk, and if not, it isn’t worth tendering it all. You take the more moderate option of the hybrid option, which is potentially lower risk. That is the fundamental question for me. It is basically how pissed off you are with the current service. (CLINICAL CHAIR, Meeting 3)

The document described three risk assessment criteria (strategic, reputational, and financial) but in the meeting the issue of risk was presented with a slightly different emphasis, thus:

> The key considerations when completing the risk assessments were as follows:
>
> - Is the commissioner breaching any regulations?
> - Are there other providers who can deliver the service?

- How likely is it there will be a procurement challenge?
- What is the likely outcome of any challenge?
- What is the impact on the current healthcare system? (PROJECT DIRECTOR)

Thus, in the meeting the documented strategic and financial risks were possibly reduced in scale in favour of the reputational and wider legal-regulatory risks. But again, there was disagreement as to how to evaluate certain risks, such as the strategic risk of destabilising partners and any consequent financial risk to the CCG:

> PERIPATETIC GP - The strategic risk for me has to be higher.
>
> CLINICAL CHAIR – Higher than what?
>
> PERIPATETIC GP – Than working with the current provider if it destabilizes them.
>
> DEPUTY CFO – If you think it is a £10 million contract it…[interrupted]
>
> NORTONDALE GP – We had a discussion last week and didn't it come out that they are providing it at a loss.
>
> PROJECT MANAGER – The soft intelligence says they are.
>
> CHIEF NURSE –They say they are so presumably this would strengthen their financial position if they lost the service.
>
> PERIPATETIC GP – I doubt they would look at the £10 million in that way.
>
> DEPUTY CFO – That does make the risk higher.
>
> CHIEF NURSE – To the Trust?
>
> DEPUTY CFO – No to us.
>
> CHIEF NURSE – How does that make it higher to us.
>
> DEPUTY CFO – Because if it isn't an affordable service it will cost us more if we tender it.
>
> CHIEF NURSE – But do you believe that?
>
> DEPUTY CFO – I have not seen any evidence.
>
> PROJECT DIRECTOR – That is the problem.

This again showed that a lack of data in in relation to the services in question made finding a common objective assessment of risks difficult. It appeared that those who were least supportive of the current provider (the Trust) and most enthusiastic regarding tender (CHIEF NURSE, PROJECT DIRECTOR, PROJECT MANAGER) tended to downplay the risks. Conversely, those who appeared more concerned regarding the risks (here the PERIPATETIC GP and DEPUTY CFO) may have been more sympathetic to the current provider both in terms of their current performance and the destabilising effect of a tender. (DEPUTY CFO did not demonstrate any

particular support for the Trust but was mainly ill at ease with creating any further financial risk through the uncertainty of a tender process.)

The issue of reputational risk was mainly framed in terms of the CCG and its wider GP community, who had consistently voiced their dissatisfaction with community services. Thus, "If we continue with the current service it is a big reputational risk with our current practices" (NORTONDALE GP, Meeting 3). There thus appeared a counter-position between the 'strategic risk' of destabilizing the wider health economy and main provider and the 'reputational risk' of possible alienation of the CCG's local constituent GPs.

After the lengthy discussion the meeting recorded the voting status of all participants who would have a vote in the eventual Governing Body meeting (as opposed to a vote of the total participants in the meeting). The vote was recorded as:

Table 17 - Voting summary on option appraisal at meeting 3

Governing Body (voting) member	Option
NORTONDALE GP	C
ELLERTON GP	C
AUDIT CHAIR	C
GP VICE CHAIR	C
PRACICE MANAGER	C
HOSPITAL DCOTOR	C
CHIEF NURSE	C
PERIPATETIC GP	D
CFO	D
CEO	D
CLINICAL CHAIR	D
LAY PATIENT REP	*Not present*
NOTLAM GP	*Not Present*

Voting summary – Option C - 7 votes; Option D - 4 votes

The business case and supporting presentation were more developed by the time of this meeting and thus the discussion may be seen as reflecting a more mature stage in the process. It was by now reasonably clear where some of the Governing Body members were positioning themselves. The risks attendant in the options were now being more clearly articulated and there was a sense of the process moving forward to completion. It was not evident any significantly new information appeared prior to this meeting or indeed subsequent to it as part of preparation for the actual Governing Body. Consequently, this meeting may be seen as the main opportunity for formal discussion of options in detail between the main decision-makers.

The meeting was generally good-humoured but did feel more intense and the approaching point of actual decision was more evident, the vote at the end of the meeting demonstrating the need for the group to assess the likely decision outcome.

Meeting 4

Attendees: CLINICAL CHAIR (meeting Chair), GP VICE CHAIR, NOTLAM GP, NORTONDALE GP, CHIEF NURSE, PRACICE MANAGER, LAY PATIENT REP, AUDIT CHAIR, CFO, CEO, PROJECT DIRECTOR (11 people).

The session was the formal CCG Governing Body, held in public and had 11 participants (10 of the Governing Body members plus the Project Director). Participants made 92 verbal contributions totalling 6,720 words. The meeting had a business case as a formal document to approve or reject as part of the decision-making process.

This meeting was the Governing Body meeting of the CCG where the subject for decision would be discussed and an initial decision made. As this meeting was a statutory governing body meeting (at corporate board level) it followed a much more formal approach than any of the previous meetings. The meeting was held in the council chamber at the Nortondale Council Offices. Although meetings 2 and 3 had structured agenda, papers, and were carefully planned, their happening away from public gaze allowed a free exchange of opinions and ideas that was lacking in this forum. Similarly, humour that was heavily evident in the discourse of meeting 1, and subtly present in meetings 2 and 3, was largely absent in this case. The PROJECT DIRECTOR, as the lead for the discussion, spoke for a significant proportion of the meeting, with CHIEF NURSE and CEO making major contributions. Other Governing Body members made contributions, but more as points requiring clarification than main statements in themselves. The CLINICAL CHAIR was very clearly the chair of this forum, the chair-person role possibly occupying a more formal position due to the very formality of the meeting.

The Governing Body considered the paper presented by the PROJECT DIRECTOR, the final business case for commissioning of community services for the CCG ('Out of Hospital Care Final Business Case'). This case reflected some of the discussions occurring in meeting 3 and may have been influenced by wider discussions with decision-makers in the intervening three weeks. As with the business case at meeting 3, the one to this forum included the same content structure (see above) and provided a list of options for consideration and decision. The revised options presented were (verbatim reproduction from 'Out of Hospital case Final Business Case'):

a) **Do Nothing:** This option is non-competitive. The service would remain with the current provider and the specification would be unchanged.
b) **Managed Change Programme:** This option is non-competitive. Each LOT would be re- specified in line with the agreed model and delivered through a managed change programme.

c) **Competitive Tender:** Each LOT would be re-specified and delivered via a formal competitive process
d) **Combination of Options B and C.** LOTS 1, 3 and 6 would be re-specified and delivered through a managed change programme. LOTS 2, 4, and 5 would be re-specified and delivered

Reference to the option list as described in meeting 3 above shows that the significant change for options b) to d) is the introduction of specific 'Lots' to the options. Thus, the six different parts of the community services that had been identified were then constructed into biddable groups ('Lots') that could be commissioned individually or collectively. This appeared to be an admission from the previous discussion that an all or nothing approach to a procurement option may not achieve group consensus, or a required majority: whereas breaking the sections of the services into definable groups allowed some specific issues, such as Nortondale locality concerns, to be addressed. The option considered in meeting 3, of competitive tender for all the services as one whole was no longer presented as an option. Thus, the case detailed: "Following consultation with the CCG clinical and managerial team, the out of hospital care programme has been divided into six separate LOTs" (Out of Hospital business case). There was no further explanation given for removing the 'option c' as presented in the business case to the previous business committee (Meeting 3). This may demonstrate the influence of the discussions at Meeting 3, the presumed assumptions and subsequent conversations regarding Nortondale, and the 2nd dimension power of the officer group to form agendas with specific options presented, and others excluded. Thus, the business case presented at Meeting 4 documented types of service included and excluded within the project scope:

Inclusions

1. Community Services
2. Intermediate Care
3. Community Equipment and Wheelchair Services
4. Podiatry

Exclusions

5. Paediatric community services/child development centre

(Out of Hospital Final Business Case Draft June 30, 2015)

"Community Services" here related to a range of service including District Nursing and Community Therapies. Intermediate Care was primarily facility (bed-based) based rehabilitation in some form of unit. By the Governing Body meeting the business case had been amended from the 5 service areas to six:

- Lot 1 is the community model for Nortondale. What this model includes is District Nursing, Fast Response, Community Therapies, and intermediate care, including any facility-based service.
- Lot 2 is the community services for Ellerton. That includes the same elements of the service as Lot 1 [but for Ellerton].
- Lot 3 is specialist children's services

- Lot 4 - Podiatry.
- Lot 5 – equipment and wheelchair services; and
- Lot 6 - Is defined as the specialist community services which is defined as predominantly community-based specialist nursing, specialist therapies and community geriatricians. (PROJECT DIRECTOR presenting from the 'Out of Hospital business case July 22, 2015').

Most obviously the groupings had been changed by splitting the 'community services' element into its two geographical parts: one the urban centre of Ellerton; the other the rural area of Nortondale. Although this appeared to emerge as a compromise and to placate the Nortondale GPs who were un-enthusiastic about tendering, this split was less than clear to all participants:

> NORTONDALE GP - Can I ask you about Lot 1? Are the Stillington practice in Lot 1. Historically they have received community nursing services form 3 different sources. Is that Lot defined by the practice area, or where the patients are registered, or by geographical area?
>
> PROJECT DIRECTOR – Again this is one of the things that will be defined by the ongoing work. We have had some initial discussions about the Lots and this is the interim proposal. But again, the work needs to be done on the specific populations within the Lots.
>
> NORTONDALE GP – This has been a problem for this practice, and it would be nice to get that sorted at this stage.
>
> PROJECT DIRECTOR – But you can't tie District Nurses to specific practices, as you can't really do that. It is nice and fine in somewhere like Notlam but in other areas it is more complicated.

Although this may reflect the inevitable problem of trying to draw specific boundaries around geographically diverse rural areas, it may also reflect a desire to achieve political compromise between decision-makers in the CCG, above a need to make coherent service configurations. One element that may have influenced the split between Nortondale and Ellerton may have been the intermediate care bed base at Notlam Hospital (in Nortondale), the inclusion of which within an open market tender may have been controversial. Thus, one point of clarification being, "So anything that is currently defined as Notlam Hospital within the current community services contract would be within that Lot [1]" (CEO). (As a small community hospital, it was considered vulnerable to closure in the recent past, the local community had a high level of anxiety regarding any service changes. The one of the Nortondale GP practices (that of NOTLAM GP) also received payment for providing medical support to the intermediate care unit.)

The evaluation criteria used in the option appraisal remained the same (VFM, patient experience, service delivery, and demonstrable outcomes). The risk assessment methodology, however, was modified following feedback at the previous meeting and now assessed risk in terms of:

- Does the option undermine the cohesive working and agreement within the local health and social care community to work in partnership?
- Does the option deliver the CCG strategic plan?
- Is the option affordable?
- Will there be a perception that the CCG is not fulfilling its commissioning responsibilities by Council? of GP Members; NHS England; Public; Partners?

The scoring method was a simple 0-3 for each criterion, with no weighting for individual criteria. Risk scoring was averaged across the risk dimensions with an assessment of whether the risk options were low, medium, or high.

Table 18 - Final business case option scoring

Option	Value for Money	Patient Experience	Service Delivery	Demonstrable Outcomes	**Total**
a)	**0**	**1.5**	**0**	**0**	**1.5**
b)	**0.5**	**2.0**	**1.5**	**2.0**	**6**
c)	**2.5**	**2.5**	**2.5**	**2.0**	**9.5**
d)	**1.5**	**2.0**	**2.0**	**2.0**	**7.5**

With the following risk assessment score for each option

Table 19 - Final business case option risk scoring

Option	Risk Score (Average)	Risk Description
a)	**12**	**High**
b)	**11**	**Medium**
c)	**13**	**High**
d)	**11**	**Medium**

There was no explanation in the case or in the meeting presentation from the PROJECT DIRECTOR as to the reasoning for the distinction between the 'high' and 'medium' risk scores, although the numerical differences as shown above, were small.

The business case recommended the Governing Body support Option d). This having a lower option score than Option c) but balanced by a considered lower risk profile: "The associated risk is lower than Option C and in addition the key benefits from the initial assessment still apply" (Out of Hospital Care Final Business Case, p.13). The perceived benefits of the preferred option were described as:

- Can test value for money for key elements of the service
- Provides opportunity for innovation/service developments
- Provides opportunities to bring new ideas to local health community
- Supports strategic drive for sustainable services in Ellerton by increasing capacity and range of providers.
- Provides a higher certainty that the Provider will deliver the specification
- Ensures the CCG is meeting requirements and offering contract opportunities, therefore reduces the risk of legal challenge
- Supports partnership working by including a managed changed element to the programme (Out of Hospital Care Final Business Case, p.13)

Following the PROJECT DIRECTOR's presentation of the business case the Governing Body examined the case and asked a number of questions. This started with a conversation between the PROJECT DIRECTOR and the CHIEF NURSE (as questioner). This explored element of the service specification and then the discussion moved quickly onto the subject of risk. The LAY PATIENT REP, member with responsibility for patient engagement stressed the need for whatever the outcome was, that engagement with the CCG's stakeholders and wider community was one of the necessary next steps. The CFO added comments regarding risk, that one of the risks not scored in the case was that of the resource cost of pursuing a procurement. This was not mentioned and thus not quantified in the case and to the CFO appeared potentially significant: "even if we are using existing staff and existing resources does that need another, say £150,000 of resources, they can't be doing anything else when they are doing it" (CFO, Meeting 4). This was dismissed relatively quickly by the GP VICE CHAIR, and the AUDIT CHAIR with little consideration to actual cost: "To be honest if you followed the logic of that argument you wouldn't do any of it at all" (AUDIT CHAIR Meeting 4).

The next part of the discussion focussed on the decision to procure or not the specific items of Lots 1 and 2. Consensus seemed to have been reached relatively quickly on the benefit of procurement for Lots 4 and 5 (Podiatry, and Wheelchair and Equipment services respectively) and managed change (not procurement for Lot 3, specialist children's community services). There was little debate about the management of Lot 6 (specialist community nursing services) and this appeared to be accepted as being managed according to the proposal of Option D (that is, managed change). Following debate regarding whether to adopt the business case recommendation, to support Option D as the preferred option, the meeting considered the recommendation and final decision. CEO suggested a modification to Option D, with a period of managed change to try and develop services without procurement for the Ellerton area for a period of 12 months, which if unsuccessful would then trigger a formal open procurement. The lack of consensus from the Governing Body members on the decision resulted in the need for a recorded vote. The CCG Governing Body did not routinely take votes on all matters: the meeting chair (CLINICAL CHAIR) stating, "I usually try to achieve consensus if possible". CEO commented later that he may have

not suggested the vote if he had realised the likely balance of votes (that is 9 to 1). The CLINICAL CHAIR closed the meeting with, “I think that is very fair and it is useful to have that debate in public and it makes it very clear we have made an active decision, and this is not something that has got in under the radar”. Retrospectively at interview the chair commented:

> Perhaps I could have Chaired it a bit better but you know I think that we work in such a way and we make decisions in such a way that I am very comfortable with those decisions because I think people are given the chance to give their opinion and we give enough time and space to allow everybody’s opinion to be heard and to influence the decision that is made. (CLINICAL CHAIR interview))

The vote was recorded as:

Table 20 - Final business case voting Meeting 4

Governing Body (voting) member	Option D in business case
CLINICAL CHAIR	Yes
GP VICE CHAIR	Yes
NOTLAM GP	Yes
NORTONDALE GP	Yes
CHIEF NURSE	Yes
PRACICE MANAGER	Yes
LAY PATIENT REP	Yes
AUDIT CHAIR	Yes
CFO	Yes
CEO	No (proposed modified Option D)
ELLERTON GP	*Not present*
PERIPATETIC GP	*Not Present*
HOSPITAL DCOTOR	*Not present*

9 voted in favour of the proposal, one voted against, there were no abstentions and 3 Governing Body members were not present. (The PROJECT DIRECTOR was present in the meeting and presented the business case but was not a voting member of the Governing Body.)

Comparison of the four management meetings

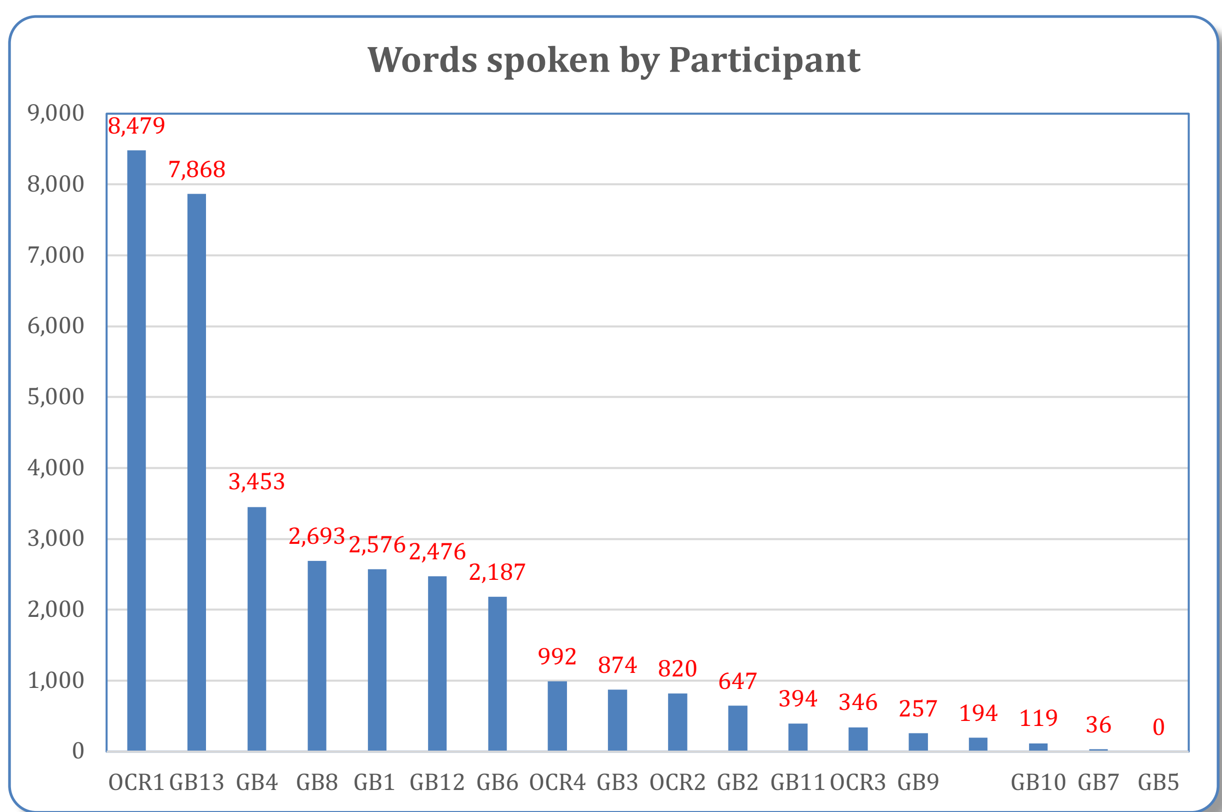
The analysis of the participant contributions demonstrated the variable engagement of the participants across the meetings in the case study. This tests the inference of “Substantial variation in participation” (Cohen 1972, p.3) amongst those involved in organizational decision-making. Thus, the 18 participants in the process had a range of presence in the meetings: 3 participants (CHIEF NURSE, CEO, PROJECT DIRECTOR) attended all 4 meetings; 9 attended 3 sessions (CLINICAL CHAIR, ELLERTON GP, PERIPATETIC GP, NORTONDALE GP, AUDIT CHAIR, CFO,

PROJECT MANAGER, DEPUTY CFO, AD COMMISSIONING); 2 attended 2 meetings (GP VICE CHAIR, PRACICE MANAGER); and 3 only attended 1 session (NOTLAM GP, HOSPITAL DCOTOR, LAY PATIENT REP). One participant (AD PRIMARY CARE) although playing an important role in the decision-making process and had a senior role in supporting the Governing Body, didn't participate in any of the sessions. More than merely the presence in meetings, analysis of the verbal contributions in the sessions showed a wide variation of input. Analysis of the contributions was influenced by the earlier work of Bezemer (2014). Furthermore, the findings explore not merely the presence participation (that is whether decision-makers were actually in the meetings) but their active participation: whether they were actively contributing to the decision-making debate. Thus, some individuals had much greater oral interventions. A summary of verbal interventions by total words is provided below:

Table 21 - Summary of verbal contributions of meeting participants

Participant	Words	Contributions	% Words	% Contributions	Meetings attended
PROJECT DIRECTOR	8,479	235	24.6%	17.6%	4
CEO	7,868	230	22.9%	17.2%	4
PERIPATETIC GP	3,453	154	10.0%	11.5%	3
CHIEF NURSE	2,693	146	7.8%	10.9%	4
CLINICAL CHAIR	2,576	112	7.5%	8.4%	3
CFO	2,476	67	7.2%	5.0%	3
NORTONDALE GP	2,187	134	6.4%	10.0%	3
AD COMMISSIONING	992	68	2.9%	5.1%	3
ELLERTON GP	874	52	2.5%	3.9%	3
PROJECT MANAGER	820	58	2.4%	4.3%	3
GP VICE CHAIR	647	23	1.9%	1.7%	2
AUDIT CHAIR	394	11	1.1%	0.8%	3
DEPUTY CFO	346	19	1.0%	1.4%	3
PRACICE MANAGER	257	11	0.7%	0.8%	2
GP VICE CHAIR	194	13	0.6%	1.0%	1
LAY PATIENT REP	119	2	0.3%	0.1%	1
HOSPITAL DCOTOR	36	1	0.1%	0.1%	1
NOTLAM GP[32]	0	0	0.0%	0.0%	1
Total	**34,411**	**1,336**	**100.0%**	**100.0%**	

Figure 21 - Graph of words spoken by participants in management meetings



This demonstrates the range of interventions across the group and the preponderance of certain individuals in the process. What could not be determined merely by the numerical word contribution was whether the most vocal participants were proportionately the most influential on the eventual outcome. What may be inferred is that:

- The role of the chair in meetings may be important (shown by Bezemer 2014) in managing the meeting dynamics but it may be less important in influencing the decision outcome.
- A project director or manager (PROJECT DIRECTOR in this case) may assume a very prominent position in a process and shape how decision meetings unfold.
- A senior executive (in this case the CEO) may provide an apparently disproportionate input compared to peers; although less disproportionately related to the level of accountability and responsibility.
- Senior executives and officers may hold significant influence on shaping meeting agendas and deciding what is discussed, and thus what is decided. This corresponds to Lukes (2005) three dimensions of power. This may be seen as sitting more heavily with the PROJECT DIRECTOR and the CEO than others in the process.
- Cohen's (1972) "substantial variation" is seen in the extremes of meeting participation where two Governing Body members (NOTLAM GP and LAY

PATIENT REP) were present and voted in the eventual decision-making meeting but were not present at any of the preceding discussions.

Within the concept of negotiated order, the findings allow consideration of whether certain participants have greater influence on the creation of organizational coalitions or on the establishment of certain cognitive frames.

Development of the option appraisal

A thread running through the meetings was the option appraisal to establish the preferred solution to achieve the service improvement. This evolved over the course of the case and can be seen as part of the way in which a consensus was achieved. Thus, options evolved as:

- Meeting 1 – Verbally described options but not detailed in a management paper. Following discussion on whether the options were on the types of clinical service model; or the options to achieve the implementation of a service model. The initial options considered included differing types of procurement.
- Meeting 2 – Emergence of three options: work with the existing providers; tender all services; tender some services (specifically podiatry and community equipment). No preferred option was stated in the presentation to the meeting.
- Meeting 3 – The addition of a 'do nothing' option making a distinction between the managed change option of working with existing providers and just keeping the same service as currently. The other options remained the same. (Although Option D described a combination of tendering and managed change, it did not specify which services would fall into each category.) Option C, all services to open tender, was recommended as the preferred option.
- Meeting 4 – The explicit emergence of 'Lots' to separate out the service elements into six groups. The four options were largely the same as in Meeting 3, other than Option D (the combined approach) now had clarity as to which services would be tendered and which not. In the final case Option D, had now become the preferred option, being both recommended in the business case and approved by the meeting.

Although Meeting 1 listed five options the later debate in the session distilled this down to a seemingly binary choice between open market tender' and 'work with the current provider' ("So at this stage we are just looking at 2 options?", PROJECT DIRECTOR Meeting1). This binary choice changed in the appraisal journey, with a move away from tendering all services into a combined approach and within that the separation of the Nortondale services as a separate Lot. At the end of Meeting 3, the CHIEF NURSE referred to the potential voting choice of NOTLAM GP, in that they "would almost certainly vote for D". Thus, by Meeting 3, the decision split across the Governing Body was 7-4 in favour of Option C as against Option D (Options A and B were discounted from the appraisal by the voting stage). The latter comments in Meeting 3 focussed on defining more clearly Option D. Thus, meeting chair NORTONDALE GP asked, "Do we need to define what [Option] D is? I think we do need for a group of us to meet and

define what D is, as we can't really score D until we know what is in it". This implied that with definition either D may become the preferred option or that the group may establish a clearer consensus on Option C (recognising that 2 of the Governing Body members were not present for the meeting). Even before the end of the meeting members were suggesting how the eventual Lot approach may be shaped: "The lots last year defined Notlam and Nortondale as a separate package, and that may make a lot of sense" (CHIEF NURSE, Meeting 3). This may have been in response to the overall higher risk assessment of Option C in the business case, and a last-minute further risk element described relating to the community hospital: "there is a huge reputational risk in putting out a tender that includes Notlam Hospital. I am not trying to scare people but there is a big risk" (CEO, Meeting 3).

By the stage of Meeting 4, Option D included much greater clarity as to the service split and became the overwhelming choice of the meeting. (CEO opposing with a suggested amendment to Option D, rather than the choice of a different option.) The option appraisals had their genesis in the previous work in the CCG on its general and community strategy, and in the case itself in the discussion at Meeting 1. At none of meetings 2,3, or 4 did any participants propose alternative options. It is unclear from the meeting and interview transcripts whether this reflected the fact of the options being considered as the only viable ones, or whether the meetings assumed there were no other options if a business case included a range of options.

By the point of the decision to use partial market procurement the CCG appeared to have delayed a decision on to the form of the procurement. In the Meeting 1 discussion the options discussed included choices between 'single open tender' and 'a process of competitive dialogue'. At the consideration of the final business case, types of tender were not specified and the vehicle to achieve tendering appeared to be left to a later decision point by the project board to be created as from one of the business case recommendations.

The ultimate business case appeared to represent not merely a rational iterative analysis and evaluation of the options and the supporting evidence: but as much a pragmatic need to accommodate internal and external stakeholders, so that the preferred option was one that allowed the establishment of a negotiated order in the CCG. The progress of the option appraisal and the pragmatic changes made by the participants were consistent with the concept and assumptions of the negotiated order.

Chapter 6 – Analysis and discussion of triangulated research findings

Introduction

This section analyses the findings from the collected research data: of the four observed decision-making meetings in the case study and the follow-up interviews with the case participants. The interview data findings are triangulated against the meeting data within a common coding system.

The detailed description of the meeting data and assessment against the developed analytical codes are contained in the preceding chapter. The findings were analysed within the developed conceptual framework and against the original research objectives of the project. The findings analysis formed the basis for the development of theory provided in the next chapter.

This section provides reconciliation of the research findings with the originally stated research objectives. The project research question was “What are the factors that influence strategic decisions in healthcare commissioning: a negotiated order perspective” and the intended research objectives within the context of a strategic decision-making process:

- How do the influencing factors on decision makers present themselves, how do interest groups become involved in the process and how do they exert influence?
- How does this influence manifest itself in relation to the CCG’s cultural and power dimensions (its negotiated order)?
- How may decision-making processes be improved to maximize utilization of resources consistent with the NHS and CCG strategies?

The last objective of improving decision-making processes will also be considered in the following and conclusions chapters.

This section provides:

- The context of wider NHS strategy at the time of the case study and the organizational strategy in place at the CCG.
- The appearance of the influencing factors in the research data and their analysis within the conceptual framework.
- The use of language and conceptual frames within the observed discourse of the case study.

National strategy - NHS England’s ‘Five Year Forward View’

The CCG strategy was developed before the arrival of a major strategic document in the year before the case study. In late 2014 NHS England (NHSE), the recently established national body directing the process of English healthcare commissioning, published this major strategic statement: the Five Year Forward View (5YFV). This

was a strategic planning document published prior to the start of the research. This document and its analysis in the case study shows the establishment of major themes developed by NHSE; referencing the 5YFV strategic themes to the CCG strategic objectives; and assessment of the role of the 5YFV in the CCG decision-making process. Here the major themes of the 5YFV are summarised below.

5 Year Forward View Strategic Themes

- The need for improvement in prevention and public health. This reflects an assessment of the relatively 'weak' implementation of the proposals from the Wanless (2002, 2007) reviews. Therefore, there is a need for 'hard-hitting' actions on reducing obesity, rates of smoking, and alcohol abuse.
- A greater use of patient control of services, particularly those requiring more intensive long-term packages of care, through mechanisms such as personal health budgets. This aimed to improve patient involvement in care planning (sometimes described as 'co-production') and was also hoped to reduce spend through patients and carers making more efficient decisions.
- A reduction in the barriers between care provision, such as the evident separation between care designated as 'health' and that as 'social'. In care areas such as that of continuing healthcare[33] discussion often centred not on the care itself but on the question of 'who pays' between the NHS and Local Authorities.
- Locally designed care delivery and a move away from the NHS as a 'one size fits all' system of care. Local health communities will be 'supported' in choosing the care delivery options suitable for their communities.
- The development of alternative models of care delivery for out of hospital care. The models are labelled as, 'Multispecialty Community Providers' (MCP) and 'Primary And Acute Care Systems' (PACS). The MCPs/PACS are seen as incorporating elements of GP services, social care, and mental health to support more care delivered in patients' own residences.
- Urgent care services (including GP out-of-hours care, Accident and Emergency, and ambulance services) should be delivered within greater integration between providers. The CCG in the case study had already gone down this road with the establishment of an integrated Urgent Care service immediately prior to the date of the study.
- A requirement for a 'new deal for primary care' (NHS England 2014, p.4) with greater investment in General Practice but accompanied by changes in how primary care is delivered. This was followed shortly afterwards with a separate 5 Year Forward View for General Practice.
- A continued need for significant efficiencies within the NHS to deal with the forecast growing demand. This is estimated as a need to close a funding gap projected to be £30 billion by the year 2020/21. 5YFV infers there will need to be a major contribution to closing the gap from NHS efficiencies, but also a likely need for additional funding from tax revenues.

An early feature of the health policy of the coalition government was a renewed focus on the benefits of competition and market mechanisms (see Department of Health 2010). This was a theme of the 2010 white paper, although arguably diluted by the time of the 2012 Act itself (Timmins 2012). The 5YFV in its 41 pages does not even use the word ‘competition’ once: suggesting a shift in emphasis. The shift may not reduce the need for NHS organizations to procure services through the appropriate market mechanisms and section 75 in the 2012 Health and Social Care Act enshrines a need to consider how services are procured and the opportunity for all relevant providers to access open market procurement where provided. It may be, however, that the 5YFV removes the issues of ‘privatisation’ and ‘competition’ from the centre of the policy debate. This may be seen as messages sent to the NHS commissioning architecture that competition is no longer a criterion against which success will be judged; at least not in isolation.

The 5YFV was published 8 months prior to a UK general election. Produced from a public service by intention seen as party-politically neutral it may be seen as, to some degree, an attempt to shape the likely health policy for any potential government and thus allow a degree of stability in the NHS. Consequently, there may be observed a conflicting sense of, on the one hand discussion on the need to transform the NHS and respond to the economic environment by service overhaul; and on the other a need to prescribe policy recommendations that are likely to be palatable to all of the major parties of the next government. Overall its direction and content does not appear to stray dramatically from previous strategy documents over the last two decades (see Strategic approaches to commissioning in Literature Review sub-section 2).

The organization strategy in the case study

The CCG had developed an organizational strategy as part of its requirement to gain authorisation as a statutory body in 2012. The strategy described a plan from 2012-16. This had been refreshed in the planning for subsequent financial years (including the 2015-16 year) but was largely unchanged in scope and direction. The CCG ‘strategy refresh’ did take account of the 5YFV and its main themes, but these were not considered sufficiently different from the original strategic direction to warrant a significant change in direction. As above, it may be argued the strategic priorities of the NHS nationally and locally had not changed markedly over the preceding decade.

The overarching mission statement of the CCG was to improve the health and wellbeing of its population and the three main dimensions of the strategy were (NHS Ellerton and Nortondale CCG Integrated Commissioning Strategy 2012-16):

i. Commissioning sustainable, high-quality services within the available resources (people, money, buildings).
ii. Delivered by a stronger community system, integrating care across the whole care economy.
iii. Securing improvement in priority areas of health need and reducing health inequalities.

The first objective included reference to managing within the CCG's financial resources. Two important historic elements were influential in this aspect: the previous Primary Care Trust's (PCT) troubled financial history and the financial difficulties of the District General Hospital (DGH) in Ellerton. In the former of these this resulted in the CCG starting its history with an inherited deficit. This was successfully re-paid in its first year of operation, but the spectre of financial difficulty remained. In the case of the DGH, this had been recently acquired by a large local Foundation Trust with an agreement from the Department of Health for a period of additional funding: but this was recognised to end in 2017 and possibly add further financial difficulties to the health community.[34] The third objective related to the generally poor health outcomes from the deprived urban communities in central Ellerton, as contrasting with the better health of the rural communities in wider Ellerton and Nortondale. The health challenge included a large population of the frail elderly, which placed a significant demand on community-based services (primary care, community therapy, district nursing, and social care). The second objective is the one driving the decision process in the case study and showed a strategic intention to move the focus of healthcare commissioning away from acute hospital care and to provide greater support to keep people, particularly the frail elderly, in their normal residences (own home of care home).

In terms of the Porter (1985) and Miles et al (1978) typologies it is difficult to neatly fit the CCG strategy into one category. CCG Objective i appears as both Reactor (addressing chronic financial pressures) and Defender (in seeking to preserve services in a fragile DGH). Here the focus may be on cost leadership as for Porter (1985) but there is no obvious Porter equivalent for the need to preserve effective clinical services in a public service. CCG Objective iii appears also as Reactor in one respect as it is a reaction to the health need assessment in the locality. Conversely, this may be seen as a legitimate attempt to use an assessment of the corporate environment to shape strategy and improve outcomes, consistent with Boyne and Walker's (2010) suggestion performance improvement is a higher priority for public services. Thus, this may be seen as largely Prospector, but in a Reactor strategic frame. CCG Objective ii may be that which is most consistent with the Prospector definition, but with an element of Defender in relation to preserving the primacy and capacity in primary care. Thus, this is a Prospector based Analyzer strategy. Overall the CCG strategy, as many in the public sector may be, is largely a Reactor strategy with Prospector influenced Analyzer tendencies. In the Mintzberg et al. (2009) typology the strategy appears most obviously to fit with the Planning and Design schools. (Assessing some of the emergent schools from the document alone would appear to be difficult, as assessment of strategy as practice in retrospect is probably required.)

Rumelt (2012) provides four signs of 'bad strategy': fancy words masquerading as strategic concepts ('fluff'); a failure to face the real corporate challenges; confusing goals and strategic objectives; and 'bad' objectives that are unrealistic or don't address major issues. The CCG strategy would appear to face the challenges of its community particularly the historically difficult finances and operational performance of its hospital sector. The objective of strengthening community-based care did appear as a realistic

means of addressing the weak hospital system and of improving care outcomes (if primarily for the frail elderly). There may be seen to be some confusing of goals and objectives, and indeed the overlapping of definitions may be problematic. For Rumelt (2012) strategic objectives should address a specific issue or direct a particular action. This may be seen to be true in objectives i and ii but for 'Securing improvement in priority areas of health need and reducing health inequalities' this may be seen as relatively vague, although the objective was underpinned by more specific actions around targeting smoking and obesity. NHS leaders may have become anaesthetised against an overdose of grand sounding words and jargon, thus there may be legitimate accusations of elements of 'fluff' in the strategy. An example may be the use of 'transformation'. This is used as a term for change and improvement (for example in the 5YFV), but it may be questioned whether much of the aspired 'transformation' is genuinely 'a marked change in form, nature, or appearance' but rather a series of incremental improvements.

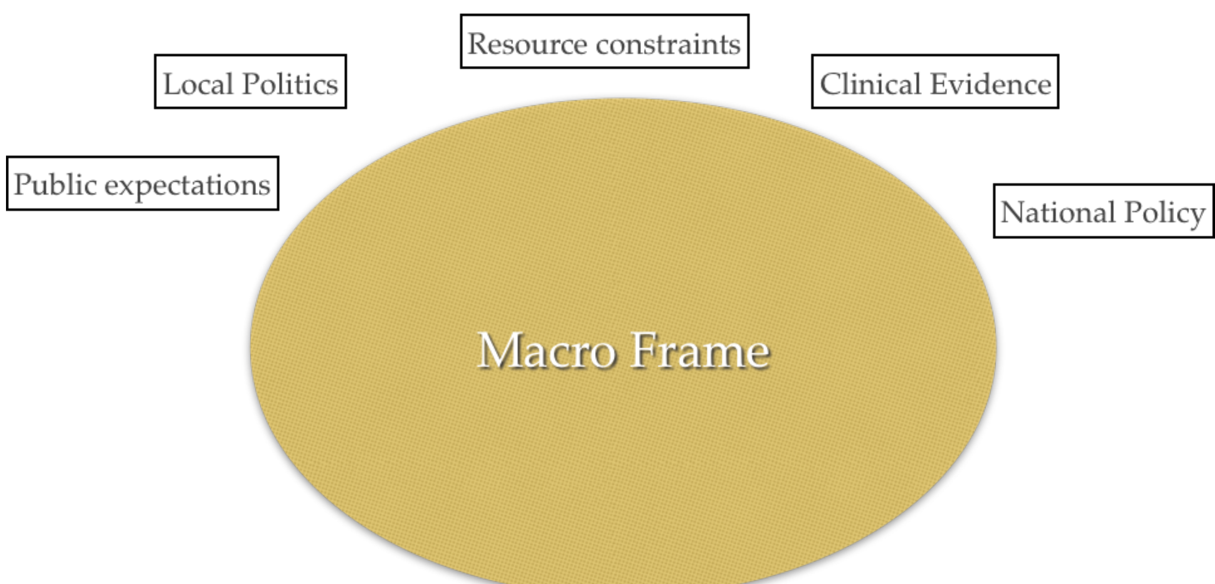
Strategic decision-making and the execution of strategy

In the review of concepts of strategy, consideration was given to the typology of Miles et al. (1978). This included the definition of some strategies being those of 'engineering problems': that of implementing what the organization wants to do. In this case study the issue of the case study was significant in terms of its financial size, its importance on patient care and service performance, and the political and partnership implications of how it would be managed. It was, however, less a decision about what direction the organization should take and more one of how the strategy should be implemented, specifically its second strategic objective: "a stronger community system, integrating care across the whole care economy" (CCG Integrated Commissioning Strategy 2012-2016). That it is a decision regarding strategy execution should not be seen as reducing its importance or its qualification as strategic. Bossidy (2002), as one example, suggests that the execution of strategy may be the biggest challenge to business organizations, more so than the development of strategies. Thus, "strategies most often fail because they aren't executed well" (Bossidy 2002, p.15).

The case study is, therefore, a study of a strategic decision regarding strategy execution and implementation. This may explain some of the balances described in the influences on the decision-making process and indeed some of the discussion of the participants. The decision was one of 'engineering' problem solving. Consequently, the engagement of wider stakeholders, such as patient and user groups, which may be expected to occur more evidently in the development of strategy was largely absent in the study. Similarly, as the discussion included that of whether to use open market procurement, detailed engagement with potential providers was shaped by the need to consider good procurement practice and commercial confidentiality.

Influencing factors: their manifestation and relation to the negotiated order

All of the influencing factors appeared within, and were inevitably shaped by, the wider strategic context of the decision. The influencing factors were in part linked to demographic and background profiles of the decision-makers and appeared at the three framing levels. The influences as developed in the conceptual framework are considered from the analysis of the research data, in particular the linguistic reference to concepts within the case study discourse.



The macro influences were those of the overall decision-making environment, and decision actors did reference the legal framework and the NHS regulatory environment. For example, NHS England and NHS Improvement (formerly Monitor) were discussed, "There is a risk that our assurers, such as NHSE see us as not doing our job" (AD Commissioning, Meeting 2)[35]. These factors appeared as shaping the general decision-making theatre but had only limited reference in the meetings or in the interview data. The regulatory environment was referred to almost as a pretext upon which to take an already preferred course of action: "I don't know why we don't just say we are tendering because of the legal obligations?" (Chief Nurse).

Evidence

There was little reference to published evidence, in part as the participants appeared to conclude there was limited published research that was useful, the CFO commenting, "I don't think really there was any hard evidence all the way through it" (CFO, interview). For the Governing Body clinicians this appeared problematic as,

“people like the GPs who like evidence, don’t they, before they will make a decision and I think they really struggled with the fact that you are basing it on ad hoc information” (AD Commissioning, interview). But also, that individual decision-maker bias had to be recognised: “I sometimes think people just don’t hear it if they have got a view then however good the evidence is for something else then they will find a way of just not hearing it and if there are enough of them of the same view” (Deputy CFO, interview). There also appeared for some participants a lack of clarity about what evidence may have been needed. Thus, an interview response was:

> Question – was there sense, from your perspective as a Lay Member, where you feel you would have benefited from more data or was the information in the business case sufficient really?
>
> Lay member Audit – I actually don’t know.

The individual evidence of experience was considered both important and also a necessary substitute where empirical information was lacking. Thus, the GP clinical chair commenting, “It’s not strictly evidence-based in what you term the scientific nature, but it is evidence-based because it’s based on your own experience” (Clinical Chair, interview). Furthermore, this experiential evidence was seen by some as the only clinical evidence that could be used: “I suppose in terms of that sort of lack of evidence you kind of then assume the worst. That they haven’t got any evidence to show us value for money therefore you have to assume there probably isn’t” (Project Manager, interview). Some GPs even suggesting that in some cases their personal experience may be more useful than published evidence:

> what we have now is true insight into what the theoretical models on paper are delivering in real life. So rather than sitting in a room and designing a model that looks perfect but on the ground isn’t delivering we now know which ones are delivering and not delivering… so there is I think a very positive outcome from having that ability but I also think that if we put in a strategic view I think it does form a bit of bias which might make the decision a bit skewed (Ellerton GP).

Or alternatively that the quality of the published evidence was low:

> I spent an enormous amount of time and energy trawling through the evidence base that exists around outcomes in community and primary care and there is an absolute dearth of it out there, there is nothing, there is a desert of information around that and in a truly objective way all the papers that I read were based on anecdote and were entirely subjective (Clinical Chair).

Whilst expert opinion is a recognised form of evidence in the hierarchy, it is accepted to be generally a lower quality of evidence (Evans 2003). Although Schwenk (1990) suggests expert decision-making may be effective when the context corresponds to the experts’ knowledge base, even this may be problematic. Einhorn’s (1974) study of pathologists describes variability of decision-making both between experts and within experts asked to repeat similar tasks. Whilst forensic analysis of pathology specimens may reasonably always have a degree of error, it may be necessary to recognise this

margin and consider that in strategic decision-making such margins of error may be as wide or wider. The margin of error, even for experts, may widen where decisions are subject to competing sources of data and influences, sometimes described as 'noise' (Kahneman 2016). Noise may be ever present in strategic decisions, as the differing levels of influence explored in this case study demonstrate.

Clinical 'experts' as a source of evidence in a decision-making process may be helpful in support of rational decisions. But the clinicians in this study were predominantly from one main clinical background (6 GPs and one GP practice manager in the 13 decision-makers, and 6 of the 8 clinicians being GPs). So just as the comments of Chan et al (2005) that the published medical evidence is a selective sub-set of potential evidence, so the clinical decision-makers in this study were a selective sub-set of all available clinical opinions. It may be argued that for 'clinical commissioning' to effectively use the available evidence in a balanced manner it may require clinical decision-makers to be drawn from a broad cross-section of the clinical community. As such CCGs may be seen to fail in providing a balanced source of clinical, expert opinion.

Although the use of evidence to support decision-making may be seen as beneficial (Kovner 2009) it may be overly optimistic to assume that the evidential assessment made from drug therapy Randomised Controlled Trials (for example) can apply in strategic decisions. Rather decision-makers will need to use subtle judgement to assess complex choices with competing influences, conforming to the description of being *decision under risk* (Kahneman and Tversky 1983). Furthermore, decision models may always be 'non-rational': or more appropriately boundedly rational (Simon 1997). That is, decision-making within an environment of: corporate performance management (satisficing); inadequate or incomplete information; decision-makers subject to heuristics and biases; and a decision process shaped by cognitive frames. Despite its boundedness, CCG/NHS (and wider public sector) decision-making may be more rational and effective if decisions are at least in part driven by a clear corporate strategy, as will be explored later.

National policy

National policy was referenced in relation to the overall CCG strategy in terms of supporting greater capacity in community care, but it did not appear to shape the actual decision. However, the main business case (Out of Hospital Business Case) did cite national policy documents, such as the 5YFV, as supporting references for the strategy and the recommendations in the case. National policy is more obviously evident in the wider CCG strategy, which was seen as driving the business case: "There is a model consistent with that in the CCG strategic Plan" (AD Commissioning, Meeting 1).

The improvement codes were primarily driven by active clinicians or those with recent experience (often negative) in trying to redesign clinical services. This appears consistent with the original intentions of the 2012 Health and Social Care Act: that is to make clinical leaders central to NHS decision-making. Thus, although the context suggests a focus on cost reduction, decision types will continue to also be driven by a

desire to improve the quality of patient services. The national drive for clinicians being empowered to shape commissioning decision-making appeared to be manifested in the case study.

Public expectations

Public expectations were not mentioned to any great degree and the word 'patient' appeared infrequently through the meetings (35 occasions) and interviews (10). The CCG had engaged in wider public consultation of the current service but had not done a specific consultation on the proposed model, possibly due to the uncertainty if a new provider suggested a very different delivery method of the model. Thus, one interviewee commented, "there wasn't really anything to engage on – because you would be going and saying would you like a service where lots of different people come at different times, a disconnected service, or would you actually like a seamless service where the same person comes" (AD Primary Care, interview). Similarly, there was little discussion as to local politics (as opposed to the organizational politics within the NHS and public services).

It is worth recording at this point that the CCG had undertaken wider consultation and discussion with patient groups in developing it model for community services and this engagement was referenced in the Out of Hospital Care Business Case. The Project Director commented, "we had also done some stakeholder analysis prior to going through those sorts of meetings so we could bring that to the table as well as this is what the patients are telling us" (Project Director, interview), reflecting the discussion was on the clinical model and not the route to delivery.

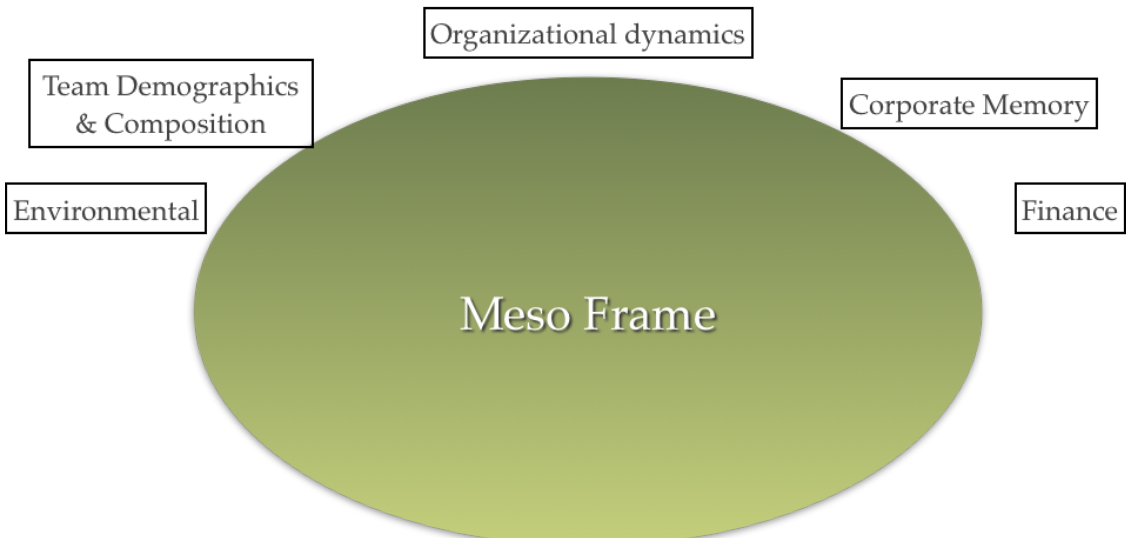
It may be argued that the decision under question was primarily a decision of strategic *implementation* and as such was not one that would be typically discussed with patients or the wider public.

Resource constraints of finance and workforce

Resource constraints, primarily financial were recognised as a limiting factor of decision scope, for example the limited ability of the CCG to invest further in the services in the case study. The proposed financial budget for the service in the business case was set at that of the existing service cost. This did reflect the inability of the CCG at this time to consider additional investment, whilst also rejecting the opportunity to try and find direct cost savings. Clinical decision-makers were clearly concerned the project should not be seen as a means to save money only: "Or there is a £1m coming out of community services and filling the black hole from secondary care" (Peripatetic GP, Meeting 2). This is consistent with the original spirit of the NHS reforms white paper (Department of Health 2010) in allowing local clinical leaders to prioritise decision-making. It may, however, be seen as an impediment to financial control in an age of austerity, if clinicians are unwilling to risk service reduction in search of cost savings.

The type of strategic decision may be referenced to the earlier assessment of the CCG strategy as balanced between Reactor and Prospector (within the Miles et al. (1978) typology). Thus, the clinical driver for improvement tended this decision towards a Prospector/improvement direction, which although reactive to some extent did not focus on cost reduction. This may have been more likely as the CCG was not in financial difficulty at the time of the study. (Latterly the CCG did post a deficit in the following financial year and speculation may arise whether the same approach would be taken in a deficit environment, or with the benefit of hindsight public services should always focus on cost reduction, even during financially stable periods.) However, the decision subject and the general discussion in the process appeared consistent with the CCG's strategic objective regarding stronger, more integrated community services. Furthermore, the references to staffing instability and concerns regarding maintaining workforce levels ("But the staff are leaving" Chief Nurse, Meeting 1) may have provided a general influence that the workforce constraints, at least in the short-term may be more significant than those of finance.

Influences on the meso frame



Meso influences were more obviously apparent in the data, although the influences described in the original conceptual framework tended to merge into each other as seen in the data.

Environmental and corporate memory

Both the environmental and corporate memory influences may be seen to include recent examples from the case study locality and neighbouring areas of similar decisions. Two referenced in the data were recent open market procurements, both

with, at the time of the study, less than successful outcomes. These influences appeared to have a polarising effect on the decision-makers. Thus, one quoted,

> it has made the people who are already quite sceptical about procurement more sceptical, but I think it's made some of the people on the Governing Body more entrenched in saying you learn from that …I think that strengthened the view amongst people in the Governing Body that we should be going out to tender. (Chief Nurse, interview)

Conversely, the more risk averse CFO stated, "having been through a big procurement and having seen some of the things that had happened with procurements elsewhere I was coming along with the fact that procure if we must rather than is it the right thing" (CFO, interview). Thus, Dennett's "crashing obviousness" ((Dennett 1992, p.80) was not seen in the varied interpretations of the previous CCG procurement. Without this common assessment, there appeared no sense of an agreed 'objective' conclusion to the learning from the experience. As this was a recent and major event, its importance was high and its consequent polarizing effect significant.

The environmental influences included that provided through the CCG's stakeholder community and manifested itself as *reputational* and *political risk,* also associated wit*h* the stakeholder code. This provided a degree of polarization across the decision-makers. Some saw the major risk as the NHS political risk of alienating a major partner (the FT running the current service): "if you bring in new providers, they may be able to make more radical changes, but it will bring risks on instability" (CEO, Meeting 1). Others the impact of the CCG's reputation with its constituent GP practices, "If we continue with the current service it is a big reputational risk with our current practices" (Nortondale GP, Meeting 3).

Finance

The research context was during a period of public sector austerity. This may have suggested that strategic decisions would have a strong financial element: that of cost reduction or productivity increase. This was not evident as a significant direct driver in the project, although by no means absent. The desire to improve community services would likely increase productivity and efficiency, but there was no clear financial efficiency quantification expressed in documents, meeting discussion, or interviews.

In an age of austerity, finance would be an expected influence factor. In the case study, finance appeared most visibly as a risk factor, particularly in terms of moving to open-market procurement. Using procurement was not seen as a likely opportunity for cost reduction, despite other public services using tendering to that end. This risk aversion may have been stimulated by existing financial pressures promoting a desire to avoid further deterioration. This having primacy over opportunities to improve finances. Thus, finance would be seen as risk avoiding within the spectrum of Prospect Theory (Tversky and Kahneman 1981), suggesting the financial influence and the *Risk* concept was to make decisions that did not make the finances any worse. (Although

the cases study occurred within a period of public sector financial tightening, it was also in a year where the CCG under scrutiny achieved its financial targets.)

Organizational dynamics

The organizational environment and the external organizational dynamics included the consideration of the impact on local politics within the health community. One of the discovered risk codes was the political risk of impact on other, particularly NHS, organizations: both risks to the partner body and risks to the quality of the CCG's relationships. Thus, in Meeting 2 there was discussion of 'destabilisation' and 'disintegration':

> Clinical Chair – One of the main risks for me is the relationship with our current provider.
>
> Project Director – It may affect the levels of negotiation.
>
> Chief Nurse – You could argue it will strengthen our relationship with our current provider. Because at least they will know we are prepared to go to the market, whilst at the moment they don't.
>
> CEO – I do think it will negatively affect our relationship. I do think it potentially undermines the wider strategic programme.

The debate reflected the level of discontent expressed by a number of decision-makers regarding the existing service provider. This appeared to be a major factor in driving the improvement theme and was demonstrated most obviously by the Ellerton GPs and who were part of the Group 1 coalition (see below). The CCG Clinical Chair stating:

> part of me was saying well just learn by people's historical behaviour and relationships that you currently have with the acute Trust and say to yourself is that likely to give you a successful outcome or as successful an outcome as going out to tender. (Clinical Chair, interview).

Later in the interview the chair was even stronger on the relationship with the FT:

> That was the one killer blow was the way that the Trust behaviour had actually destroyed some of those relationships and the perception from certainly the GPs and from other practice staff I talked to as well. As I didn't just talk to my colleagues I talked to other practice staff as well and the perception was that they had actually messed it up and what was a good service had become a less good service, despite what they were purporting to be ways of improving the service and I think that's what annoyed people really (Clinical Chair, interview).

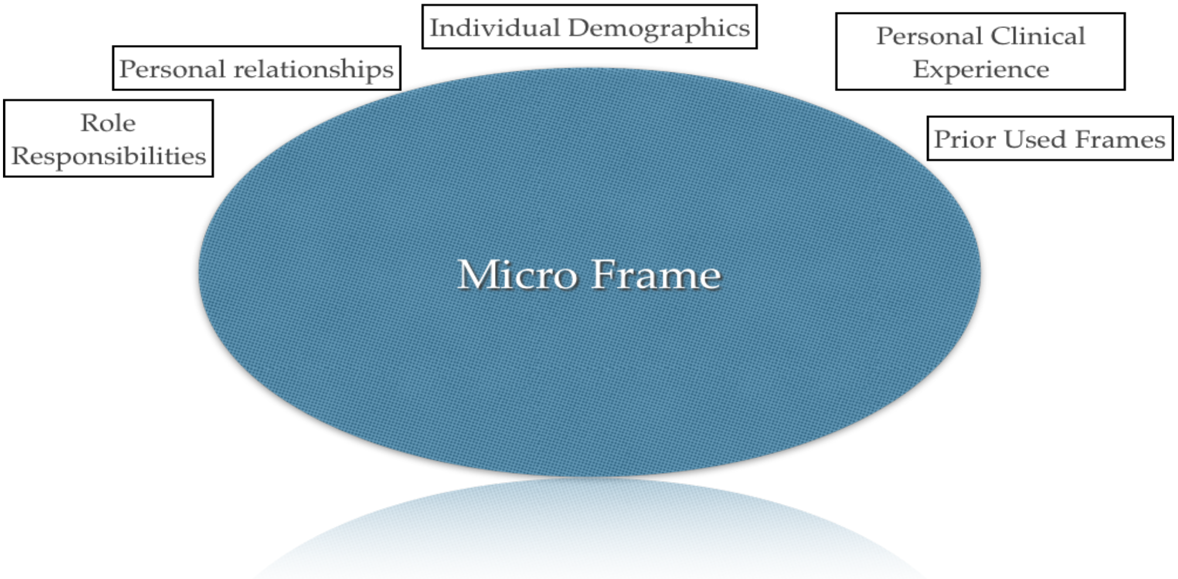
Similarly, the Chief Nurse commented, "just put aside any relationships that were already there and get rid of some of the baggage" (Chief Nurse, interview). From another perspective, "It's impossible to ignore what people say isn't it and at the Council of Clinical Representatives people have kind of rubbished the community services" (Assistant Director of Commissioning, Interview).

The balancing discussion, as seen by the CEO in the exchange above, was less in terms of defending the existing service, and more in terms of needing to maintain a reasonable working relationship with the Foundation Trust, who would still be a partner in the health care system. The debate on organizational dynamics became more of a discussion as to the decision-makers opinions of the current provider of the service under scrutiny, as seen above, than an objective assessment of the future provision.

As with the risk concept throughout, there appeared a relatively polarised discussion as to the relative risks presented and the scale of risk the CCG should accept. The evident polarisation is considered as a factor in the process of creating the negotiated order.

Cultural and power dimensions in the negotiated order

The influences identified in the micro framing level can be considered with the assessment of how culture and power were demonstrated.



The demonstration of the negotiated order

The negotiated order concept appeared to manifest itself in relation to the decision-making team composition and the internal organizational dynamics, and indeed all of the influences originally identified in the micro frame. Thus, the clinical members of the CCG Governing Body tended towards being mostly 'pro-tender' and driven most heavily by the *Improvement* theme. The meeting dynamics may have suggested a

greater unity of thought in terms of the need to improve. Furthermore, the *Improvement* theme included emotional drivers, such as the *frustration* code. Thus, in Meeting 1 the frustration elements emerged in the following exchange:

> Chief Nurse – The biggest risk is to do nothing.
> CEO –That seems like it now, but after a major change it may look different.
> Chief Nurse – Yes but we are already seeing lots of staff leaving community services and going to work for GP practices.
> Peripatetic GP – We are not losing staff from the heath community.
> Project Manager – I am less concerned people don't want to change. The staff engagement exercise showed the staff did want things to change.

The frustration was in part a desire to improve current services, but also appeared to stem from previous attempts to change service delivery with the current service provider. For example one stating: "I think we have been here before with [the FT] and they are not going to change if we don't push the button on that" (Chief Nurse, Meeting 3); and a GP referencing the difficulty in achieving management support, "the issue is the blockage in the systems that are put in place by the management" (Ellerton GP, Meeting 1). A further exchange in Meeting 1 referencing other services run by the FT:

> Peripatetic GP - When we realise we may not be getting where we want to be, then we tender. We have not tried this with this service.
>
> Ellerton GP – Not with this service but with many others. We have tried that, and it didn't work.
>
> AD Commissioning – We have an improvement trajectory for A&E and it is going backwards.

This appeared possibly to generate an informal coalition from the combination of active intervention (the *Improvement* theme) and emotional recognition of shared difficulties (such as the *Frustration* code). There was, nevertheless, a general consensus that the services in question needed to be improved, as confirmed by the CCG Chair, "The fundamental question here is do we want to continue with the current service or change it" (Clinical Chair, Meeting 2).

The senior non-clinical officers were more cautious regarding open market procurement, in particular focussing on various forms of risk. Conversely, the junior CCG officers who had struggled to achieve service change with the existing providers, also showed the same frustration theme. Thus, the decision-makers who were most obviously nervous about tender, may be seen as those with the highest level of formal accountability and responsibilities: particularly the Chief Executive Officer (CEO) and Chief Finance Officer (CFO). For them risks were possibly more tangible. Contrary to the pro-tender coalition, it may have been more difficult to generate a coalition and fellow-feeling for the Risk themes, as these were largely defensive (trying to stop things getting worse) and also based on rational assessment (such as political risks) rather than an appeal to more emotional drivers. Such polarisation may be seen to present a

challenge to the concept of clinically led commissioning. Facilitating clinical commissioning may be seen to involve creating an environment where clinical leaders can shape healthcare policy: but ideally a *safe* environment. Making space for clinicians requires providing opportunities and capacity to make the necessary decisions: ultimately allowing clinicians to decide on policy according to their objectives for improving healthcare delivery. The safety requires ensuring that this space excludes opportunities that take the CCG and its leaders into dangerous places: potentially steering a decision-making process away from areas that may breach statutory guidance, allow bodies to mount a legal challenge the CCG, or take financial decisions that will undermine the corporate sustainability. This decision involved forces driving simultaneously in opposite directions. One example debate shows differing approaches to risk in the second meeting:

> Clinical Chair – One of the main risks for me is the relationship with our current provider.
>
> Project Director – It may affect the levels of negotiation.
>
> Chief Nurse – You could argue it will strengthen our relationship with our current provider. Because at least they will know we are prepared to go to the market, whilst at the moment they don't.
>
> CEO – I do think it will negatively affect our relationship. I do think it potentially undermines the wider strategic programme.

The CCG Chair perhaps summarized the differing approaches to risk in Meeting 3 showing the juxtaposition between the improvement and risk themes:

> The bottom line for me, is there a benefit from tendering the whole lot worth the higher risk, and if not, it isn't worth tendering it all. You take the more moderate option of the hybrid option, which is potentially lower risk. That is the fundamental question for me. It is basically how pissed off you are with the current service. (Clinical Chair, Meeting 3)

Interview participants recognised the different status of services within a sub-locality of the CCG, the Nortondale area (Nortondale identified as a coding theme above but having a significant impact on the process). This was recognised in part due to the quality of services being considered of better quality, and in part from the desire for the Nortondale GPs not to want (or need) the same level of change as the rest of the CCG locality. Interviewees made explicit references to the area, often implying that the Nortondale GP group needed to be accommodated in a pragmatic solution. This extended to a GP prioritising the preservation of the services received by their own practice to what may have been a better overall outcome for the CCG. Thus, is responding to a question regarding the appropriateness of using different lots in the tender process they commented:

> From my personal perspective yes because it meant we could keep Nortondale out of it but from the perspective of the CCG I think it was probably not such a good

> idea because it made it more complicated so you going to have to spend much more management time. (Notlam GP, Interview)

Interview participants tended to suggest that the need to avoid Nortondale being part of any tender was an unspoken assumption at the outset. Although this was not the decision of the business committee (Meeting 3) there was an acknowledgement this may need to be accommodated to keep the Nortondale GPs content. The Chief Nurse recommending an option of tendering separate lots, despite voting for the whole procurement option and this being overwhelmingly supported in the meeting: “The lots last year defined Nortondale as a separate package, and that may make a lot of sense” (Chief Nurse, Meeting 3). The development of the option appraisal (see page 184) demonstrates how the proposed options and business case were amended between meetings 3 and 4, to accommodate a different option allowing the Nortondale service to be excluded from open tender.

Whilst there were no explicitly defined coalitions stated in the case study, from the behaviours in the observed meetings and from analysis of the interviews, there were several groupings that operated in the process. The organizational coalitions may be seen as:

- Group 1, the pro-tender grouping – membership GP Vice Chair, Ellerton GP, Hospital Consultant, Chief Nurse, Practice Manager, Project Director, AD Commissioning, AD Primary Care. This grouping included the strongest clinical voices for improvement and the officer members who had experienced the most disappointment about redesign work with the existing providers. The group has an aggressive approach to risk taking, and saw limited downsides to tender: “How will it be any worse?” (AD Commissioning, Meeting 2).
- Group 2, the risk management grouping – Peripatetic GP, Audit Chair, CFO, CEO, Deputy CFO. The group has only one Governing Body clinician and included the two senior finance professionals in the decision-making group. The grouping appeared concerned regarding the financial risks associated with the uncertainty of tender responses, and the political effects of destabilising the current providers, who would remain providers in other local service areas.
- Group 3, the balanced grouping – Clinical Chair, Notlam GP, Nortondale GP, Lay Patient Rep, Project Manager. Here members could see the benefits of the pro-tender grouping (acknowledging the Improvement theme) but recognised there were risks, accepting things could indeed get worse following a tender.
- Group 4, the Nortondale grouping – Notlam GP, Nortondale GP. This was a small subset composed of the two Governing Body members from the Nortondale area. This grouping functioned primarily to preserve the status quo in the Nortondale area, whilst simultaneously supporting more radical change across the rest of the CCG.

- Group 5, the corporate grouping – Audit Chair, Project Director, AD Commissioning, AD Primary Care. This grouping coalesced around the need to follow corporate processes and focussed on legal requirements and what was necessary to functionally proceed with the process. This grouping was less driven by the achievement of an outcome and more by ensuring proper processes were followed.

As can be seen by the membership, the groups had some overlap.

The negotiated order concept and the role of power within the CCG may be seen as evident in the agenda shaping and option appraisal, where certain individuals (and by extension any related coalition) had influence over the process. The use of slide presentations and meeting documents were used as multiple devices. One device being that of discussion shaping: although this shaping may not necessarily create frames itself, it may nevertheless provide a *framework*. This framework creates limitations and boundaries for the ensuing discussion. The meeting members are thus directed towards discussing the provided content. They are not formally forbidden from introducing other issues or items; but the process of agenda setting makes it more difficult to move outside of the framework. This is consistent with the project's use of Lukes (2005) three-dimensional view of power. For a deciding body such as a corporate board this suggests there is a requirement to understand *who* controls and *how* they control the agenda setting. Without this understanding boards may be confronted with requests to make a decision on the issue to which they are presented: but not, necessarily the issue that they want to decide on. This may go much further than mere 'agenda setting'. Not merely creating a list of things to talk about in a meeting, it is creating a framework of the subjects to discuss, in what depth and relating to what information. This should not be seen as creating psychic jails, which imprison decision-makers. But it is very much not presenting decision-makers with a blank sheet upon which to write a new narrative for a specific issue. The concept of framing may be instructive here. The frames of the agenda setters create, or modify, a framework, which then shapes subsequent frames, and so on. An observation about corporate decision-making is that it may often ignore stated corporate objective and values. Thus, for Keeney (1992, p.3),

> Values are what we care about. As such, values should be the driving force for our decision-making… Instead, decision-making usually focuses on the choice among alternatives. Indeed, it is common to characterise a decision problem by the alternatives available. It seems as if the alternatives present themselves and the decision problem begins when at least two alternatives have appeared.

The role of power in this scenario (possibly neglected by Keeney (1992)) is in part to shape the discussion both to shift focus away from values and objectives (for whatever reasons) and to control the posing of alternatives. Therefore, the frame in use at the points of decision-making will be influenced by the powers of certain actors. Some of who will have greater power than others. This may be most obviously seen as belonging to the executive officers. They will have greater time, being fully employed

as professional managers in the organization, and will also usually have some degree of line management responsibility (and thus power) over other officers who may be involved in creating business case and similar documents.

Discourse framing and the negotiated order

The discourse analysis of language used in the case study may be seen to demonstrate mechanisms at work in managing the CCG negotiated order and shifting power relationships to deliver the observed decision.

The Group 1 used the language of the Improvement theme to establish a frame on a drive to improve patient services alongside a dissatisfaction with current service delivery. This was enhanced by somewhat antagonistic language about the current service provider (at one point referred, tongue-in-cheek, as like a marriage with "domestic abuse" (Meeting 1)). As discussed above, this may be seen as a risk-seeking discourse with an acceptance that losses in service provision had already occurred. This may be seen a frame and discourse with a strong emotional element: in part due to the absence of balancing empirical evidence.

Group 2 used language more couched in a fear of deterioration: particularly financial, and the political impact on partner relations. Thus, Group 2 appeared as risk avoiding within prospect theory, and tended to use language focussed on the potential negative impact of more radical changes. This appeared as appeals to moderation and considered assessment and may have been a less powerful communicative discourse than the more emotional style improvement appeals of Group 1. The recent experience of some members from Group 1 in unsuccessfully attempting to improve services may be seen to add weight to their arguments and to influence Group 3. For example, "Not with this service but with many others. We have tried that and it didn't work" (Ellerton GP, Meeting 1) and "We have an improvement trajectory for A&E and it is going backwards" (AD Commissioning, Meeting 1).

The apparent imbalance in emotional strength of the competing frames may have been important on the impact of the decision-making discourse on Group 3, who, through taking a balanced position, were assessing the relative strength of opinions expressed by the other decision-makers. The lack of empirical evidence provided in the process may have added to the strength of the more emotional arguments: the counterbalancing influence of factual information was largely absent. Thus, in Meeting 3 it was stated, "We don't have a great deal of information on the services and these are essentially contract value lines" (Project Director, Meeting 3), followed by further discussion on the quality of available service data.

> Project Director – It is probably worth saying we are working to get some more activity information and some more detail, so we can do a proper analysis.
> Nortondale GP – Is there not a duty for them to provide the information?
> Deputy CFO – We are not sure what information is supposed to be provided within the community MDS [Minimum Data Set].
> Chief Nurse – It has been delayed.

Project Director – There was some national work on community services benchmarking. At the moment we haven't seen anything from that.

This example is consistent with one of the axioms of bounded rationality (Simon 1997, 1972): that of decision-makers having imperfect information. This lack of data and empirical information may have strengthened the position of Group 1, relying on more personally, if professionally, based evidence. Similarly, it may be seen as an example of satisficing (Simon 1997): decision-makers will find the best *available* option from the available information and not necessarily attempt to get the best *possible* option. Thus, the lack of evidence from service information appeared to be accepted by meetings participants, and there was little discussion as to how further higher quality information could be created.

When the more emotional arguments were led by clinicians, driven by an improvement led discourse, the counterbalancing elements, even accepting the levels of risk, appeared as relatively weak. Indeed, the Group 1 discourse did not ignore or even minimise the attendant risks: rather they accepted them as the necessary price for improvement, "There are risks attached to it, but we are at stage where we have to take risks" (GP Vice Chair, Meeting 4). This may have been a mechanism in securing the support of the Group 3 members in establishing the eventual majority for the decision. The acceptance by most of the group of a different solution to the Nortondale was another means of achieving a near-consensus for a decision. This arose as a pragmatic solution and recognised early in the process. Whether this was objectively seen as appropriate was not challenged. Some decision-makers accepted that a compromise around Nortondale would be inevitable: "There is always the empire of Notlam"[36] (Hospital Consultant). (Notlam being a market town and largest population centre within Nortondale and the site of the Nortondale community hospital.) This approach of seeking to both marginalise the voices opposing Group 1 (that is accepting risk as necessary and not be avoided) and to accommodate the most militant opposition (that is accommodating a different Nortondale) was reminiscent of a favoured change management approach, Force Field Analysis (Hooper 2000). Thus, effective strategies do not merely seek to increase the pressure of driving forces but seek to reduce the effect of restraining forces. This appeared to be effective in reconciling Group 3 and 4 with Group 1 and establishing a relative hegemony over the Governing Body.

A further consideration from analysing the discourse was the asymmetry between perceived loss and gain between Group 1 and Group 2. The asymmetry across prospect theory between risk seeking 'loss recovery' (Group 1) and risk avoiding 'gain protection' (Group 2) may be seen as unbalanced due to the impact of prospect theory and also the overall majority of clinicians in the Governing Body (who tended towards supporting Group 1). In some of the language used (again, "There are risks attached to it, but we are at stage where we have to take risks" (GP Vice Chair, Meeting 4)) Group 1 displayed traits similar to those described by Navon (2013). Thus, perceived gains or outcomes varied from the likely actual outcome. Navon describes the tendency for 'switch seekers': those who in certain situations will choose to switch to

another options (for example sell-off poorly performing financial assets, or switch lanes in a busy motorway) even when the evident benefit of switching is minimal or absent. Navon explains this partially through a consideration of the *envelopes problem*[37] where paradoxical decision-making may arise through incorrect framing of the problem (see Navon 2013). In the case study Group 1 being driven by dissatisfaction with the current service and service provider: "poor experience of partnership working with the current provider" (Chief Nurse); "the acute Trust had taken on the contract and done very little to improve it and in fact in some cases people's perception was that they had actually caused a deterioration" (Clinical Chair). The discourse almost assumed that a likely outcome from a tender would be a new provider: however, objectively in an open tender process the current provider, having greater knowledge of the services under tender would have as good, if not better chance, of winning any tender process (assuming they were a bidder). This may be seen as an example of egocentric framing (Navon 2013): seeing problems from one's own perspective alone and assuming one's own situation is fixed. For the negotiated order this may be a useful means of influencing the undecided (Group 3) with the promise of a possibly attractive outcome ('you may get a new provider') not entirely balanced by a corporate process argument (from Group 5) that a different provider is by no means certain. In situations of dissatisfaction, risk seeking and switch seeking may seem attractive as they are the active options, they involve a positive action, rather than passive (not changing providers or staying in the same motorway lane).

Although it would be a mistake to over-simplify positions into a binary opposition, in some respects the data may suggest a stronger emotional group with supporting arguments against a weaker emotional, but more analytically based risk group. Healey and Hodgkinson (2017, p.112) state that, "when personal and financial stakes are high, the brain is awash with emotions", which may suggest in situations such as the case study, the strength of emotionally based arguments, when linked to the pre-existing biases of decision-makers, may be stronger than apparently rational arguments, based on information. Furthermore, in some cases counter-balancing information may have limited appeal. Karlsson et al. (2009, p.23) discuss research into investors decision-making where, they "collect additional information conditional on favourable news and avoid information following neutral or bad news". They call this behaviour the 'ostrich effect', in reality probably best seen as a nuanced version of the confirmation bias (Nickerson 1998).

The framing of arguments in the process, particularly the juxtaposition of Groups 1 and 2, and Group 1's ability to both influence Group 3 and reconcile Group 4, demonstrated the powerful use of framing in support of creating the negotiated order. Despite what appeared to be reservations about the tender option from Group 2 participants. Returning to the framing level summary table of codes (from the Methodology chapter)

Framing Level	Research Codes
Micro	Improvement Service redesign Behaviour
Meso	Stakeholder Corporate process Risk
Macro	Risk Corporate process Stakeholder

it may be observed that the most powerful frames in establishing coalitions, particularly those that bound Group 1, and shifted Group 3, were those from a micro level. Thus, the frames that may be most important in establishing coalitions and shaping a negotiated order may be those that relate more closely to individual experience and perspective. This is consistent with the influence generated by the availability heuristic (Tversky 1974): one may overstate the likelihood of events based on one's ability to recall similar events. There appeared to be little challenge of the clinical view that services were poor or deteriorating, even though the Nortondale experience, from the same service provider, was superior. Thus, the Group 2 challenge was not of the arguments (and thus codes) used by Group 1, but rather from resulting risks inherent in the proposed solution. It was also evident, as described above that the Group 1 arguments were seen as being based on positive objectives (contained within the Improvement code) and linked to emotional positions within certain, particularly clinical decision makers.

Reflexive view of research objectives

Background and context

As a Chief Officer the decision certainly did feel strategic, in that it was of large financial value, of strategic importance in linking to a major objective of the corporate strategy, and it was considered of high clinical importance by the CCG GPs. It was also of no surprise that such a decision subject and its decision-making process should be complex and messy. In my opinion, they almost always are. Thus, my role as CO in the process was not to avoid the complexity or the mess (this may be a futile attempt to confront an unavoidable corporate reality). Rather it was to assist the CCG in navigating through the complexity, so that despite it boundedness, the process was as rational as possible. The challenge in the organizational context is often that colleagues do not expect or sometimes accept the complexity and messiness of the decision-making process. Thus, organizations can be beset with decision-making tools such as 'decision trees' and 'critical paths', which although containing some degree of utility, may also imply the (probably) false possibility of a truly 'scientific' technique that can arrive at the allegedly 'correct' decision. The case study did not see the use of anything particularly complicated in support of the decision: a fairly common scoring matrix provided a means of establishing the best option from the option appraisal.

The assessment of finance as not a major factor in driving the decision is not particularly surprising from the perspective of the CCG CO. Although NHS commissioning organizations will have the responsibility for allocating large amounts of resource, most of this will be effectively 'pre-committed' on existing services. Consequently, financial improvement tends to focus on incremental in-year attempts at cost improvement and cost containment, often through a large series of smaller financially targeted actions. It will also be difficult to maintain the support of senior clinical colleagues in any major change process if the only objective is financial.

Influencing factors

The external influencing factors presented a challenge for the participant researcher. The research exposed differences in approach due to background and position of the individual decision-makers. Thus, as a decision-maker with a particular place in the process, my interpretation of the significant influences may reflect a bias towards those that I consider important. Specifically, I was considered to be a member of Group 2, the risk management grouping, and thus exhibited, and documented the belief in the significance of the risks associated with the project, and an aversion to the tender route, in part as this was considered a riskier option. The risks felt more evident in the aftermath of the CCG's Urgent Care procurement in the previous year. Furthermore, the emergence of a national direction towards greater service integration implied a lesser emphasis on competition and thus tendering. This direction to service integration encouraged the existing Foundation Trust (FT) provider to suggest that tendering was bad idea and one that would possibly deteriorate relations between

themselves and the CCG. This may have been seen as a veiled threat; or a realistic assessment that as the current provide a decision to tender the service would inevitably be seen as a significant criticism of them as a provider. This provided an interesting dynamic for me as the Chief Executive Officer, as I had a higher level of engagement with the senior FT team than most of the other decision-makers. This may have made me, or at least appear to be, more sympathetic to the FT, a view expressed by other participants in the process.

The impact of corporate memory on perception of influence was also affected by the position of the researcher. The influence of corporate memory was likely to show to some degree the experiential learning of my role as the chief officer in charge of the organization who managed the Urgent Care procurement undertaken in the year prior to the case study. This was raised as an issue by interviewees and within the discussion of the management meetings. At the time of the study, in my role as CEO I had, at that point, a somewhat negative view of that procurement, as its early stages of implementation were flawed. (The service delivery did not fully meet the tender specification until the very end of the first financial year of the contract and was, therefore, only partly meeting the specification at the time of the case study.) This may have been communicated through discussion in questioning and in my contributions in the meeting discussion. None of this contribution, however, may be seen as invalid. Rather the reflexive element arguably enriches further the discussion as to recent corporate experience and how procurement was seen in the organization.

Cultural and power dimensions in the negotiated order

The dynamic of the negotiated order provides an interesting perspective for the reflexive critique. This included the consideration of the organizational coalition and thus the potential development of groupings within the process. This was possibly shaped in the research reporting by the perspective of the researcher: how did coalitions appear to me?

What was evident before the process began, or at least the start point of the process documented as the case study, was that certain colleagues had a very critical view of the FT provider who ran community services. This tendency appeared to promote a culture of ‘anyone but them’ in looking at how to improve community care. Consequently, I was aware as we moved in to the process of deciding how community services would be improved there would be a strong move to include tendering as a solution. What is evident as I reviewed the research data was that the ‘tender or no-tender’ discussion appeared to become the dominant theme in the process. Thus, colleagues may have felt that the service model of integrated community care wrapped around General Practice was already agreed and thus didn’t need to be discussed in detail. If this was the case, as it appeared, then the major discussion point would then be how to deliver and achieve the model, rather than the service model itself. However, the strong sense of frustration (a key word in the discourse) felt by some individuals did seem to drive a strong emphasis on creating a new provider. If this was indeed the

view (‘anyone but them’) then achieving this end required, almost by definition, a move to open tender. Thus, the discussion moved quite quickly to a split between what may be seen as, on the one hand a drive to move to open market tender, and on the other an attempt to assess the risks of the tender option and the other alternatives.

Reflecting on my initial order data coding, I had first of all developed a ‘frustration’ theme, but on consideration this did seem to over-state the negative driver in many colleagues. Although frustration remain as a second level code, it felt appropriate to be more balanced and to accommodate frustration within a wider *improvement* code. Frustration was a factor but overstating this theme would neglect the genuine desire to improve services apparent in all colleagues.

The interview process, by dint of using language to frame discussions, was heavily influenced by the researcher. Thus, the interview questions were the creation of the researcher. They were generated after consideration of the content of the observed decision-making meetings. As these were transcripted verbatim, there was a transparency of the content against questions and thus would allow critique by any external reviewer. That said, although the process was transparent, and one would argue valid in research terms, there was a clear steer from the researcher towards the issues that I considered important. As this steer was considered to be consistent with the research question and objectives, this would again not undermine the research validity. There may, however, have been the use of certain terms, such as ‘frustration’, which although volunteered by interviewees in the earlier interviews were then fed back in later questioning. This would be seen as an appropriate generation of research data through an iterative process; however, certain terms may have assumed greater importance to me as a researcher. Nevertheless, the impression of importance of certain terms within the discourse arguably provides the embedded researcher with a stronger sense of which terms are significant in the discourse: that is those that shape the social construction of meaning within the case study.

Views of the reflexive researcher shaping the thesis

The negotiated order is an established and observed social construct (Fine 1984). It may not, necessarily, be stated that it is always observed or always present. Strauss (1963, 1982) may have demonstrated that when organizations are researched with a view that allows the discovery of the negotiated order, the negotiated order is indeed found to be present. This does not, however, necessarily provide evidence of the negotiated order as a constant feature of organizational behaviour. And despite research demonstrating evidence for the negotiated order (Strauss 1963, 1982, Fine 1984), and theoretically developed causal mechanisms for the order, the evidence may not be seen to support establishing any form of social law that dictates the order will always be present. Consequently, the reflexive critique must acknowledge the researcher’s pre-existing observations on the behaviour of negotiation within his experience of organizational behaviour. The conclusions from the observations were reinforced by literature such as that of Strauss (1982). Thus, the research needs to

recognise the potential for confirmation bias, through the researcher seeking to find the phenomena they believe to be present. Similarly, any analysed causal mechanisms need to be triangulated against the recorded data and further scrutinised against alternative explanations. This would appear to be a beneficial aspect of the rival explanations approach.

Areas where my views as a researcher were modified, somewhat, by the research process were in decision-making and the role of strategy. In the research design of thesis project as with previous research (Cox 2012) there was a strong influence of the concept of bounded rationality (Simon 1997). My tendency in this stream of thinking was to see that although there may be elements of a general rationality, decision-making often is remarkable by its limitations and distortions (for Simon (1997) the boundaries, for Kahneman (2012) the biases and use of intellectual short-cuts). Whilst the research and personal experience appears to confirm bounded rationality as a feature of management decision-making, this project does confirm that decision actors may often seek rational solutions. Thus, Cohen's (1972) 'garbage can' model of decision-making should not be seen as a description of decision-making anarchy, but another exploration of bounded rationality. My experience of the process was that my colleagues were limited by context and information in the messy environment; but decision-makers did not appear to give up on the search for the best reasonable exploration.

As described in the chapter on conclusions and implications for practice, the research slightly reoriented my approach to strategy. As the process of strategy is also messy and complicated it has been tempted to be somewhat cynical about the resulting documents and statements which the process produces. Much of my earlier thinking on strategy was influenced by Mintzberg (2007, 2009) and to a lesser extent by Weick (2001). I would not infer a major change in assessing the importance of Mintzberg in the realm of strategic thinking. Arguably any suggestion that his discussion of the emergent nature of strategic thinking undermines strategy as a process may be misplaced. As is discussed in the literature review Mintzberg is a subtle and balanced commentator. Thus, Mintzberg's influence on me may not have changed too much, but the need for strategy as an intentional, directional process may have been strengthened. Thus, no less Mintzberg, but possibly more Porter. Similarly, the much less intentional, 'planned' approach to strategy as discussed by Weick (2001), seems to be now more of an entertaining and thought-provoking commentary on organizational behaviour than analysis of the practice of strategic management.

The rival explanations were seen as a means of challenging the researcher's own assumptions and testing hypotheses for the causal mechanisms. It may be seen, however, that the likely hypothetical explanations provided will tend to be generated from the researcher's own experience and knowledge base. Two of the rival explanations (TP2 the Balinese cockfight, and TP4 the dialectical model) reflected conceptual thinking the researcher had been exposed to prior to the start of the project. The other two explanations (TP1 the orderly process improvement, and TP3 actors in

search of a strategy) had some reference to the researcher's experience of organizational decision-making, both in its 'model' form (TP1) and its more chaotic practice (TP3). Consequently, one may ask whether the rival explanations analysis is appropriately exhaustive and whether plausible explanations were ignored.

The test of the appropriateness returns to the research methodology and whether the proposed causal mechanisms proposed are sufficiently plausible to explain the observed outcomes. Furthermore, the model appears to satisfy Clegg's (1989) tests for theoretical adequacy: exhaustiveness, independence, and consistency. To test the model further, however, it may be helpful to consider multiple researcher approaches to the subject and its application to minimise researcher bias.

How will I see this project influencing my future approach to research? I would see this as a model that could and arguably should be used in future research. It may always be unusual for chief executives of organizations to conduct such research. They would need to have the energy and appetite to do so, and for most busy executives this seems unlikely. That said, managers across differing levels of management may consider it as a model, although probably more suited to doctoral level study than masters, due to the possibly lengthy timescale of data collection.

The potential conflicts imposed upon the researcher provide challenges to the validity of the research and the veracity of the project overall. This may be merely a different series of challenges than those that meet the researcher in general; but nevertheless, the conflicts need to be exposed and explained. The reflexive critique as provided here may be considered necessary, as does an explicit description of how the challenges are managed within the methodology chapter.

As a practicing manager it seems important to research subjects that are important as a practitioner, not merely subjects that are deemed to be of academic interest. The case study here has been instructive in my ongoing management education, possibly echoing Mintzberg's earlier assertion that, "managing is neither a science nor a profession; it is a practice, learned primarily through experience, and rooted in context" (Mintzberg, 2009, p.9). Therefore, future explorations for me will continue the search into how we make decisions in organizations and how we behave in the decision-making process.

Chapter 7 – Interpretation of Findings and Development of Theory

Heaven in a grain of sand?

After the hard work of data analysis, the journey then allows for the interpretation of what has gone on and seek to gain learning about what has gone on and how this may inform future work and thinking. In his work on cultural interpretation Geertz (1973, p.44) defends the cultural analysis of anthropology from some of its critics:

> It is not whether phenomena are empirically common that is critical in science…but whether they can be made to reveal the enduring natural processes that underly them. Seeing heaven in a grain of sand is not a trick only poets can accomplish.

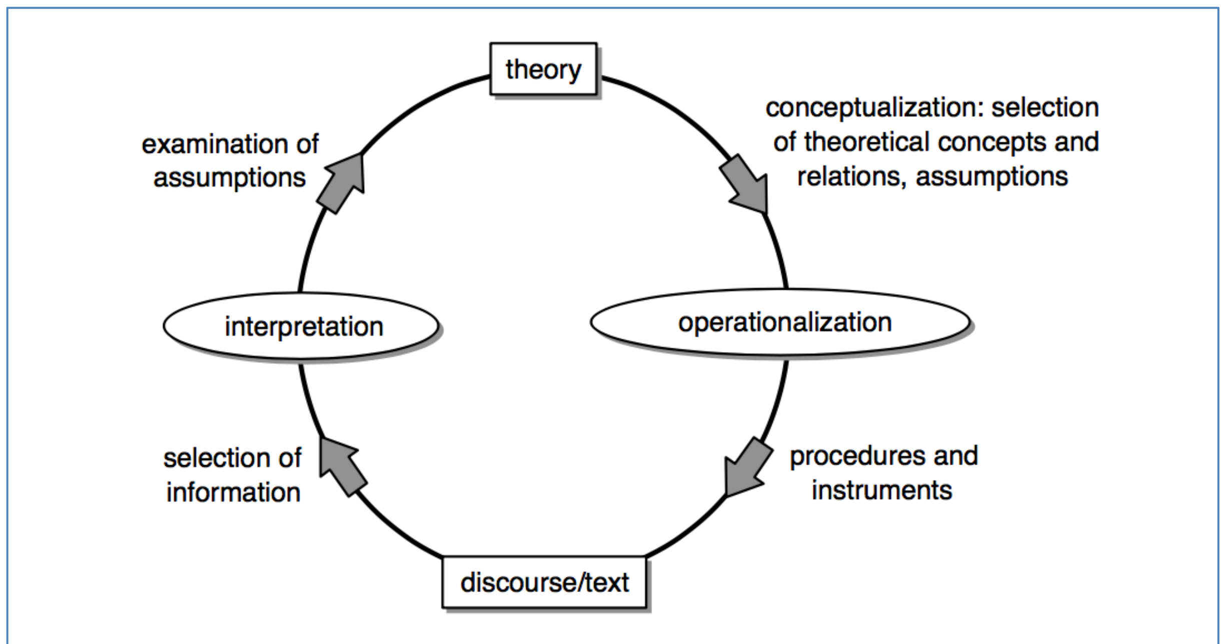
Thus, the development of theory and attempts to make analytical sense of the research data is the task of this chapter. Although it seems that aiming to see heaven may be a little ambitious.

Introduction

From the discussion of the findings within the conceptual framework it is now possible to conduct interpretation of the analysis and develop theoretical understanding of the findings. The theory will then provide overall conclusions, identify the contributions to knowledge, and establish the practical management implications of the research. In this chapter the findings will be analysed through the prisms of theoretical models as rival explanations, producing a synthesised overall explanatory model. This is then further developed as the main theoretical output of the thesis: a social power model for negotiated order.

Meyer (Wodak and Meyer 2001, p.19) provides a circular description of the empirical research process using discourse analysis: the interpretation cycle.

Figure 22 - Empirical research as a circular process (from Meyer 2001)



Fitting the theoretical perspective into the model we may summarise the analytical process of the research project:

- Development of data coding
- Triangulation of coded themes across the data sources
- Production of theoretical perspectives
- Re-examination of perspectives against the discourse analysis
- Synthesis of explanations into case study providing model for causal mechanisms in the CMO framework

This chapter provides the analysis of research data through:

- The theoretical models developed through the analytical process are described as three competing explanations.
- A fourth explanation, synthesising the three competing explanations, provides the summary theoretical explanation from the analysis.
- The explanations produce a resulting social power model as the means to describe the discovered causal mechanisms in the project,

Rival explanations

Yin (2009, p.133) suggests a useful analytical strategy in case studies is that of rival explanations. The following describes alternative competing explanations that attempt to provide a theoretical explanation of the mechanisms explored in the study.

Theoretical perspective 1 – Decision-making as an orderly process of corporate improvement

The literature review section on strategy included descriptions of strategy in its more classical corporate terms as an orderly intentional process. This is consistent with the economic rational model (Smith 1950, Blume and Easley 2007) and even if the boundedly rational model (Simon 1997) puts limitations on decision-making's effectiveness and efficiency, it is still describing a largely rational process with utility to the organization. Simon (1978, p.14) states, "reasonable men reach reasonable conclusions in circumstances where they have no prospect on applying classical models of substantive rationality". Thus, from this perspective the case study ultimately described a path of: identified need; confirmed desired service model; appraisal of potential options; evaluation to preferred model; and decision to agree preferred model and instruction to implement decision. In this version of events the apparent coalitions and cliques described by some decision-makers were largely an insignificant superficiality that didn't affect the process. Rather the discussion between the different groups was not a struggle of power and influence but a rational debate between competing opinions. Thus, the preferred option emerged from what appeared as a rational desire to improve service quality (the improvement codes) and the subsequent discussion refined the proposal to account for competing concerns (for example, the risk codes), producing the preferred option through rational examination.

This is the simplest explanation and suggests power was mainly exercised in Lukes' (2005) first dimension. The apparent coherence of the Governing Body clinicians was not principally a collective use of power, but rather an expression of clinically led decision-making consistent with the original intentions of CCG commissioning (Department of Health 2010).

This perspective does not adequately explain the different groupings that appeared, some of which seemed to hold relatively static positions and represent particular views throughout much of the process. The negotiation around the Nortondale code appeared to be driven from a pragmatic desire to accommodate a sub-group, not a rational assessment of whether different Lots between Ellerton and Nortondale achieved better outcomes. However, some participants considered the process fair and transparent for example:

> I didn't think there were any hidden agendas, I have been in the game a long time and you can sometimes recognise when deals have been done over the table and around the committee room, you vote for me and I will vote for you. There was none of that and has never been a hint of that. (Lay Patient Rep interview)

The other shortfall in this explanation is that it may not adequately account for the importance of power in the process. The genesis of the research project began primarily as an attempt to study decision-making. As the project developed although decision-making remained at the core of the case study, the analysis shifted

increasingly to the behaviour of the individuals and groups within the process. Linked to this was a consequent focus on different degrees and uses of power and influence. Therefore, it may be inferred that a first-dimension, pluralist description of power will inadequately account for the differing approaches to risk; the movements between different coalitions in creating the ultimate negotiated order; and the evolution of the option appraisal and final decision option.

Theoretical perspective 2 – Decision-making as a Balinese cockfight

The negotiated order concept appeared to be demonstrated through the research and may prompt the question as to whether the order was static (largely as the power dynamics were at the start of the process) or dynamic (shifting and re-created in the decision-making process). The question aligns with the exploration of framing. Thus, the macro frames may be relatively fixed (national context and regulatory guidance) but open to interpretation; the meso/organizational frames notionally agreed but subject to re-negotiation; and the micro level based on pre-existing experience (thus partly determined) but subject to group influences.

Geertz (1973), in a celebrated monograph, describes the cultural significance of the cockfight in Balinese society. His 'thick description' interprets the occurrence not merely as a local sporting event, but as one deep with cultural importance for the society. Thus, the cockfight is,

> An image, fiction, a model, a metaphor, the cockfight is a means of expression; its function is neither to assuage social passions nor to heighten them (though, in its play-with fire way, it does a bit of both), but, in a medium of feathers, blood, crowds, and money, to display them. (Geertz 1973, p.444)

For Geertz (1973) the event does not simply demonstrate social characteristics (power relations, hierarchies, etc.) but helps to reinforce them. But this is not just reinforcement but interpretation on behalf of the community allowing it to make sense of its social stratification.

> What sets the cockfight apart from the ordinary course of life, lifts it from the realm of everyday practical affairs, and surrounds it with an aura of enlarged importance is not, as functionalist sociology would have it, that it reinforces status discriminations (such reinforcement is hardly necessary in a society where every act proclaims them), but that it provides a meta-social commentary upon the whole matter of assorting human beings into fixed hierarchical ranks and then organizing the major part of collective existence around that assortment. Its function, if you want to call it that, is interpretive: it is a Balinese reading of Balinese experience; a story they tell themselves about themselves. (Geertz 1973, p.448)

This view of mutual interpretation of position within a community is consistent with Parsons' description of power as reflecting a "normative determinism" (Clegg 2006, p.194) and driven by socialization.

If large scale (strategic) decisions are the main *events* of the CCG, does the decision-making process act to reinforce the demonstrated negotiated order and to promote self-interpretation from the members of the organization? Using Lukes (2005) three-dimensional model of power, the decision-making process may be seen as demonstrating in management practice the spread of power and influence in the CCG. Furthermore, the power relations may be considered to be largely present and underlying within the CCG. Thus, the decision-making process demonstrates:

- Who holds different types of power according to the three dimensions
- How interpretive frames are used in the process
- Which decision actors sponsor particular frames

In this interpretation the outcome of the process is largely determined by the initial conditions. In the CMO model the *conditions* having a predominant role as *mechanisms* driving the *outcome*.

The pro-tender coalition included a significant number of clinical decision-makers. The reassertion of clinical priority in the CCG decision-making process may be seen as a result of the case study. CCGs originated from a desire from the then Secretary of State for Health to promote decision autonomy. Thus, the 2010 White Paper stated, “The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia” (Department of Health 2010, p.4). Thus, the clinical Governing Body members in part acted as a (loosely) coherent group and may be seen as driving through a starting presumption (on the quality of experienced services) despite objections or problems.

This perspective does, however, describe a relatively fixed series of relations and power balances within the organization. Thus, this may assist in explaining the creation of the observed coalitions, and their power bases. The coalition formation and dynamics appeared to be *subject* rather than *power* based. Thus, the professional and demographic backgrounds of participants may have influenced their opinions and ultimate decision-making, but this was driven by the subject matter, more than obviously a desire to gain or reinforce power and position in themselves. Furthermore, this model may not help to explain the evolution of the options in the process of the accommodation between certain groups that drove the eventual decision consensus. The observed process of negotiation and tensions between groups in the process appears more as a struggle to achieve either predominance or accommodation: not obviously a process to reinforce previously determined relations.

Theoretical perspective 3 – Decision-making as actors in search of a strategy

Many texts on corporate strategy identify the importance of the corporate environment within which the strategy is developed (Johnson 2005). Models such as PESTLE[38] (Johnson 2005) explicitly recognise strategy doesn’t happen in isolation of the wider

environment. Similarly, Thompson (1993) identifies the necessary balanced requirements for successful strategy: Environment-Values-Resources (EVR) congruence. We may align this concept of strategic balance with both the concept of the structure-agency relationship, and the multiple layers of framing (macro-meso-micro). Thus, in the case study the outcome may be seen as the result of the framing mechanisms, being both a product of and an influence on the corporate environment.

The issue of framing is not merely the presence of the wider corporate environment: the role this environment will play on creating the negotiated order is how this is interpreted and used in creating order. Thus, the cognitive frames used in relation to the wider environment (essentially the macro frames) will provide a view of this external world. But it will be a created and interpreted world. This was demonstrated in the study with a different interpretation of the legal constraints on the decision: the importance of legal procurement issues needed to be interpreted and agreed. By the stage of the decision itself this appeared as a minor issue, possibly in part due to the lack of agreement amongst decision-makers as to its relevance.

The meso (corporate) level did not concern itself only with resources, but also corporate memory of previous decisions including how resources were used. This area also showed how different actors provided varying interpretations of commonly experienced events. Indeed, the variance appeared to work to polarise groups rather move to a consensus. Thus, pace Dennett (1992), when the waves of obviousness are not crashing on the shore, the scope for polarisation is greater.

One may expect the scope for difference across decision-makers to be greatest at the individual level. From the case study this level may be seen as being the most important framing mechanism in driving the outcome of the negotiated order. Paradoxically, for the individual members of the observed coalitions, the intragroup variation of individual frames was small. (For example, the personal experience of clinicians within Group 1 was largely uniform.) Thus, the creation of the negotiated order described a struggle between groups to establish hegemony over the process, rather than a debate between individuals to establish a common set of values. It may be seen that the superordinate values (such as strategic objectives to improve patient care) were largely common and almost taken for granted. But the means to achieve the value set and the prioritisation of actions was debated between the active coalitions in the process.

All of which infers that if good corporate strategy demands a congruence of environment (internal and external), available resources, and values, the implementation of strategy will involve a negotiated order that also synthesises the different levels of cognitive framing. An implication for organizations may be that development and implication of strategy may need to take account of those involved in its development and execution. This is reminiscent of Vail’s comment (quoted in Weick 2001, p. 57):

> One mistake the arts would never make is to presume that a part or role can be exactly specified independent of the performer, yet this is the idea that has dominated work organizations for most of the twentieth century.

From this, consideration may be given as to how strategies can be flexed according to the individuals involved in developing and implementing those strategies. If strategy is, from one interpretation, about 'where we want to go' and 'how we want to get there': in this interpretation actors may have differing pictures of what 'where' looks like; and changing views what 'how' means. Thus, for this interpretation, the negotiated order is a constant process of synthesising different views of the strategic objectives and creating a consensus as to how implementation will unfold. Each event will create its own negotiated order anew, evolving from what came before.

This perspective may be in danger of moving too far away from the project's realist methodology and towards an overt relativism. Thus, whilst the corporate world does need to be interpreted, not all interpretation may be considered equal; and the external structural world will provide an overarching context for the decision process. The interpretation will occur in a context and the pre-existing power relations may be of importance: corporate and personal histories cannot be ignored. However, this model does identify the concept of the struggle of ideas in the process and the outcome of the process being one of either resolution to consensus agreement across all, or the emergence of a predominant view achieving hegemony over the organization.

Synthesised Theoretical perspective 4 – A dialectical decision-making model of the negotiated order

Although Yin (2009) states rival explanations are mutually exclusive and cannot coexist, the rival explanations described above appear to have some overlap and support developing a coherent overall theoretical perspective of the case study. This may be more analogous with the narrative analysis of Czarniawska (2004) who discusses narratives as often having multiple plots. Thus, the rival explanations are synthesised into an integrated theoretical view of the case study.

Theoretical perspective 1 (TP1) assumes the decision-making process as a relatively orderly, rational process in support of corporate process, but may be seen to fit the real-world events to an abstract model of how decision-making 'should be'. The interpretation of theoretical perspective 2 (TP2) describes a relatively static process. Conversely, for theoretical perspective 3 (TP3), there may be an over-estimation of individual perspective and looseness of process. For TP2 structure and history may be over-stated; for TP3 they may be under-stated, and the role of agency inflated. (This may return to Archer's (1995) critique of upwards and downwards conflation of structure and agency.)

The integrated synthesis of the case study uses the frame of dialectics. (One summary of dialectical thinking is provided in Harvey (1996).) A dialectical approach may be summarised as:

- An emphasis on process and flow rather than fixed structure
- Parts and wholes are mutually constitutive of each other
- The interlocking of factors entails "the interchangeability of subject and object, of cause and effect" (Levins and Lewontin, 1985, p.274)".
- Systems tend to be internally heterogeneous and internally contradictory
- Transformative and creative behaviour flows from these internal contradictions
- Change is a characteristic of all systems

Dialectics describe a complex process of contradictions: contradictions that are a necessary part of the system's unity (Winter 1989). The resolution to the contradictions is seen as the establishment of the negotiated order. As this order does not produce a uniform consensus it requires the achievement of a cultural and ideological predominance and authority: hegemony (see Clegg (2006) and Anderson (2017)).

Using a dialectical approach, the different perspectives may be synthesised into a unified explanation of the decision-making in the case study.

The identification of coalitions within the negotiated order is representative of not merely the power relations of a *point* in time; but furthermore, those that have developed *over* time. Consequently, some relations will be transient and variably 'fragile'. In some cases, actors may revert back to older alliances if they appear more substantial, or if the evident contextual pressures change. But where power, position, and hierarchy exist one task for those in position may be to try and reinforce their power. Clegg (2006), in discussing Giddens, differentiates between allocative and authoritative powers. In this context allocative power may be seen as the respective professional backgrounds (clinical, managerial, non-executive) of decision-makers; whereas authoritative power will be that emerging from the process and calibrated within the negotiated order. The balance between allocative and authoritative power in the negotiated order of a CCG may be dependent on the decision subject. (This may be different from situations where the exercise of power involves economic or military resources as allocative power.) Where there is a stronger clinical element to the subject the allocative power of clinical professionals may be consolidated into authoritative power through the emerging negotiation. Conversely, more obviously financial or corporate subjects may emphasise the allocative power of executive officers. Thus, in the CCG power and influence was both historic and present; and fixed and emergent. The engagement between decision makers will determine how the power balance plays out to the point of decision.

The contradictions evident within CCGs have been seen as inevitable (Cox 2013). Thus, there may be little point in seeking to eliminate them or even to reconcile them completely. Rather the corporate necessity is to achieve a sufficient consensus and accommodation of ideas so that decision can be made and then implemented. Consequently, the task is less the complete reconciliation of differences; but more to secure an overall commitment to a course of actions that allows the contradictions to be managed without de-railing an initiative. The improvement code-risk code tension demonstrated a likely contradiction within a CCG between the clinically led desire to

improve care (even at considerable risk) against the desire to manage risk and reduce exposure to corporate harm.

The belief in strategic decision-making as an orderly process to achieve corporate objectives (as TP1) was demonstrated unevenly in the study. There was reference to wider strategy (national and local) but the complex collection of interests was reminiscent of the 'garbage can' decision model (Cohen et al. 1972). Thus, values and objectives may appear throughout (and even at the end) of a decision-making process, not merely at the beginning to inform a process. In similar terms, in his critique of Parsons, Giddens (1968) comments:

> That collective 'goals', or even the values that lie behind them, may be the outcome of a 'negotiated order' built on the conflicts between parties holding differential power is ignored, since for Parsons 'power' assumes the prior existence of collective goals.

Thus, in this study, a strategic decision subject appeared to produce a decision-making process focussed on operational implementation, arguably backed-up by underpinning values. However, this was a complex mix of power relations, corporate objectives, values, and consequent negotiations.

The decision-making process is not self-contained but occurring within a wider strategic context; one that influences and is part of the process throughout. Interdigitation is apparent in the micro-meso-macro levels being part of each other. Thus, although the three levels can be identified and described they remain interlocking with each other. Again, with Archer (1995) the process identifies both the separate presence of structure and agency and their interdependence. This is true of the process and of the individual decision-makers in the process, all who have roles beyond and outside the case study issue itself, influencing their decision-making in the case.

Thus, in this interpretation each strategic decision, although discreet, is the latest in a continual business process. Where path dependence (Arthur 1989) applies, the impact of the decisions taken in the previous periods of the business process may still be in play. Although at points of decision, reconciliation or accommodation may be reached, this may not resolve contradictions, or where contradictions are resolved the resolution will create new contradictions. Therefore, the negotiated order is a means to get to the point where a decision can be taken. From that point on, the negotiated order then begins to engage and resolve the new set of emerging contradictions.

Thus, the theoretical model of the case study describes the CCG decision-making as follows.

Firstly, the initiation of the process is an intention to act promoted by a combination of improvement drivers to develop service provision within a wider corporate strategic framework of commissioning objectives. The decision in the case study did not emerge randomly, but from a number of factors including opportunistic timing (contracts coming to their end date), local and national strategy (improving home-based care),

and clinical evidence of service imperfections. Thus, there is a rational basis for the process and the shape of the decision-making process followed a rationally constructed order of business case development (as in TP1).

Secondly, structural context drives the macro interpretive frames at work. These frames were largely unchanging through the decision and are often used to reinforce power relations, for example the reference to legal and regulatory frameworks (as in TP2). Although the frames may not change through a major decision-making process, the different macro frames may not necessarily be coherent (national policy for example, may be inconsistent and self-contradictory). At this level the contradiction is between the use of frames to reinforce position and obstruct change and to argue for the need for local interpretation of strategic guidance to implement strategic objectives in a local setting.

Thirdly, a local contextual and meso frame level of organizational culture which determines how structural frames were used and how the process developed. The organizational culture, shaped by historic negotiated orders and then shaping the current order, was an ongoing process of morphogenesis. In the study the decision actors search may be seen as less than a hunt for a strategy (TP3) and more as a struggle to reconcile the corporate strategy in place with individual aspirations and fears. For some this may be a conscious or unconscious process or retro-fitting a strategy to a decision taken or a belief held. The development of thinking at individual and smaller group levels that shaped specific thinking on issues, occurred within an already developed framework. This micro level framing may be inevitably influenced by wider contextual issues 'of the moment' which may or may not appear in subsequent strategic decisions. Thus, for any theoretical assessment of strategic commissioning decision-making, the fact that the decisions will be made by people, from differing backgrounds, with differing priorities, and access to varying information has to be recognised. (Consequently, it may be inferred that for complex strategic decisions purely 'rational' decision-making, objectively assessing available evidence may be impossible?)

Fourthly, language occurred more as a tool providing reinforcement to position and opinion and less to debate rationally and convince. The different backgrounds of individuals and groups and the differing strengths of coalitions may explain how discourse shaped the power relations and the negotiated order. The power differentials seen suggest the case study does not support Foucault's rather ambiguous term "Power is everywhere…because it comes from everywhere" (Gaventa 2003, p.4). There is, however, agreement with his later comment that "Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart" (ibid). Thus, discourse is the vehicle playing out the struggle for hegemony in the process. This struggle will link to structural and power relations. As in their study of McKinsey, O'Mahoney and Sturdy (2016, p.259) state that, "most displays of resource power also entail power over meaning through their symbolic consequences". The discourse in the study appeared to produce 'index

codes' that represented the main themes of the differing coalitions and became the tools which created the negotiated order.

Throughout the earlier analysis, Lukes (2005) three-dimensional model has been a useful framework to assess the feature of power in the case study. In developing a theoretical model from the data, in may be necessary to go beyond this approach. The dialectical perspective may suggest the dimensions are not neatly stratified in organizational politics (possible as opposed to wider social analysis). Haugaard (2003) attempts to synthesise various theories of power (including Lukes) into a typology of seven forms of power and then later, influenced by Wittgenstein, describes power not as specific definitions but as contextually dependent 'family resemblances' (Haugaard 2010). To some degree it is less important to establish whether power is at three or seven levels, but rather as Clegg (1989, p.18) states:

> Power is better regarded not as having two faces or being layered in three dimensions but as a process which may pass through distinct circuits of power and resistance.

In the dialectical decision model, synthesising the perspectives above, power in the negotiated order demonstrates the *circuits of power and resistance* (borrowing a term from Clegg 1989) and is, therefore, categorised according to a social power model. Critically this is analysis of how power was used to create the negotiated order in the decision process, not necessarily an analysis of the wider power relations in the organization.

A Social Power Model for the CCG Negotiated Order

The results of the analysis of the findings is, therefore, the social power model describing the four social powers at work in the CCG. This is consistent with the assertion that power is "a phenomenon which can be grasped only relationally" (Clegg 2009, p.207).

Power of argument

The power of argument is demonstrated through agent's ability to make convincing rational arguments, based on available (and presented) evidence. The importance in the context of decision-making is less regarding the objective quality of the rational statement and more in terms of its ability to convince others in the creation of the negotiated order. The useful reference point here is Toulmin's (1964) layout of rational argument: an argument having a *claim* supported by *data*, with the justification for the claim being the *warrant* that links the claim to the data[39]. Thus, data in itself does not present an argument; and a claim without data remains an unsubstantiated assertion. In the absence of 'crashing objectivity' the decision-making theatre may see claim and counter claim with a conflict of warrants seeking to claim ownership of the available data. (Bounded rationality again putting limits on the 'knowable' information.) Where supporting evidence (data) is weak, there may be aggressive debate between competing argument to establish a hegemonic, or compromise position. (This may be

desirable. Ready acceptance of weakly supported arguments may be indicative of groupthink (Janis 1982)). The strengths of a warrant are not merely their content or the agent of delivery: but critically the audience receiving the argument. The data from the observed meetings and the interviews demonstrates:

- A general lack of hard evidence (either published studies or service data);
- A view that some of the available evidence was of low quality ("all the papers that I read were based on anecdote and were entirely subjective" Clinical Chair);
- For some, local clinical experience on the ground was more useful, providing "true insight into what the theoretical models on paper are delivering in real life" (Ellerton GP); and,
- For some participants when asked about whether more evidence would have been useful an honest answer of "I actually don't know" (Audit Chair).

Thus, from the above it may be speculated that potentially available evidence may be almost irrelevant to the actual decision-making process. Rather, evidence has to satisfy a number of tests to become relevant. It needs to be known; recognised as having an appropriate status for the subject of the decision; be relevant to the decision-makers; and be presented in a form that can be understood and useful to the process. Thus, the power of argument is less concerned with the objective presence or truth-value of evidence: but more with its eventual consumption and use-value.

Furthermore, the power of argument will be both the argument itself and also the status and authenticity of the arguer. Thus, Haugaard (2012) discusses the power of the 'expert' in language games, using the concept of 'truth': "the use of truth creates the conditions of possibility for power" (Haugaard 2012, p.86); and "truth is the final vocabulary of power; it is the ultimate appeal beyond which lies unreason" (ibid, p.90). The authenticity of the argument, and thus a feature that calibrates the argument's power is the power of position.

Power of position

This power relates to status, professional authority, and technical expertise. Thus, using truth from the vocabulary of power, presupposes the speaker is both fluent in its language and recognised as an expert speaker. In the case study the GP clinical decision-makers were recognised as experts and their semi-privileged access to local clinical evidence (amplified by the paucity of empirical evidence) gave them power of position.

As against the power of position of the expert were the power of position of the non-clinical participants, based around their organizational authority. This includes formal authority (for example senior executive officers) and is often associated with theories of bureaucracy (literally 'rule from office') and governance (Weber 1978). This has suggested formal power and legitimacy rest with bureaucratic rules, and thus position, and are taken as a 'given' ("legitimacy of formal structures and rule-based authority cannot be taken for granted" Gordon et al. 2009, p.16). The assumption of a *given* has

been challenged and may not be supported by empirical data (Gordon et al 2009); and thus, although official position will imbue power within the observed case study process, this is contextually dependent, and only one of the powers of position. Gordon (2009) discusses the ‘right to power’ which in the case of a CCG, for example, may determine which positional power may have most influence in a particular scenario.

Power of position also includes the ability to shape agendas, papers, and structure meetings and indeed the form of a whole decision-making process. This may be demonstrated as power of information.

Power of information

Information has been described as “knowledge made visible” (Orna 2004, p.7). Consequently, the control of how, when, and indeed whether or not information is made available is a potential power. Some actors will “have the right to produce texts, to engage in discursive practice, are able to engage in the process of shaping concepts” (Clegg et al. 2006, p.304). In a decision-making process like the case study, this power may be considerable. The dual nature of power of position may be replicated in power of information. Thus, there is the information control power that comes from corporate authority. This may include agenda setting, control of meeting minutes, document production and version control, diary management, and the general flow of information circulated to decision makers. Alternatively, technical experts may have control over how much of their technical knowledge is shared and also which other (potentially competing) sources of information may be edited or discounted.

The power of information may work in concert with the power of argument: less in terms of the argument itself but more in terms of how the argument is communicated. Thus, if Media Richness Theory (MRT) (Daft et al. 1987) has validity, then the relative richness of certain types of information communication may influence the power of users in using the information to affect decision-making[40]. Thus, power of information will also be the power to affect its communication to others in the process. This may be linked to the power of relations.

Power of relations

Here are seen as threefold powers of relations: organizational authority; professional recognition; and personal.

Some members of the decision-making group were directly line managed by others in the process; particularly the officer group. Although such an officer group may come from diverse backgrounds, there may be some consistency regarding corporate purpose. Even without common purpose the impact of line management hierarchies may still be influential. In the case study all of the professional officers in the process had an ultimate (although not all direct) line management to the CEO. There was, however, no evidence this unduly influenced those in process, or that CEO used position inappropriately.

Professional recognition may allow those who share a common professional background (including training) or position to communicate more effectively and to be 'believed' more strongly in their arguments. (As described above strength of an argument warrant may be influenced by those presenting and receiving the argument). Thus, in a CCG a GP may be influenced more by the views of another GP; a little less by the views of a more general doctor; less still be another healthcare professional; and even less by non-clinicians such as professional managers. Conversely in the subject matter is non-clinical, the reverse may apply. The use of technical jargon may be another way that relations within intra-group cliques will be strengthened. (This may be a practical example of the use *shibboleth* in discourse[41].)

Personal relations (however, they may have developed) may influence the value given to particular positions. Furthermore, following Daft's MRT above, where individuals have established personal relations with individuals this may allow 'richer', that is more face-to-face communication, which may make arguments more persuasive. Roghanizad and Bohns (2017) conclude that face-to-face communications may be many times more effective than email or social media communication. If this research is generalizable to a CCG, for example, it may suggest personal relationships (which allow greater direct access) may promote more effective message delivery and thus imbue greater social power.

The literature review included analysis of group decision-making, recognising the risks of groupthink (Janis 1982) (the tendency for views to converge artificially from desire for group census) and group polarisation (Isenberg 1986) (views becoming more extreme through group discussions reinforcing and deepening initial positions). Various research on rationality (summarised in Pinker 2018) suggests wider social drivers may also influence decision-making in groups. Thus, the instincts for 'coalitional loyalty' (Pinker 2018, p.359) may encourage individuals to make decisions that support their membership of the social group[42]. Thus, the power of relations may work independently of a decision-maker's assessment of evidence.

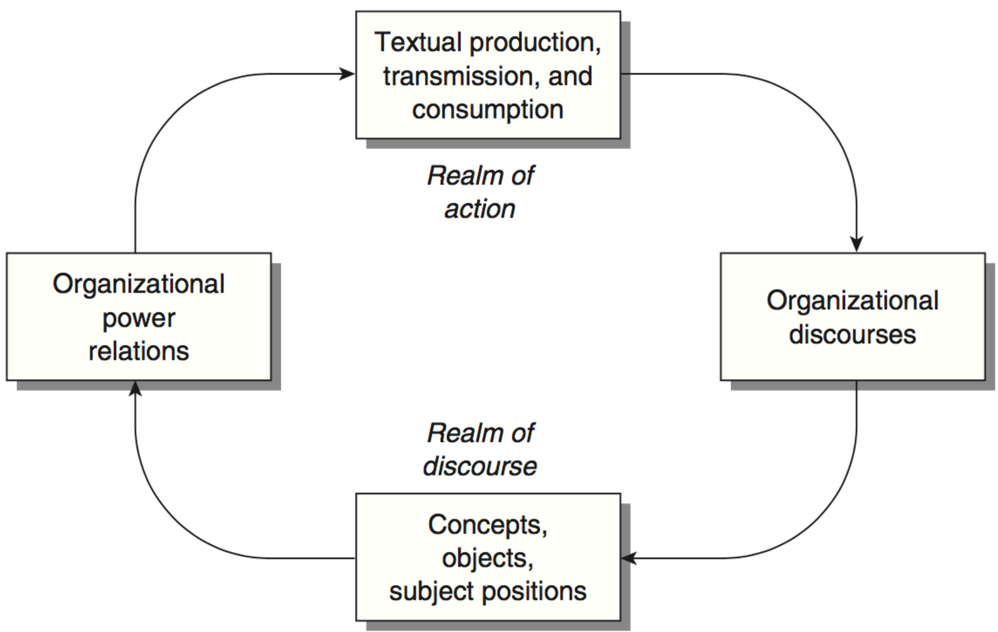
Conclusion of the social power model

All four powers are seen as operating in the decision-making arena of the negotiated order, with the language of discourse demonstrating how the powers are exercised (actually or latently) in practice. Clegg et al. (2006), following Wittgenstein and Garfinkel, discusses 'indexicality': the concept that language assumes its power from the context in which it is used[43]. Thus, the power dimensions above are contextually dependent in terms of how the groups form and which latent powers they already possess. But also, the exercise of power through discourse suggests certain themes (memes, tropes, concepts, or technical jargon) will assume greater of lesser power dependent on their wider environment. Thus, the cognitive frames identified above, discoverable through the discourse, are the tools of the power-play in creating the negotiated order. This is consistent with the observations of Beaver et al. (2007) who suggest 'harmonious'[44] boards are those that can tolerate a range of different

individual objectives. This recognises, “a pattern of personal deals, often unconsciously, so that there is no common agreement to put the interests of the company consistently above those of its directors” (Beaver et al. 2007, p.322). This returns to the necessary conditions for negotiated order as described by Nadai (2008) of tensions between participants, but opportunity for exchange and compromise. Thus, the social power model recognises that powers will be spread across individuals and groups; that the exercise of power also implies resistance to it (Barbalet 1985); that resistance does not necessarily imply conflict (ibid).

The degree of influence of different social powers is contextually dependent and related to the dynamic interaction between the interest groups within the overall organizational coalition. The model thus agrees with Barbalet (1985, p.541) in that social power relations will be “asymmetrical and reciprocal”. The hypothesis resulting from the model is that in a CCG environment the ultimate consensus of a decision-making process with be driven by the produced negotiated order. The CCG negotiated order will be a product of the balance between different groups and individuals in the process: for Giddens “power relations are always two-way” (quoted in Barbalet 1985, p.542). The final balance dependent on the degree of the four social powers lying with the respective groups. Discourse thus becomes the apparent form of the social powers are used in the creation of the negotiated order. Clegg et al. (2006) describe the mutual relationship between power and discourse in an organization. This is consistent with the analytical dualism of the research ontology, maintaining theoretical orientation to both structure and agency within the project, consistent with Archer (1995) and Fairclough’s (2005) siting of discourse analysis in critical realism.

Figure 23 - Relationship between discourse and power (from Clegg 2006)



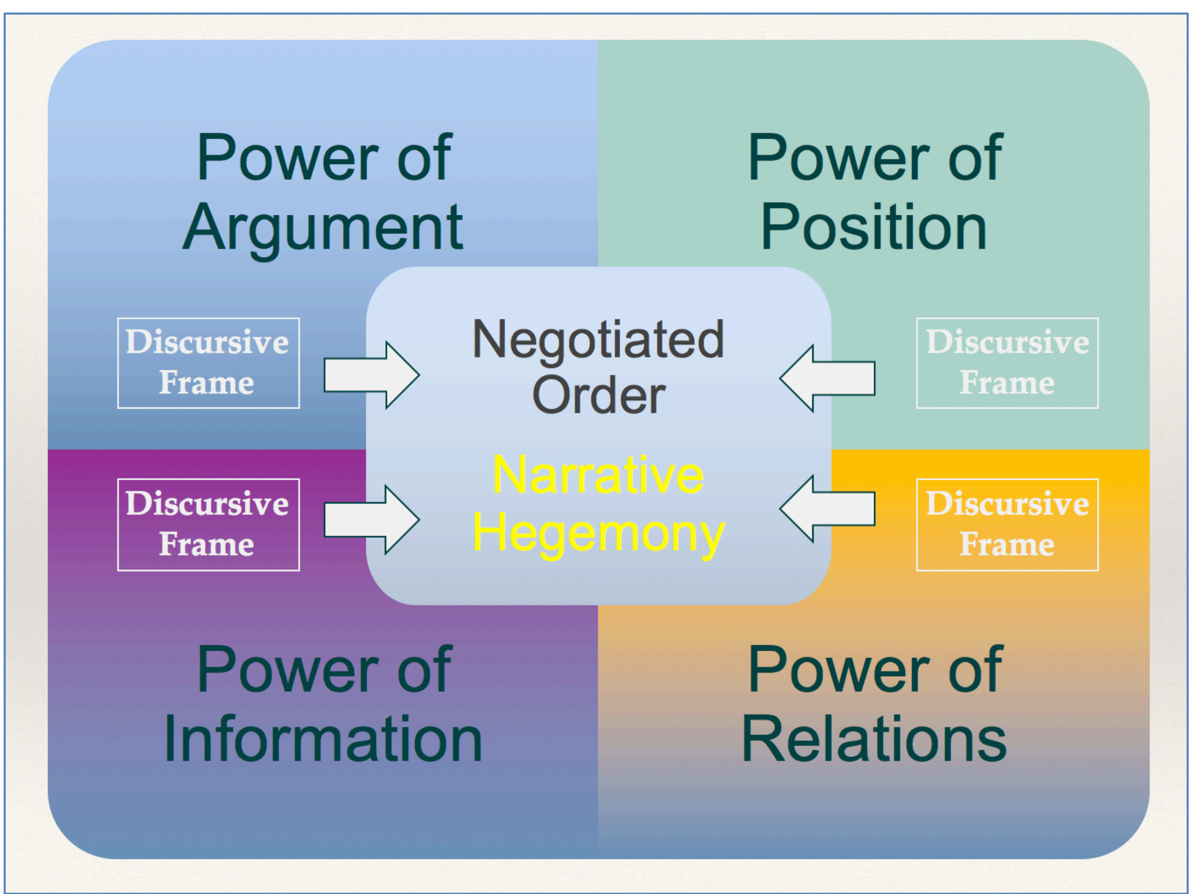
Thus, for the coalition of Group 1, the lack of objective empirical evidence regarding service quality gave their personal experiential evidence greater power of argument, supported by power of relations within the Governing Body (many members working in primary care) and power of relations with the wider GP community, underwritten by the latent power of position in being expert professionals in community care. In the discourse the dialogue on improvement included more emotive terms that if recognised by other participants may have had an emotionally binding effect, for example, “I think the frustration of not making any improvements or not making any progress was felt by everybody” (GP Vice Chair, Interview). Thus, the contextual power in such a discourse is the association with others, the emphasis on not just improvement but on lack of attempted improvement, and also the relational word ‘everybody’ staking a claim that the feelings were felt widely across the health community.

From an opposite perspective Group 2 had a much weaker claim to wider GP support, and although the senior officers had more control over information flows, the ‘knowledge made visible’ was more from clinical experience and thus outside of direct officer control as power of information. The risk concept was strongly felt, but somewhat overridden by the desire to improve care: this may have been reversed if the financial environment within which the CCG was operating had been much worse. Thus, in such circumstances the financial risk factor, possibly supported by financial pressure from regulators, would have increased the power of position of CFO and CEO (and thus Group 2).

This analysis is the genesis for the proposed organizational social power matrix. The matrix identifies sources of power within the coalitions discovered in the research.

Furthermore, the power relations then influence the negotiated order at the end point of the decision point. For example, the accommodation of Group 3 (the balanced group) with Group 1 may have been influenced by power of position (of the clinical professionals) and of power of relation (as co-professionals with an historic professional and personal association). The ultimate hegemony within the CCG seen as power related group to group negotiation bringing Group 3 and Group 1 together, added to the pragmatic negotiation of adjusting the tender basket to exclude items controversial to Group 4 (the Nortondale group). This was most obviously demonstrated in the changes observed between meetings 3 and 4. The change in the business case option appraisal (see page 184) to exclude a 'tender all' option brought Groups 1, 3, and 4 together into a political accommodation where the positions of 1 and 4 were reconciled and where the risk concerns of Group 3 were minimised. Group 5, by focussing more on process were seen to follow the clinically led majority as long as due processes were observed. Thus, by the time of meeting 4, all but one of the decision-makers was content to support the recommended options.

Figure 24 - Organizational Social Power Matrix



The model sees the negotiated order as the product of the power relations. Those working in the decision-making process will have differing levels of each power, depending on both the structural context and the relations with other agents. Thus, a financially driven strategic decision, for a financially challenged organization, in a time of general NHS austerity may increase the power of position of finance professionals

(possibly enhanced by their ability to control data and thus have power of information). Conversely, where the focus may be on improving a clinically unsafe service (possibly under a public spotlight of safety concerns), powers may rest more strongly with clinical professionals (even if a decision had a negative financial consequence). Thus, each social power dimension has reference to its contextual influences and uses and shapes cognitive frames. Groups and individuals with specific powers will use particular frames and certain texts will consequently appear to control 'ownership of the text'. Therefore, it is possible to return to the concept codes from the data and describe them through the prism of the social power model. This affirms that the field of play in the power struggle of the negotiated order in the CCG, is that of discourse.

- The improvement code was a useful element as all parties would subscribe to improving the quality of services. In the CCG strategy documents, there was an objective to strengthen community-based care, and a developed model of integrated care across different disciplines. This was, indeed, the motivation for the issue in the first place. This was, however, owned by Group 1, co-opting Group 3, within the dialogue of 'something must be done' and 'risks are worth taking. Thus, this part of the discourse assumed the clinically led power of argument, supported by power of information (sitting more in some decision-makers heads than in empirical evidence). The Group 1 – Group 3 co-option appears to have been in part based on professional recognition, thus power of position and power of relations. Not only did the improvement code reference a need for services getting better, but also by the frequent (46 words and 135 codes) use of the frustration sub-code, referenced a more emotional feeling of obstruction and delay, and reinforcing the power of relations between those who recognised the frustration.
- The risk codes sought rather than to compete with the improvement code but to soften its impact, and thus may be seen as having a lower power of argument (along the lines of 'we know we need to do this, but there are risks'). The very nature of the *risk* concept is a measure of uncertainty and thus, the competing codes were between improvement of an under-performing service area (a given) and a risk of deleterious effects if change takes place (an uncertainty). The framing of the discourse, particularly in the absence of an acute financial position, weighed a largely clinical decision-making group away from risk. In the discourse risk thus assumed a somewhat defensive tone. Furthermore, the typical association of risk and reward may have made the contextual (indexical) use of risk as merely a necessary consequence of taking action.
- The corporate process codes used in the discourse were primarily concerned with the constraints imposed on the CCG and the process of the case. The early 'struggle' to own the legal issue (was the CCG required to tender or not) was ambiguous and seemed to disappear from the meeting debate by the time of Meeting 4. The other discussions were largely about the conduct of the process and there may have been the most 'rational' discussions, thus seeking to achieve a consensus of view, rather than compete for power of argument.

Corporate process may suggest powers that would sit with the organizational professionals within a power of position.

- The behaviour codes showed competing versions of events: some suggesting cabal-like decision-making of certain groups, others that the process was transparent and open. This despite the relative maturity of the decision-making group.
- The Nortondale code demonstrated a relationship between the expert professional power of position and the power of relations. Thus, the Nortondale GPs deferred to the views of the Ellerton GPs once the issue of Nortondale was removed as part of the Tender Lots, even despite one of the Nortondale GPs stating they didn't agree with tendering NHS services as a principle. Thus, the Group 1 pragmatism was mirrored by Group 4 and may be supported by reflection of mutual technical expertise (common professional training and clinical occupation) and established personal relations over time. Again, there was little rational debate (thus limited power of argument) as to why Ellerton and Nortondale should be so different.
- The stakeholder code referenced wider relations and was in some respects a competing field of different groups seeking to use differing stakeholders as support for their case. Thus Group 1 appeared to own the support of the wider (largely Ellerton) GP community: as against Group 2 who described the risks to the relationships with others, particularly existing NHS providers. The aforementioned power of argument that the services needed to improve from that currently provided by the local FT, may have weakened Group 2's power in this dimension.
- The service design code was focussed on the design of a new service model and how this may support service evaluation through a process. It was largely a power of argument and probably seen as a mutual forum for discussion of development and not a ground for a power struggle.

It is proposed that this model can be applied to other strategic decision-making in the NHS and potentially much wider. The ultimate decisions made may reflect more the allocation of power and the creation of cultural hegemony within a group, than an objective assessment of what may or may not be the objectively best decision. The creation of the negotiated order then is the mechanism where the power relations take place and ultimate order the deciding point in what decisions are taken. As this model encompasses Simon's (1972, 1978, 1997) main rationality boundaries (cognitive limitations, information limitations, leading to satisficing behaviour), it is proposed that the model is a more comprehensive form of assessing bounded rationality within strategic decision-making. As the exertion of power and influence in decision-making reflects internal and external factors, of agency and structure, the model allows an effective means of addressing the research objectives.

Triangulating the power model with the original conceptual framework produced a synthesised social power model of the negotiated order within three framing levels:

Figure 25 - Social Power Model of Negotiated Order Within 3 Framing Levels

Thus, within the critical realist framework, the decision outcomes and the observed discourse appear within the empirical domain. The coalitions and behaviours of the decision actors in the practice of decision-making were in the domain of the actual. The social power matrix is the analysed theoretical mechanism that occurs in the domain of the real.

In concluding its development, the model may be tested against three criteria for a theory's adequacy as listed by Clegg (1989): exhaustiveness, independence, and consistency. The model is considered to be exhausted within the project as analysed in that it contains the elements of power demonstrated in the case but would allow the introduction of differing power dimensions within the three levels of framing. The model is independently verifiable within a stand-alone case-study framework, and although socially occurring can be assessed independently of other social phenomena. The model is considered to be logically consistent with the analysis presented from the literature review, the research data in the project, and theoretical analysis. Furthermore, the model is consistent with the dialectical approach (Winter 1989, p.49) in describing not a fixed state of affairs within the case study; but its emergence as a morphogenetic product from the socio-economic context, thus also describing how the social power relations, and their cognitive frames, will continue to change.

Chapter 8 – Implications for Strategic Management in the NHS

Blah, blah, blah

As a management practitioner, research may be of interest for many reasons; but to be truly useful it should inform management practice. Thus, for Freire (1998, p.30), "Critical reflection on practice is a requirement of the relationship between theory and practice. Otherwise theory becomes simply 'blah, blah, blah,' and practice, pure activism". As a practitioner 'pure activism' doesn't seem too dreadful, but for informed rational management decision-making, perhaps the learning from research and the theory it generates should be the ultimate aim. So not 'blah, blah, blah', but hopefully practical actions that may improve how organizations make their decisions, or at least make their decision-making.

Introduction

Following the research findings and developed theory this section describes the implications for management practice, applicable to both NHS organizations and management practice more generally. The issues identified here are not considered exhaustive but aim to select what appear to be the most salient points of learning from the research. One of the motivating factors in initiating the project was the desire to learn from the research to inform management practice and thus this chapter is seen as providing potentially valuable insights for management and leadership.

The chapter discusses the identified implications for management practice:

- The influence of evidence, its use and non-use on decision-makers.
- The role of emotion and intuition in the decision-making process
- How the presence of individuals within the decision-making process may affect outcomes
- Attitudes to risk management, including financial risk
- The potential benefits of scenario modelling as a management tool
- The roles of strategy and leadership

Influence of evidence, decision heuristics and external review

Evidential decision-making may be an appropriate aspiration for strategic decisions, but the quality of available evidence may vary, and on occasions lack high quality empirical sources. The 'hierarchy of evidence' as used in healthcare decision-making, particularly within the conceptual approach of evidence-based medicine (EBM) (Gray 2009, Greenhalgh 2010), may be a useful reference model for evidential decision-making in management (Briner 2014); however, it may not be easily replicated in complex strategic decision-making processes. Rarely there may be an equivalent source of evidence to a Randomized Control Trial (RCT), seen as the 'gold standard'

of EBM (Greenhalgh 2010). Instead in strategic decisions the available evidence may be in multiple layers of uncertain quality and volume.

The use of clinical decision-makers does provide a local, experience-based evidence form that may be useful where high quality evidence is lacking. In such cases, however, consideration may need to be given to the role of decision bias (Tversky and Kahneman 1974) and how decision-making bodies may mitigate against such biases. The composition of decision-making bodies may be important in this respect, and the selection and development of members of such bodies may need to explicitly accept a need to form balance. Thus, for management practice selection needs to consider the group as a whole, rather than merely selecting the most able or most qualified. For strategic decisions that require some element of clinical evaluation the use of external, third party expertise may be beneficial and guard against groupthink and group polarisation.

Local expert views as evidence can be appropriate (Gray 2009) but where they are not balanced by significant higher quality evidence it may be suggested that decision-making processes should use a formal collection of local expert views (thereby avoiding accusations of using anecdotal evidence) and possibly submit such local views to external evidential review. This may be dependent on timescales and where rapid decision are needed such review may not be possible. However, in cases such as this one where processes are mapped into a lengthier timescale such a formal external review may be helpful in attempting to create more objectivity. Balanced against this may be the need to act more quickly and not necessarily for all decisions to follow an evidence-based medicine model. (Goodwin 2011, reports frustrations expressed as to the NHS ‘obsession’ with the use of Randomised Controlled Trials, particularly in service change, where they may be seen as too slow and expensive.) Returning to the theme of complexity and ‘messiness’ (Pidd 1996), it may be inferred that in strategic decision-making an expectation of a precise role for evidence as providing a clear decision solution may be illusory[45].

This is not to say that the approach of evidential decision-making (such as Kovner 2009) or the tools of evidence-based medicine (see Gray 2009) have no value in strategic decision-making. But their use needs to be accepted as containing inevitable limitations. Strategic ‘messy’ decision processes may rarely produce a clear outcome as to what action to take: even so, transparency regarding the grounds supporting options and the reasons for decision should be as explicit as possible. There may be benefit in organizations seeking to promote actively the use of evidence, particular within management decision-making. A report from CIPD (2017) into the practice of human resources managers reported that of the 629 respondents, 26% rarely or never used management literature in support of decision-making; and 42% rarely or never used consulted results from scientific research. Although this sample may not be representative of managers in other organizations, such as CCGs, it may show a tendency not to seek higher quality evidence in management decision-making. This may further accentuate the bias that could be provided by a selective group of clinical

experts. Thus, the task for those overseeing strategic decision-making should include managing the use of evidence and the likely biases of those considered to be experts in their field.

Emotion and intuition as frame shapers

The Pizarro and Bloom (2003) position of intuition from experience as an explanation for much of the clinician decision-making, may be a more appropriate than emotion being a driver of intuitive decision-making. This is not to underplay the potential role of emotion in such practices, but rather not to underestimate the importance for some of the decision-makers of their long professional experience. Experience that may inevitably shape their views. This may be further emphasised by neurobiological research into the construction of human emotion (see Barrett 2017). Thus, for Barrett (2017, p.31):

> Emotions are not reactions to the world. You are not a passive receiver of sensory input but an active constructor of your emotions. From sensory input and past experience, your brain constructs meaning and prescribes action.

From this perspective, the decision-making process may not be seen as evidential vs non-evidential, or rational vs emotional. Rather it is to recognise the background experiences of individual and group decision-makers that will influence the decision process. This influence will shape how evidence is sourced and used, and where evidence is unavailable the non-evidential criteria that will be used.

As with the evidential point above, where an appropriate level of empirical evidence is lacking decision-making bodies will need to be aware of the influence of biases such as the availability heuristic (Tversky 1974). Where strong positions are established quickly in a process, as was seen by the views of Group 1 in this study, critical challenge should be applied to review any founding assumptions for their validity.

The role of intuition and emotion thus presents a challenge similar to the concept of 'conflicts of interest' (COI). COI is recognised in the public sector as requiring formal management (through declaration of individual conflicts, for example and as summarised in the National Audit Office report (NAO 2015)). Potentially this is of even greater importance during service procurement. The case study shows that it may be important to assess demographics, social background and individual opinion shaping within a decision-making group, not merely whether individuals have a directly obvious personal interest in the process. Again, the promotion of diversity in a decision-making group may be necessary to ensure optimal evaluation of options in a strategic decision. At the outset of a strategic decision-making process it may be helpful to audit the decision-making group and assess the composition, conflicts of interest, and perspectives of those involved. This may indicate whether external support would promote improved decision-making.

Similarly, whilst it may be a mistake to assume positions taken quickly in process are the result of simple emotion, when intuition and learnt behaviour may be the underlying

factors, there should be an explicit acceptance that emotion will be a factor in decision-making, strategic or otherwise. Healey and Hodgkinson (2017, p.112) suggest that "many organizations go about formulating their strategies and implementing them as if emotions do not exist". They recommend that organizational leaders should consider the presence and role of emotions in strategy, accepting, in their terms, that strategy will not be a cool, rational process, but actually 'hot' with emotion. This may confirm the benefits for senior managers in organizations having well developed emotional intelligence, as much as well-developed rational analytical thinking. Thus, if emotion is ever present and probably more obviously present the larger the significance of the decision, it may be helpful for decision-makers to be more explicit about how they feel about a decision subject and the options presented. The cognitive frames in use will, perhaps inevitably, be partly shaped by emotions. As such it may be helpful to try and openly identify the emotional factors in play.

Influence of collective presence

Testing the hypothesis of Cohen et al. (1972) the study confirmed that decision actors had variable levels of involvement (*presence*). Inspired by Bezemer (2014) the comparison of decision-maker input confirmed even more the variability of presence, acknowledging that this was the visible presence (what was seen and heard) not necessarily an invisible presence: that is more general and 'behind the scenes' influence. The summary table and graphs in chapters 4 and 5 demonstrate the range of 'presence' in the formal meetings of the case study. This clearly shows that, at least in the management meetings themselves, the input of decision-makers varied hugely.

Decision-making bodies may benefit from recognising the possibility of this variability and consider whether in certain circumstances some decision-makers could be removed from a voting process, if their background involvement up to that point is too limited. Thus, decision-making processes may need structured meetings arranging at the outset and clearer recommendations as to minimum input levels for decision-makers. It is unclear as to specifying minimum levels of presence will change the level of influence individuals or groups may have within a process.

The level of input from individuals should also be considered within the realm of meeting structure and agenda management (agenda management in its widest sense). In figure 20 the single biggest contributor was the Project Director. Often the large meeting contribution from the Project Director began with a lengthy introduction of a documentary business case and (on two occasions) PowerPoint slide presentation. The implication of this may not only be that it tends to allow the director/introducer of subjects to become dominant in discussion (at least in terms of contribution volume), but also that any subsequent debate will be framed to some degree by the introduction. Thus, if we add in the possibility of the anchoring heuristic, then for significant decision-making meetings the early framing of discussions may reduce the subsequent opportunity for wider discussion. Challenge may be important and necessary, but it will be only that: challenge to a previously stated position. And if

this position is contained within a formal presentation or business case it may be seen to be difficult to oppose, or at least that a stated position becomes the default. To improve management practice, it may be necessary to recognise this factor and, perhaps, introduce business cases later in meetings rather than at the start.

Differing attitudes to risk

Whist there was no suggestion from any parties that the decision did not involve risk, the attitude and appetite for risk varied significantly. The obvious difference was between the risk approaches of Group 1 and Group 2: within this distinction between the clinically focussed group and the corporate/finance focussed group. This may be seen to echo the entrepreneurial-manager distinction described by Busenitz (1999, and Busenitz and Barney 1997): entrepreneurs having a lower appreciation of risk and greater use of heuristics in decision-making. Similarly, Joyce (2015) describes the tension between elected politicians in the UK government wanting to take more risks (as with the CCG GPs) and their professional civil servants who wanted to counter-balance the risk taking. Again, this may suggest decision-making bodies should search for balance in their composition. Furthermore, clinicians/entrepreneurs may need to accept they under-estimate risk; senior officers may need to accept the reverse.

Organizations will need to discreetly identify their risk appetite within all strategic decisions. As prospect theory appears to be a well-established (if nevertheless still contested (Levy and Levy 2002)) decision-making concept, in strategic decisions it may be worth bodies recognising the risk asymmetry and assessing how individuals fit within an asymmetric risk assessment. This may allow challenge and review of risk positions and a resulting more consensual approach to corporate risk. A diagrammatic representation of risk as in the prospect theory value function (Kahneman and Tversky 1979, 1992) may provide a more sophisticated risk assessment than the conventional ‘impact multiplied by likelihood’ scoring system alone.

Importance of collective views in framing

The process involved in the case study did not include any explicit reflective analysis by the organization or the decision-makers. Although such reflections occurred as part of this study there was nothing planned within the process itself. Thus, a desire ‘to get on with the business’ may encourage decision makers not to consider what they are doing as they are doing it. Ron et al. (2006) discuss the use of post-flight debriefing of fighter pilots as a model for use in the ‘learning organization’ with so-called ‘after-action reviews’: “Post-flight reviews are first and foremost vehicles for learning from experience to improve individual, group and organizational performance” (Ron et al., 2006, p.1077). The apparently rich learning seen in the detailed study of actions through the research interviews may suggest there would be benefit in sourcing some of this type of reflection and analysis in the process itself. This may be unnatural to decision-makers but may support improved process management and organizational learning for future decisions. (The case study data included reference to a recent

procurement experience, which appeared to be significant for some participants: however, there was no reference to a post-procedure review of the process.) Therefore, this suggests strategic decision-making, particularly when occurring over an extended period, should schedule de-briefing sessions that review not merely the decision (or progress to decision) but actually the process of decision-making itself. Deliberate time for reflection in a strategic decision-making process may allow the greater explicit discussion of cognitive frames (even if not described as such) and thus the more open development of a collective view on cognitive framing. One may consider going even further and exploring whether there are opportunities for more explicitly merging techniques of management and research. Thus, the study of meeting behaviour and interviewer reflection sued as research tools in this project may be adapted for use 'in the field' to aid reflection and guard against sub-optimal decision-making practices.

Scenario modelling and 'pre-mortem'

Klein (2007) discusses the use of the pre-mortem technique (the hypothetical opposite of a post-mortem), seeking to achieve 'prospective hindsight'. This may be seen as a version of scenario modelling, but with a specific focus on decision-makers exploring what may go wrong. Such an approach be most useful when participants deliberately attempt to critique their own preferred option. Pre-mortem type analysis was not observed during the case study and there may be benefit in adopting the tool as a regular part of any major decision-making process. This may assist assessing risk in a project, accepting that different cognitive frames may produce a varying appetite for risk. Therefore, it may be worth organizations considering that alongside the development of decision option appraisals they may establish 'scenario appraisal'. After the selection of a preferred option organizations may benefit from a detailed pre-mortem analysis of what may be the negative and positive outcomes from the preferred option.

The use of alternative means of discussion decision subjects, such as pre-mortem, may allow a richer body of analytical information to be generated in a decision process. Similarly, Watson (2003) discusses the use of 'playfulness' in decision-making discussion, with a 'technology of foolishness' complementing more traditional rational approaches. This may be of particular assistance where decisions are very complex or where evidence is equivocal or absent.

Financial risk boundaries

The case study happened during a period of austerity and an atmosphere where the financial pressures in the NHS were continuing to increase. The CCG at the time, however, was still in relative financial health. The risk discussions in the case study were the main focus of financial consideration. The financial risk assessment was discussed and owned by the finance managers: but there was arguably insufficient detailed assessment of the financial risks. This seems to be largely due to the inexact

nature of the risks known (an obvious feature of risk itself) but without a degree of greater clarity it appears that the financial risks were only really owned by a group of officers in the process all of whom had some financial accountability. This despite the Governing Body as a whole having accountability for CCG financial performance. As the impact of austerity may bite ever deeper in the public sector, strategic decisions may benefit from a clear financial framework at the outset, including whether major changes can even be considered if they do not support financial improvement.

The need for strategy

Earlier it was recognised that in public sector bodies, strategy will have three main functions: long-term corporate plan; stakeholder communication device; and performance management tool. With the increasing focus on public sector performance management there may be a danger that strategy development will focus on addressing desired performance management objectives and become un-owned by organizational leaders, or so large and complex that clear strategic objectives are lost. This may be an example of Mintzberg's 'strategic planning not strategic thinking'. For management practice this affirms the need for organizations to have their own strategy; that corporate leaders and stakeholders recognise the strategic objectives as their own; and that the strategy and main objectives are clearly articulated. The decision process did generally follow the CCG's developed, published strategy. Although the research confirms the Cyert and March (1992) assertion that organizations tend to lack 'goal consistency', and that objectives are a "continuous bargaining-learning process" (Op cit, p.33), it does not reduce the benefits of strategy as an essential part of corporate leadership. Indeed, Cyert and March (1992) also describe objectives, rather than seeking to 'maximise' or 'minimise' outcomes, as providing an 'aspirational level' that may change according to circumstance. This is presented by them in terms suggesting it reduces the benefits of and need for formal strategy. The research here infers the opposite: the presence of diverse interest groups, uncertain data, conflicting political priorities, and a generally 'messy' organizational environment affirms the need for overarching strategy and strategic objectives. Moreover, despite the CCG being part of a wider NHS, it may be argued that any statutorily autonomous public sector body (CCG, FT, Local Authority) needs to perform its own strategic thinking and develop its own strategy. A strategy that, despite the presence of ambiguity and scope for interpretation, is owned by the corporate leadership.

The role of leadership

If the presence of the negotiated order as shown in the case study is a regular social phenomenon in organizations, one may ask whether its 'ordering' requires any form of coordination or orchestration. If it does, the follow-on question may be who the person in the organization is responsible for this facilitation. This role may sit with those in leadership positions, particularly CEOs and Board Chairs. Although some authors may propose that the concept of leadership is ambiguous (Pfeffer 1977), or that much of its

usefulness relates to its ‘romantic’ element (Meindl et al. 1985), there remains a belief that leadership is a necessary and important part of the modern organization (Hooper 2000, Grint 2010a, Joyce 2017). The NHS has developed examples of leadership frameworks to demonstrate how it sees leadership being performed and leaders developing (for example, see NHS Leadership Academy 2011). Such frameworks may include competencies that support the coordination and oversight of negotiated order, if not explicitly. They may not, however, recognise the benefit in considering an explicit role of facilitation and coordination of a negotiated order process, particularly when strategic decisions are being undertaken. The case study, by supporting the concept of the organizational coalition, may infer that in managing strategic decisions leaders may have limited scope for visionary leadership. Communicating a single vision to a diverse group of decision-makers, influenced by a range of forces, may be difficult. Rather the role of organizational leadership may be to act as coach, coordinator, umpire, and provider of balance. This may promote assessment from organizations regarding whether their leadership development supports effective working and facilitation with a negotiated order. Leadership development framework may over emphasise the role of the leader as director, planner, and motivator; and under-estimate the role of the leader as cultural navigator within the organization’s sociology. Joyce (2017) comments that during strategic implementation leaders may need to deal with organizational culture in one of three ways: ignore it; adapt the strategy to the culture; try to change the culture to fit the strategy. Such options may be a general choice for leaders in management practice. From this research, however, it may be inferred that culture may be a significant factor in major strategic decision-making processes: the negotiated order being, in one respect, the product of the factors of decision subject, corporate environment, and organizational culture. Thus, there may be benefits in leaders recognising (not ignoring) cultural factors; providing clarity as to strategic direction (but being aware of the possibility of needing to adapt strategy); and engaging in the negotiated order to support most effective decision-making. Returning to strategic decisions as messy and wicked issues, leaders may need to consider Grint’s (2010b, p.13) prescription:

> The leader’s role with a Wicked Problem, therefore, is to ask the right *questions* rather than provide the right *answers* because the answers may not be self-evident and will require a collaborative process to make any kind of progress.

An organization’s leadership may shoulder the major burden in seeking to achieve rational, evidence-based decision-making. Achieving this end may require understanding and working within the cultural context of the negotiated order. Consequently, well-ordered project plans may appear to manage the technical stages of strategic decision-making. For a process to be more wholly ‘rational’ and evidential, the leadership may need to consider a more comprehensive cultural decision-making framework, that recognises the presence of the negotiated order in strategic decisions.

Concluding thoughts on strategic implications

For those familiar with the concept of bounded rationality much of what is considered as the implications described above may be unsurprising. The limits to cognitive capacity and the variability of evidence may be thought to be sufficiently well established that senior managers should make accommodation for such limitations in managing major decisions. What may have been insufficiently recognised is that the composition of decision-making bodies will shape the rational boundaries. Thus, the role of clinical leaders in CCG decision-making has its own impact on the creation of the negotiated order and the dynamics of decision-making.

There does appear to be benefit in using more explicit and formal ways of detailing and discussing how and what evidence is used and how this may inform the use of tools such as scenario modelling. Similarly, as risk was a major factor in the case study this may be best treated by organizations seeking to agree a more uniform corporate risk position (even if negotiated) than by having a significant differential in risk assessment and appetite across decision-makers.

The roles of strategy and leadership confirm the need that for strategic decisions to be as effective as possible it may require high quality senior management following good practice in larger-scale, longer-term thinking; supported by meaningful leadership of the organization and its major stakeholders. Fundamentally, the research also demonstrates the facet of strategic decision-making being a process and not an event. The concept of *decision-making process* has been used and evident throughout: however, it is important to recognise that the management of decision-making needs to address the process as a process, and not just as a series of discreet elements. Thus, for Witte (1972), "the organization of a process affects the efficiency of this very process". Those engaged in and particularly those tasked with leading and overseeing decision-making may need to manage the whole process and recognise the processual nature of the task. Improving, for example, the volume and quality of available evidence may not necessarily improve the decision outcome if other parts of a process provide equivalent distortion. The process as described in the research data and the resulting social power model suggest improving decision-making may require a balanced approach to understanding the power dynamics at play, an explicit recognition of individual and group biases, and a need to structure and manage the decision process as an organizational process.

The structuring and management of the decision-making process may also need to take into account the type of decision at play and how a process relates to the available evidence. Thus, decision-makers may be confronted with various different types, four that require differing approaches may include:

a) Operational with strong established evidence base and with clear decision point.
b) Operational with established but possibly equivocal evidence base, where context and situation may be important.

c) Operational or strategic with equivocal evidence base, various contextual factors, but clarity on desired outcome and available resources.
d) Strategic with a weak, equivocal or generally complex evidence base, multiple environmental and contextual factors, and uncertainty as to desired outcome and available resources.

For a) research suggests (Meehl 1954) that the use of expert opinion is best served in developing algorithms to allow step by step detailed decision-making, which are then administered by a neutral administrator or computerized system (actuarial decision-making). Removing the individual or group discretion from the process allows more rigorous application of the algorithm with evidently greater decision success.

In b) type decisions where, “the state of the world conforms to the expert’s assumptions” (Schwenk 1990, p. 172) it may be more effective to have one or a group of experts in a particular field. In such cases a degree of discretion and choice may be beneficial and simple algorithms not sufficient to cover all eventualities or to recognise the importance of context.

For type c) decisions requiring the evaluation of evidence and options related to a defined outcome would suggest group decision-making may be more effective with a diverse group providing more consistent evaluation of evidence (Blinder and Morgan 2000, Lombardelli et al. 2002) or where the collective knowledge base allows more sophisticated assessment of options (such as in healthcare multi-disciplinary teams, Gray 2009).

Decision type d) may be described as the 'true' strategic decisions. That is, they are complex, multi-factorial, involve multiple agencies, with an uncertain evidence base, with conflicting assessment of the desired outcomes. Such a type is thus consistent with our definition of strategic decisions as described in the literature review and matches labels of strategic 'messes' or 'wicked problems'. In such cases it appears beneficial for these decisions to be taken by a wide group of agents with diverse knowledge bases. The role of evidence here is important, but based on this research one may suggest two sub-categories:

d1) may be complex strategic decisions where there is a significant body of evidence. This evidence base may be complex, equivocal, and subject to debate amongst decision-makers. As such this would not comply with the definitions of types a), b), or c) above. Nevertheless, with detailed analysis further clarity may emerge, particularly if the analysis occurs within the context of the organisational strategy. There should be no expectation that 'crashing obviousness' may emerge, but that with a diverse range of experts and stakeholders there may be a more evidential decision that can be seen as more rational and more likely to achieve corporate objectives.

d2) may be types where a significant body of evidence would be ideal, but either largely absent or widely variable such that limited conclusions could be drawn from the presented information. The case study in this research may fall into

this definition. Further research may be required as to how best to manage such cases. From this research one may hypothesise that with a weak evidence base, and where there is not a very short timescale, decision-makers should consider accessing a wider range of experts and partners to develop an evidence base, even if a lower quality local base of practitioners and service users. In this case study the patient and public engagement occurred before the case study phase as part of service specification development. There was no active engagement of the public or wider partners during the case study period itself. In some cases, such as this one, consideration may need to be given to the complexities of market tendering, and conflict of interest. But that may not be a sufficient reason not to look at a more widespread way of generating evidence to support a decision.

From all of the above we may suggest that one practical implication for decision-makers is the benefit of stratifying decisions into the types that allow consideration as to the available evidence. This would infer that there should be differing approaches to decisions, based on the type and that a 'one size fits all' approach may be a sub-optimal way to conduct decision-making. For strategic decisions in particular a differentiation between d1) and d2) may improve decision-making. This may immediately appear counter-intuitive to organizations who may assume they need decision-making consistency: in reality such differentiation may tailor the right approach to the needs of specific decision types.

Chapter 9 – Conclusions

Introduction

The final section ends the project with a summary of the main conclusions from the research and the considered original contribution to theory. Discussion is also provided as to opportunities for future research and areas for management learning from the project.

To succinctly answer the research question, one may state: the factors that influence strategic decisions in healthcare commissioning are those that emerge within the creation of the negotiated order in the organization. Thus, there will be external, internal, group, and individual influences at play: but how they actually influence the outcome of a decision will be shaped by the interaction of the group dynamics, hypothesised here as the activities of the social power model. Thus, the level of influence of any particular factor will be related to its level of power in the process. The level of power related to the particular form negotiated order in the decision praxis.

From this summary we may further conclude that:

- There is something observed that fits the description of the negotiated order
- This process of constructing the order is the driver for the ultimate group decision outcome
- This outcome is considered to be primarily the result of the distribution and accommodation of power within the decision-making group.
- The power struggles and negotiation may be demonstrated through a combination of ‘deal-making’ accommodations and competitions between different cognitive frames.
- The beneficial impact of clinicians being a significant voice within NHS commissioning may be as yet uncertain and whilst probably bringing advantages, may also expose other possibilities for bias.
- The variable presence of evidence in strategic decisions may need to be explicitly recognised. Although in such decisions value-neutral evidence may be difficult to establish, there appears little reason to avoid a rigorous search for available evidence and where an initial search provides limited results widening evidence collection within the decision process.
- There are a number of areas where decision-making may be improved, but there may need to be a real-world recognition of the role and place for emotions, biases, and the phenomena of bounded rationality.

The negotiated order is alive and well…

…and thriving in the world of strategic decision-making. The recognition of a negotiated order is not a novel finding. It may be concluded, however, that for strategic decision-making processes (involving scale, complexity, and uncertainty) all decision will be the outcome of negotiation. The negotiation between different groups (sub-

coalitions) and multiple cognitive frames may tend to have three types: developmental (where the discourse synthesises different frames and ideas to produce improved understanding or better action planning); competitive (where discourse is between competing frames and the process will resolve the dominant theme); and accommodative (where the discourse allows pragmatic adjustment of position to accommodate multiple groups or frames).

If information is 'knowledge made visible' (Orna 2005) then the study of texts and language use made discourse the means of allowing the creation of the negotiated order to become visible. Although, inevitably, there may have been latent powers, opinions, and relationships not visible in the discourse: the conclusion of the research is that analysis of the discourse allows the struggles, interactions, partnerships, and disagreements to be realised to the researcher.

The research began with an attempt to explore strategic decision-making through the prism of the negotiated order: the organizational phenomenon perceived as being critically important in organizational behaviour. Strategic decision-making in the case study was not seen as a finely tuned rational process, but a dynamic social struggle. This was a struggle to achieve a better service outcome for patients that all decision-makers would agree with; however, the influences demonstrated the role of negotiation and of how coalitions with a process may emerge. Furthermore, decision-making participants will not come to a process with a wholly neutral approach to the task. Watson (2003, p.101) suggests that decisions are events where people consciously or consciously seek to "fulfil duties; meet commitments; justify themselves; distribute glory and blame; exercise, challenge and reaffirm relationships; seek power and status; further personal interests; simply have a good time". Thus, the constituent parts of the negotiated order re-form (morphogenesis) based on the structurally, contextually dependent power relations. It is this process that is proposed as the prime mechanism for strategic decision-making in CCGs.

It may also be noted that the composition and variable commitments of CCG Governing Body members may amplify the feature of negotiation. Thus, the of the 13 voting Governing Body members in the study, only three were full time employed members of the organization. The other members had time and related financial commitments typically of approximately one day per week, with their other time being occupied in their main employment relationship (for example working as a partner in a GP practice). The seniority of the decision-makers, their variable time commitment, and diverse employment relations with the CCG may all result in active negotiation being an inevitable part of any decision-making process. As a comparison, in the study of Midlands clothing factories, Ram (1994) suggests factors tending towards avoiding rigid bureaucratic approaches and thus promoting the high degree of negotiation, are that many are small business, with complex ethnic, familial, and cultural relationships.

As is described in the implications for management chapter above, recognising the presence of the negotiated order may necessitate adapting the processes for decision-making in cases of strategic complexity. The social power model does not suggest

evidence-based analytical thinking is negated in strategic decision-making: far from it, as decision makers looked for and wanted to use evidence. Of the decision-making models described in the literature review, the case study may be seen as most consistent with the assumptions of the Garbage Can model (Cohen et al. 1972): the uncertainties of participants, problems, and solutions ‘resolved’ through the discourse of the social power model. Ultimately, the presence of the negotiated order may echo Watson’s (2003, p.102) comment that, “managerial work is essentially social and political rather than fundamentally analytical”.

Influences presented as cognitive frames

The influences hypothesised in the literature review explored in the data could be seen as discoverable through the cognitive frames presented in the analysed text. The frames were variously: influences on decision-makers (the strategic contexts within which the process operated); already present in the decision actors; and created through debate and the interchange of power relations in the process. The importance and primacy of the various frames may be related to the strengths of the different power relations present. Thus, the discernible frames in any strategic decision-making process will ultimately be produced from the process itself, accepting that such a process will have significant external influencing factors. The negotiated order, consequently, becomes the synthesis of the various cognitive frames. The synthesis involving: the selection of competing frames (that represent the different conflicting social groupings); the integration of potentially complementary frames (representing possibly a higher level of developed cognitive frames through rational discussion); and the reconciliation of alternative frames either through partial substitution or integration (this representing the pragmatism inherent in establishing coalition – the broader the coalition, the more extensive the likely level of pragmatism).

The mechanisms identified in the research described in the social power model do suggest that Watson (2003) may be correct in asserting that managerial work is more social than analytical. In which case the process of negotiation includes cognitive frames that are ultimately managed socially, rather than analytically. This is not to suggest an absence of analysis, but again to reference the bounded rationality concept, that scope and quality of analysis will be socially directed, so driven by any inherently objective reference point. For example, the decision-makers will decide what is useful evidence to consider: the evidence itself will be silent. The decision on what and how evidence is used driven by the force of external framing, and the pre-existing views of those tasked with deciding. These forces evaluating evidence and information not necessarily against objective criteria alone, but within the perspective of cognitive framing.

Strategic thinking may be difficult in a complex environment

Although the modern concept of strategy includes much beyond mere planning, it seems helpful to reiterate that a necessary element of strategy is producing an intentional plan. Recognising that there may be good and bad strategies, the presence of a coherent and, in principle, agreed strategic direction may help organizations avoid strategic decision-making becoming a series of ad-hoc, disconnected events. Furthermore, it may mitigate the impact of the social power struggle, if the participants are at least working within a common strategic framework. Thus, corporate strategy at an organizational level seems to remain important. That said, the case study suggests that as participants engage in decision-making they quickly move from strategy to implementation and the technical issues of achieving a solution may take over from a considered discussion of options. In this sense Keeney's (1992) comment regarding values, whilst important, may miss the point. Values are important, but unless values are codified into a coherent corporate strategy which is at least the basis for coalition development and negotiation, decision-making may be driven too much by individual value systems, with a consequent distraction of organizational purpose. As such the research appears to reaffirm the need for clarity in strategy development. For the author this suggests that even in a very heavily (centrally) directed political environment, each organization and leadership team needs to perform strategic thinking and develop its own strategy. The dynamic clinician-manager dynamic may suggest this is certainly true for CCGs, but one may suggest that any organization with tensions between technical experts and managers or between entrepreneurs and managers may benefit from an overarching narrative on the direction and scope of the business. This research suggests, however, that whatever the quality and nature of a strategy, in implementation and decision-making its objectives and principles may still be continually debated and negotiated.

The role of clinical leaders within clinical commissioning

This study is one of the first (possibly the first) to analyse strategic decisions in CCGs. It is suggested that the composition of the Governing Body, by involving a large number of local clinicians, does provide a richer decision-making discussion. This appears consistent with the intentions of the original 2010 white paper, which stated:

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

What is unclear is whether devolving power closer to professional who work most closely with patients necessarily produces decision-making more in patients' best interests. There was no sign that clinicians were involved in CCG decision-making merely to rubber-stamp decisions proposed by professional managers. The clinical leaders brought a strong voice as to how services should be improved and demonstrated a willingness to take risks in pursuit of better patient care. Again, this

may be seen as being in the spirit of the white paper and the 2012 act. What is less clear from the case study is whether the clinical voice present is an appropriately balanced clinical view. Furthermore, does the presence of clinicians on a decision-making body give the committee a distorted picture of what that clinical view represents. Thus, GPs are only one group of clinical staff, with a clinical view influenced by their experience and professional position. If the management of service planning and redesign, within a broader category of commissioning, is helped by significant clinical involvement (and it may be uncertain that it is) then there may be a case for redesigning the commissioning organizations (in this case CCGs) to encompass a much broader clinical composition than the current GP preponderance.

Two considerations do emerge that may need attention from the NHS: one on the differing attitudes to risk and the other on the use of evidence.

The differing risk appetite, in echoing the entrepreneur-manager and politician-civil-servant dynamics (see above), may need to be measured against the strategic objectives of the organization. Accepting greater risk in pursuit of improved healthcare may be appropriate, but the risk quantification may need balancing against corporate survival. Importantly, the GPs in this study, as in most CCGs, were part-time contractors with the CCG and all received their main sources of income from other areas (usually their own general practices). Thus, risk taking to improve services that are close to a GP's own area of work and influence, that is their general practice, may seem more acceptable and generate a greater risk appetite. A more balanced assessment of risk for the organization as a whole may produce a different approach.

The role of evidence in strategic decision-making

As described in the implications above, the varying level of empirical higher-quality evidence may shift the focus more towards the experiential, expert evidence provided by Governing Body clinicians. This may not be mere anecdotal evidence; but reflect a sound assessment of local experience from senior clinical leaders. Nevertheless, just as the published, higher quality evidence represents a "selective and biased subset of study outcomes" (Chan and Altman 2005, p.1), thus the views of local clinicians, whatever their attempted objectivity and validity, may also be a biased subset. The large body of work on heuristics and biases (for example, Kahneman 2012, Tversky and Kahneman 1981, Tversky and Kahneman 1974, Tversky 1974, Stanovich 1999, Slovic 2004) provides strong evidence supporting the assessment of boundedly rational decision-making influenced by such biases. Consequently, the benefits of local clinical input providing a championing role for the 'family doctor' must be weighed against the likely bias such clinicians may have on any decision subject. Particularly so where high quality evidence is weak, and where strategic decisions are at their 'messiest'.

The case study may be seen to be another example of actors acting with incomplete information. Furthermore, although in complex 'messy' strategic decisions individual agents may never possess complete (or even close to complete) information, the

decision-making group may get closer to a holistic view if it considers the information and evidence in totality. This is expressed in a classic paper by Hayek (1945, p.519-520):

> the problem of a rational economic order is determined precisely by the fact that the knowledge of the circumstances of which we must make use never exists in concentrated or integrated form but solely as the dispersed bits of incomplete and frequently contradictory knowledge which all the separate individuals possess… Or, to put it briefly, it is a problem of the utilization of knowledge which is not given to anyone in its totality.

Thus, one conclusion for the case study is to confirm that narrowly 'super-rational' decision-making utilising a full view of all available and necessary evidence may be rarely if ever possible for large-scale, complex, that is *strategic*, decisions. Whilst this is scarcely a new or original conclusion (as demonstrated by Hayek (1945) and Simon (1972)), it may be worthwhile recognising this limitation at the outset of strategic decision-making. The recognition of the limitation, however, does not justify abandoning a search for evidence or attempts to use what evidence does exist. It may require, though, there is explicit acceptance of framing. Evidence will rarely appear as value neutral (crashing obviousness a rarity in organizational decision-making at a strategic level). Rather the presentation of evidence will influence its interpretation. As discussed above in chapter 8, bodies may need to give consideration as to whether the structuring of decision-making processes may need to be amended to reflect the evidence available to decision makers.

The social power model may assist in understanding how the negotiated order creates framing patterns. This may be particularly so if effective group engagement is seen as a more effective means of achieving rational outcomes. Mercier and Sperber (2011) discuss how more rational thinking can be achieved by *argumentation*, whereby individuals analyse and assess proposals through discussion and structured argument. Thus, "people are quite capable of reasoning in an unbiased manner, at least when they are evaluating arguments rather than producing them, and when they are after the truth rather than trying to win a debate" (Mercier and Sperber 2011, p.72)[46]. Consequently, evidence-based rational debate may be most effective where decision-makers are primarily those evaluating proposals and not merely promoting a position. The social power model may allow decision-making processes to assess how analysis can shift to rational evaluation away from partisan solution promotion. Nevertheless, decision-makers may need to still recognise that where decisions are genuinely strategic, they may be complex, messy, and thus with rationality strongly bounded. The thesis may infer that: where the power of argument is driven by limited high-quality data and limited access to wider knowledge (low power of information), the powers of position (organizational or reputational) and relations (professional or personal) will be stronger. One may hypothesize that in such circumstances organizational decision-making becomes super-bounded.

Contribution to knowledge

The thesis confirms the original contribution to knowledge as forecast at the beginning of the project. The contribution is considered to be significant in the areas of:

- The use of participant observation as a research method.
- The reflexivity of the researcher within an ethnography
- Developing the concept of the negotiated order and in particular the dimension of power usage within it.
- The exploration of decision-making within one of the recently established NHS CCGs.
- The development of management learning and practice

There may be, at the time of production, no equivalent research into either CCG senior leadership behaviour or the progress of a strategic decision-making process of this kind. The access gained into the CCG may be difficult to replicate to the same degree and thus this study may remain a novel form of ethnographic investigation into an NHS organization of this type. It may also remain a relatively novel contribution to management and organizational literature, as there may be that few senior corporate leaders that will conduct such participant observer research. It may be seen as a potential model for this type of ethnography and could be seen as an exemplar of how an organizational leader may participate in studying their own organization. As such the research may be seen as an example of the 'insider account' approach to ethnography (Hammersley and Atkinson 1995) or 'practitioner ethnography' (Hammersley 1992) but at a more senior level than previous accounts (such as those cited by Hammersley and Atkinson 1995). Returning to the Bryman and Bell (2003) descriptions of different roles of participant observer, the project may prompt the question of whether another type of role may be necessary. Thus, although the 'complete participant' (Bryman and Bell 2003) may be consistent with the approach taken in the study, the general role described in ethnographies may still often see the researcher as ultimately distinct from the field of study. In this project the researcher was not only an active participant completely within the researched group: they were very much embedded as an experienced and well-established organizational leader. Thus, if one of the features of ethnography is "intense researcher involvement in the day-to-day running of an organization" (Bryman and Bell (2003, p.315) this was obviously evident in this study. It may be seen that the research provides an unusual example of researcher intensity due to the position of the researcher. Moreover, there may be cause to refine the participant researcher typologies as described in research methodologies (for example cited in Bryman and Bell 2003). Here the description of 'complete participant' may be inadequate. A more accurate term may be the 'embedded participant'. Previous research of this level of depth in an organization may be limited. Ram (1994) may be seen as playing a similar role through exploring the behaviours in small companies (although the cultural factors arguably limited access), but there may be no obvious equivalent in the NHS or wider UK public sector. We propose that consideration is given to exploring the embedded participant as a sub-

genre of ethnography. Although this may remain a small area for research due to the limited number of likely embedded researchers, it may still provide genuinely original insight. Hammersley and Atkinson (1995) cite positive examples from education where the practitioner researcher has been used. This has produced, “research that is more relevant and also transforms teaching” (Hammersley and Atkinson 1995, p.136). From this project may be argued that similar practitioner research in management, at a very senior level, may improve both the understanding and the practice of management. The research method employed here may be seen as a model for the embedded participant researcher role and an original contribution to the development of ethnography.

The explicit reflexive critique by the participant observer may be seen as a valuable addition to the development of understanding reflexivity and of the role of the active participant in ethnography. Van Maanen (2011a) describes three categories of ethnography: realist; confessional; and impressionist. The current ethnography may be seen initially, as providing a confessional element through its reflexivity, but within an overall realist framework. On further reflection one may ask whether the ethnography as presented here may fit within Van Maanen’s (2011a) definition of the impressionist tale. This would still be within a realist framework, but the combination of researcher position, reflexive critique, and detailed discourse analysis of the conversations occurring in the case study may be seen as a rich and complex picture of organizational culture:“ Impressionist tales typically highlight the episodic, complex, and ambivalent realities” (Van Maanen 2011a, p.119).The research thus provides a valuable contribution to the reflexive approach developing further the theoretical position of Archer (2003) and the ethnographic research methodology of Hammersley and Atkinson (1995). This supports the development of participant observation ethnography as requiring a reflexive element (see above). More widely this also allows examination of how reflexivity within organizational research may be developed and explored, but within an appropriate (and possibly realist) conceptual framework. Thus, reflexivity is beneficial as supporting the development of theory, not merely as a means to allow personal reflection or management autobiography.

In seeking to answer the research question as to decision influences the exploration demonstrates an original examination of the range of influences present. Although the stratification of frames into three levels is clearly an established technique (Cornelissen and Werner 2014), this project provides an original application and by aligning the frame stratification with the use of the negotiated order shows a rich analysis of the decision-making environment, the influences on it, and how the order itself generates influences. It is proposed that the understanding of the negotiated order and, in particular, the exploration of the power dimensions occurring within the specific influences on a public sector body, is an original and significant contribution to theory. The sociology of board level decision-making is clearly demonstrated, and the resulting theoretical production of a social power model may be seen as an original and valid analytical model that can be used to explore decision-making. The model further develops the concepts of power in organizations (as previously described by

Clegg (2006) for example), bounded rationality (Simon 1997), and the negotiated order (Strauss 1963, 1978). In these respects, the analysis of the research is a detailed exploration of the sociology of organizational decision-making in a CCG: this being unique as a study and an application of the negotiated order concept in a novel way. The negotiated order here is a tool to understand board level decision-making social relations and the research is a twenty first century application of the concept at an upper-echelon (board) level. It may be speculated that this research takes the early conceptual developments of Strauss (1963) into a more mature organizational form in a new millennium. Furthermore, the sociological approach to organizational dynamics is a novel development of the type of behavioural analysis, developed by Watson (2003) for example. This analysis is not just an updating of earlier negotiated order research, but a fusion of decision theory, particularly bounded rationality, with organizational social dynamics. The conclusion from the analytical models and the emerging social power model is that many influencing factors will be involved in shaping the outcomes of a decision process. These will include evidence, the wider social environment, and the specific situation of the decision agents, be they individuals or organizations. Although all these factors will be as important, possibly as significant as any will be the power dynamics within the decision-makers. As such the research confirms that any normative model of decision-making, such as being based on evidence for example, must still recognise the role of power in affecting the decision outcome.

The emergence of the CCGs following the NHS reforms allowed the UK health system to test the benefit of decision-making bodies populated with a majority of clinicians. This study may be the first to explore in detail a decision taken by such a body and thus allows an original consideration of the organizational dynamics that such clinical preponderance may promote. As the NHS, and indeed healthcare management internationally, explore the role of medical professionals in decision-making, this study may usefully inform how the management roles of clinicians develop. The various papers discussing NHS boards (as described in the literature review) may not explore the impact of clinical input and thus this research does allow discussion as to how clinical involvement may affect the decision-making process. Consequently, one may infer that this research is the first that explores the impact that GPs in positions of decision-making authority in the NHS may have; and the implications of such a position of responsibility may have for the NHS in future. Clinicians may bring multiple benefits to a health commissioning decision-making process: but this may come with its own complications and costs. The study provides a detailed case study demonstrating some of the dynamics that may be present when there is clinical involvement in senior decision-making.

It is suggested that this work may inform further understanding of organizational theory and assist in developing management practice. The implications for management practice described in the thesis provide a further contribution to management knowledge with practical benefits to future management practice and research. The implications for management practice from the research reinforce a need for more

consideration to how strategic decision-making is conducted (as described in chapter 7). It is not entirely clear that NHS organizations (or the wider public sector, or indeed organizations at all) are sufficiently reflective and reflexive[47] on their practice and thus able to learn from experience. The fighter pilot de-brief example (Ron et al. 2006) may or may not be particularly applicable to settings such as a CCG, but there is, nevertheless, benefit in organizations understanding how they can be more reflective. There may also be a case for challenging academic institutions, business schools in particular, to be more practice focussed and to embed themselves in the corporate world. Consideration may be given to whether the research conducted here could be used as a model for strategic reflection and organizational development, facilitated by input from business schools. Thus, during the process of the current research project and previous post-graduate research the author has been reminded of the need for work to be appropriately 'academic'. Arguably business schools need to be challenged to make sure that, despite the need for academic rigour, their research is practice based and potentially useful for the business environment.

Areas for further research

In following up on the case study subject it would be interesting and beneficial to conduct a retrospective study of the action taken following the decision point in the study. This would inform the links between decision-making and implementation and show how the power relations and negotiated order played out after the decision. It may also be beneficial, bearing in mind the question focussed on the influences on the decision-making process, for further research to investigate with some of the external agencies to the CCG their perspectives on the decision taken.

The author would recommend researchers and a sponsoring business school consider a longitudinal piece of research over an extended period where organizational behaviour and strategic decision-making can be analysed over a longer time frame than this study. Although the CCG under scrutiny is not considered atypical, there may be some peculiarities in the organization that limit the ultimate generalizability of conclusions from this research to a wider organizational scope. Thus, one avenue for further study would be conduct a similar ethnography on a major decision but across two organizations simultaneously. A recent development in organizational thinking has been that of institutional logics (Thornton Ocasio 2008). This has been applied to the different approaches of professional groups in healthcare (Reay and Hinings 2009) and may provide a further sophistication to analysing the negotiated order in healthcare bodies. Due to the politically agenda driven nature of the NHS and wider public sector, this may be relatively straightforward to design. Gaining access to the decision makers and appropriate fora may be more difficult.

Reflections on healthcare decision-making

The ambition to improve the quality of healthcare whilst working within restrained financial resources remains one of the fundamental challenges facing healthcare

systems. This challenge, working within a currently ever difficult financial environment, provides the paradox that strategic commissioning decisions will become ever more important; but be taken in an increasingly complex and uncertain context. For those charged with the responsibility for decision-making passion may use reason as its tool. But a tool to help achieve the best outcomes for the passionate desires and not merely an excuse to justify decisions from emotion or prejudice. Sapolsky (2017) infers that rational reasoning and emotion are not antagonistic in human thinking but rather complementary:

> But while emotion and cognition can be somewhat separable, they're rarely in opposition. Instead they are intertwined in a collaborative relationship needed for normal function, and as tasks with both emotive and cognitive components become more difficult (making an increasingly complex economic decision in a setting that is increasingly unfair), activity in the two structures becomes more synchronized. (Sapolsky 2017, p.58)

(This complementary relationship is demonstrated in experimental decision-making research by Bechara et al (1997) based on the somatic marker hypothesis, described above.)

Passion and emotion in decision-making should not be ignored or side-lined: they should be celebrated. To allow their celebration, however, organizations need to allow reasoned argument to have its place for the decision-making process to be as rational as it can be, bounded or not.

The complex, ever-changing nature of strategic decision-making may be described as dynamically dialectical or just plain messy. Either way crashing obviousness may be in short supply. The power struggles of different interest groups and external pressures making claims to objectivity they may not deserve. This social nature of the decision-making process is reflected in March (1988, p.14):

> Decision-making is a highly contextual, sacred activity, surrounded by myth and ritual, and as much concerned with the interpretative order as with the specifics of particular choices.

Consequently, the task for those tasked with the decisions, navigating through the dark and tangled stretches, is nevertheless to construct processes that rise to the challenge as rationally and as (nearly) objectively, as they can.

The view from the battlefield - Final thoughts of the researcher

The thesis and its associated research project have been a journey of learning and exploration. My original motivation was to gain greater understanding of decision-making in the NHS. Building on my masters' research into the use of evidence, there seemed a benefit in studying the actual practice of decision-making. This progressed to the use of the negotiated order concept as an interpretive frame: a focus on the process of coalition forming, deal-making, and power struggle within the dynamics of the organization. The subject of analysis was primarily that of language: that used in

the discussions and reported observations and the texts available throughout the process. At this point the research explored the negotiated order behaviours in the case study. Methodologically the research started out considering the larger concepts - social structure, corporate strategy, organizational environment – and through analysis moved into the micro-foundations of the case study – codes, memes, tropes, various index words. The process of analysing research data then allowed a return to considering the strategic oversight of the subject (the ‘bigger picture’). This analytical cycle was consistent with the research methodology.

Certain observed phenomena arising from the analysis were expected: the acknowledged presence of differing coordinated groups; the shifting positions and deal making; and the emergence of particular concepts (discovered as research codes). Others emerged after the analysis of the data. Thus, power was identified as a mechanism in forming the negotiated order at the outset, but the analysis suggested this may have a greater importance in the dynamics of the organization than first thought. Thus, along with the general return to the literature as the data was analysed, it was necessary to explore in depth organizational theories of power. This supported the creation of the social power model and for the author showed that in the process of organizational work, consideration should always be given to the concepts or power and influence: where it appears; who holds it; and how it is used. This assessment may be useful learning for the NHS Chief Executive: at any important decision points or when there is a need to drive through an objective or piece of policy, understand where power lies and how you can manage the distribution of power.

The re-assertion of the importance of organizational strategy was, to the researcher, a surprising conclusion. At one level this learning was mundane: at another a certain moment of clarity. A complexity of the public sector is the lamination of authority: thus, the NHS commissioning system at the time of the case study had a national, ‘parent’, body (NHS England) and a series of local bodies tasked with enacting the national direction for healthcare (the CCGs). One could, therefore, ask whether there is a need for a genuine CCG strategy: isn’t it really just the job of CCGs to implement the national vision (5YFV at this juncture)? For the researcher at least, the case study seems to confirm the need for statutory organizations to have their own strategy: inevitably informed by a national direction, but locally sensitive, and, just as importantly, owned by those to whom it should be important.

The ownership of a meaningful strategy related to the desired outcomes of the corporate body and its stakeholders is considered important. Its development and ongoing practice will occur in a complex environment. This environment may often not provide a clearly objective assessment of what can and should be done. Such objectivity may be difficult if not impossible. In complex, messy, and muddy waters features which appear obvious to all may be difficult to find. But in the absence of ‘crashing obviousness’ strategic decision-makers should not abandon the search for objectivity and the use of a scientific method. This may be influenced by the higher level of clinical input in the CCG decision-making process.

In my MBA thesis I used a reference to Richard Dawkins (2005) Ancestor's Tale as a comparison of how animal evolution may be compared to organizational behaviour. Here I used the example of the somewhat bizarre looking star-nosed mole: a creature that looks very odd, but whose anatomy is perfectly configured for its living environment. My conclusion was that in organizational decision-making, as with evolution, "an animal is the way it is because it needs to be" (Dawkins 2005, p. 250). Although I recognise this assertion may still be partially valid, probably only partially. It may be important that organizational actors do not have too deterministic view of their world, and how they use the available resources at their disposal in the quest for improvement. This brings to mind not the tale of the star-nosed mole, but the tale of the duck-billed platypus. This is another animal whose evolution makes them superbly adapted for their environment. Specifically, their bill has a major and very sophisticated function:

> The point is that the platypus bill is not just a pair of jaws for dabbling and feeding…But far more interestingly the platypus bill is a reconnaissance device…Platypuses hunt crustaceans, insect larvae and other small creatures in the mud at the bottom of streams. Eyes aren't much use in mud, and the platypus keeps them tight shut while hunting. Not only that, it closes its nostrils and its ears as well. See no prey, hear no prey, smell no prey: yet it finds prey with great efficiency, catching half its own weight in a day…They switch off three senses which are important to us (and perhaps to them on land) as if to concentrate all their attention on some other sense. (Dawkins 2005, p.284)

The lesson here may be that switching off the senses when only one is needed may be optimal. Switching off other sources of information and relying only on one (or principally on one), when it is not clear which is the most useful, may be less than optimal. Thus, for CCGs the rich and valuable information provided by local clinical leaders may not necessarily be of such quality that it should result in closing 'eyes…nostrils and ears as well'. As a corporate executive of a clinically led NHS body it prompts me to understand how to utilise the insight of clinicians without such insight becoming a distortion. Use the duck-bill but keep the eyes and ears open.

Finally, the project has continually presented me with an image of my internal polarisation. That between me the social scientific researcher, fascinated by the complex, living tapestry and tangled webs of human behaviour in organizational sociology. As opposed to me the healthcare manager, who regardless of the sociology and the interesting observations, wants to find practical ways to make decision-making better. Without crashing obviousness, the path of strategic decision-making may be complex and messy. It should still be driven by the passions of those making the decisions, but beneficially the passions need to be managed within a wider corporate approach. For the management leaders in the organization the process needs to provide sufficient development of strategic thinking to work against anecdote and bias. But also, to recognise that the process of 'negotiation everywhere' may be ever-present and a critical role is then to manage the process of negotiation. A negotiation

that could involve the expert, the ill-informed, the interested, the unconcerned, the present, and the absent. The practice of discourse may not, however, imbue any special status to expertise, information, interest, concern, presence, or absence. Discourse may, nevertheless, demonstrate that all are engaged in negotiating the organization's order. The role of the organizational leader in this environment, perhaps, is to not to attempt to 'manage' or control the process (this may be very difficult or impossible) but rather to facilitate consideration, challenge, and debate. Ultimately the factors influencing strategic decision-making will emerge in the dynamics of the negotiated order. The degree of influence of the factors in play a feature of the power balances of those creating the negotiated order, driven by reason and passion.

Glossary of definitions used in the thesis

Bounded rationality – the limitations imposed on actors in organizations (‘organizational man’) the constrict their level of rationality in decision-making, specifically, their cognitive ability, the quality of available information, and the culture of satisficing.

Case study research - an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident (Yin 2009, p. 18).

Commissioning - the process used to plan, deliver and monitor services for a population, based on strong leadership and effective relationships, great outcomes and best value (NHS England 2014). Clinical Commissioning Groups (CCGs) emerged from the 2012 Health and Social Care Act as the bodies responsible for the majority of NHS commissioning.

Commissioning cycle – the description of the commissioning process, common features being: strategic needs assessment; deciding priorities and outcomes; planning and designing services; options appraisal; sourcing; delivery; and monitoring and review (Murray 2008, p. 91).

Critical realism – a research project that is an attempt to reconcile elements of realist and subjective interpretivist approaches, with the emergence of an ontology that recognises necessary elements of multiple research approaches.

Decision - a judgement to take action made from a range of alternatives, to achieve an objective, or bring resolution to an indeterminate issue. Decision, therefore, requires choice, a goal towards which the process strives and an action resulting from the judgement.

Dual-process decision-making – often described as ‘System 1/System 2’ (Kahneman 2012) dual process separates decision-making into: a short-cut ‘fast’ process based on intuition, heuristics, and sometimes driven by bias; and a ‘slow’ measured process where information and evidence is evaluated with greater consideration.

Ethnography – a form of social science research with the direct observation of subjects in their usual social environment (Watson 2003) over an extended period of time with the researcher actively participating with the subjects in the normal cultural setting (Hammersley and Atkinson 1995).

Frame – an interpretive device to give meaning and understanding to events and processes, based on knowledge and experience.

Group polarisation - group decisions in certain situations may be riskier than the individual decisions of group members (Isenberg 1986). A group decision model where strong views become ever stronger through the decision process.

Groupthink - when the members' striving for unanimity override their motivation to realistically appraise alternative courses of action" (Janis 1982, p.9).

Hegemony - the cultural predominance of a set of ideas and beliefs that is accepted by a social group.

Heuristic – a mental shortcut ('rules of thumb' or 'educated guess') that allow speedy and pragmatic solutions to problem solving.

Internal market – public sector reforms aimed at making public sector services operate more like private sector market-based services, through the use of techniques such as competition, tendering, and plurality of provision.

Negotiation - observable attempts by decision actors to influence the organizational structures, power relations, and decision outcomes in the observed situation in accordance with the decision actors' interests and objectives.

Negotiated order - the pattern of organizational activities that has arisen or emerged over time as an outcome of the interplay of the variety of interests, understandings, reactions and initiatives of the individuals and groups involved in the organization" (Watson 2002, p. 76).

Power – the ability to change something ('power to') or the ability to make another individual or group do something ('power over').

Primary care – typically, but not exclusively, the first stage of healthcare provision, usually occurring in settings close to patients' own homes. Primary care services include General Practice, Dentistry, and Community Pharmacy.

Prospect theory – a theory of decision-making under conditions of uncertainty where decision-makers asymmetrically evaluate risk based on whether choices are framed as gain (promoting risk versions) or loss (promoting risk seeking).

Rationality – a) the 'weak' definition: based on reason; b) the cognitive scientific definition: "the actions of an entity in its environment that serve its goals" (Stanovich 2011, p.5)

Rational selection - with the evaluation and selection of alternatives as part of a value system where knowledge of the consequences of the alternatives can be assessed. This is further separated into 'objectively rational' where a decision would be seen as rational if it maximized the outcomes in a situation; and 'subjectively rational' where it is seen to maximize the outcomes given the known information at the time of the decision, although subsequent knowledge may show this information to be inadequate (from Simon 1997).

Secondary care – the term usually describes hospital-based care, occurring in District General Hospital type settings, where units typically serve a population of 200,000 or more.

Sociology - the study of the relationships which develop between human beings as they organize themselves and are organized by others in societies and how these

patterns influence and are influenced by the actions and interactions of people and how they make sense of their lives and identities (Watson 2003, p.3).

Strategy - The direction and scope of an organisation over the long term, which achieves advantage in a changing environment through its configuration of resources and competences with the aim of fulfilling stakeholder expectations. (Johnson et al. 2005, p. 9)

Strategic decision - An infrequent decision made by leaders of an organization that critically affects long-term organizational health, survival, and involve significant changes to resource allocation that impact on the organization's stakeholders.

Tertiary care – highly specialised hospital care usually delivered in larger specialist centres serving populations of 500,000 to 2 million across large geographical areas.

Value – the achievement of social purposes (Moore 2000)

Appendix 1 - Comparative healthcare commissioning

Studies of comparative health systems (for example OECD 2008) show a number of discernible patterns (see graph below). Firstly, it appears as nations become more prosperous, they spend a larger proportion of their national wealth on healthcare. Associated with the higher national income and the greater expenses there tends to be an increase in life expectancy. But for the majority of developed countries the improvement in longevity appears to grow progressively smaller, demonstrating a 'law of diminishing returns'. Some authors (LeFanu 2000) describe modern medicine as reaching a plateau where further improvement becomes ever more difficult. Such a picture implies one of the challenges facing commissioning is to maximize the scope for improvement, against the likely pattern of improvement delivering marginal incremental gain.

The second obvious pattern is that whilst most countries conform to relationships between healthcare spend and life expectancy of slowing improvement (consistent with the logarithmic trend line below), outliers exist. At the time of the OECD 2008 report, Japan shows the highest life expectancy for major developed countries with a lower spend than comparative nations, including less than half the per capita spend than the USA. Of the explanations postulated many include wider social and economic factors, such as a lower relative level of social and economic inequality (Wilkinson 2010). Other cultural, dietary, and lifestyle factors may contribute to Japan's performance (Hashimoto et al. 2011). But its lower level of health spend does not appear detrimental to population longevity. This may not be directly attributable to a system of health commissioning, or indeed of a system of healthcare at all necessarily. But it does indicate that a nation's health may be influenced by how it uses its resources, and the search for value for money in healthcare may be a factor that should be of high priority for governments. (Shibuya et al. (2011) state new drugs take on average 3.7 years after first clinical use in the world to market launch in Japan. Whilst seeming to restrict the population's access to newer drug therapies, such delays may significantly reduce overall drug costs, with evidently no population level impact on health outcomes.)

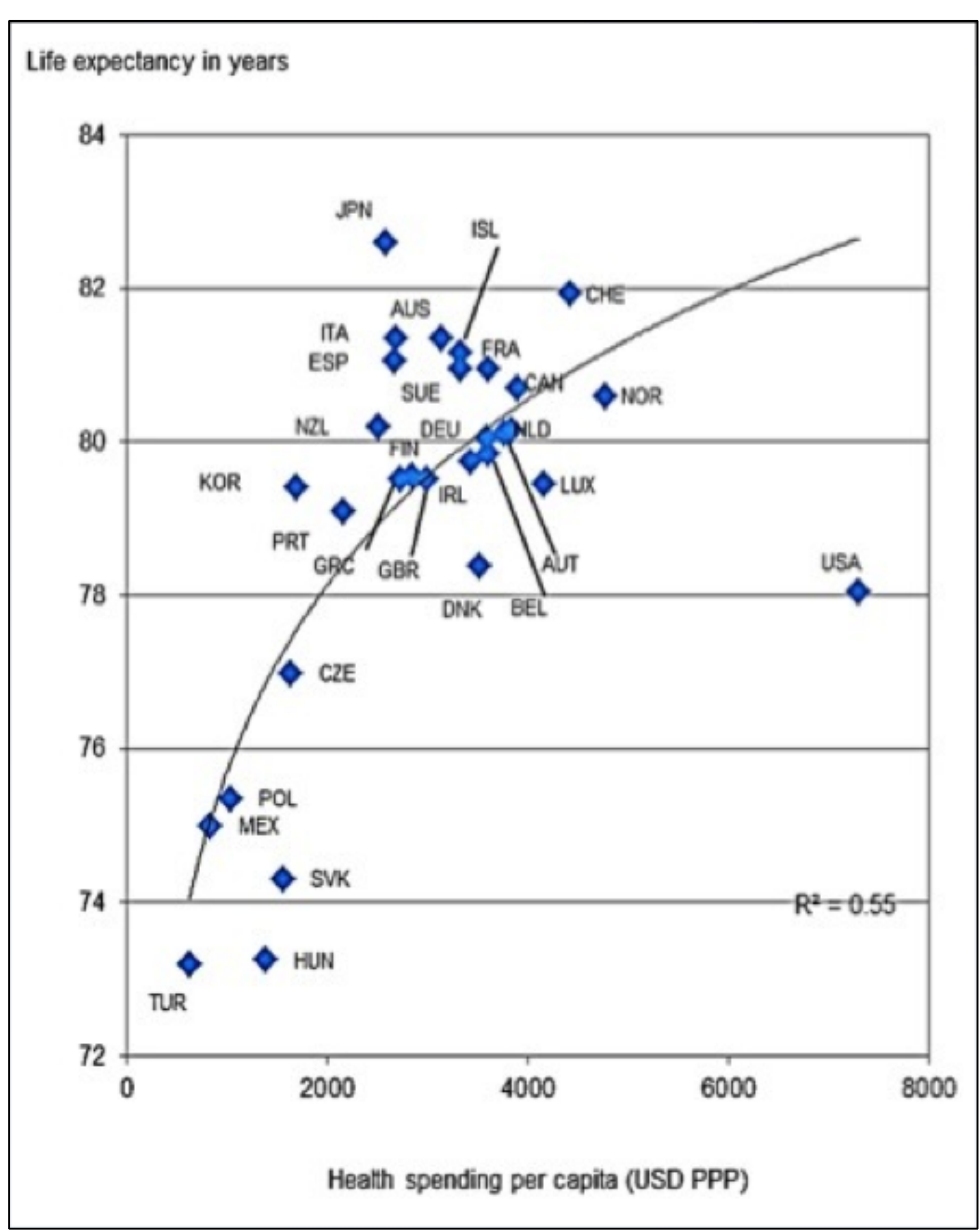


Figure 26 - OECD Review of Comparative Health Systems 2008 – funding compared to life expectancy

This conclusion is amplified by consideration of the data's 'villain': the USA. Spending more than twice as a proportion of GDP on health than Japan and substantially more than its major European comparators, the USA shows disappointingly poor health outcomes. Although there are wider contributory factors that influence the results, studies suggest that after accounting for possible causes such as violent crime, the results remain a significant outlier (Muennig 2010). Muennig (2010) suggests there may be links between the very fact of high cost and the poor outcomes:

> Finally, unregulated fee-for-service reimbursement and an emphasis on specialty care may contribute to high US health spending, while leading to unneeded procedures and fragmentation of care…unusually high medical

spending is associated with worsening, rather than improving, fifteen-year survival (Muennig 2010, p. 8).

The graph below shows how USA health outcomes for 45-year-old women remain the worst of the peer group in 2005 compared to 30 years earlier. Furthermore, the USA in 2005 demonstrates outcomes marginally worse than the Netherlands 30 year prior.

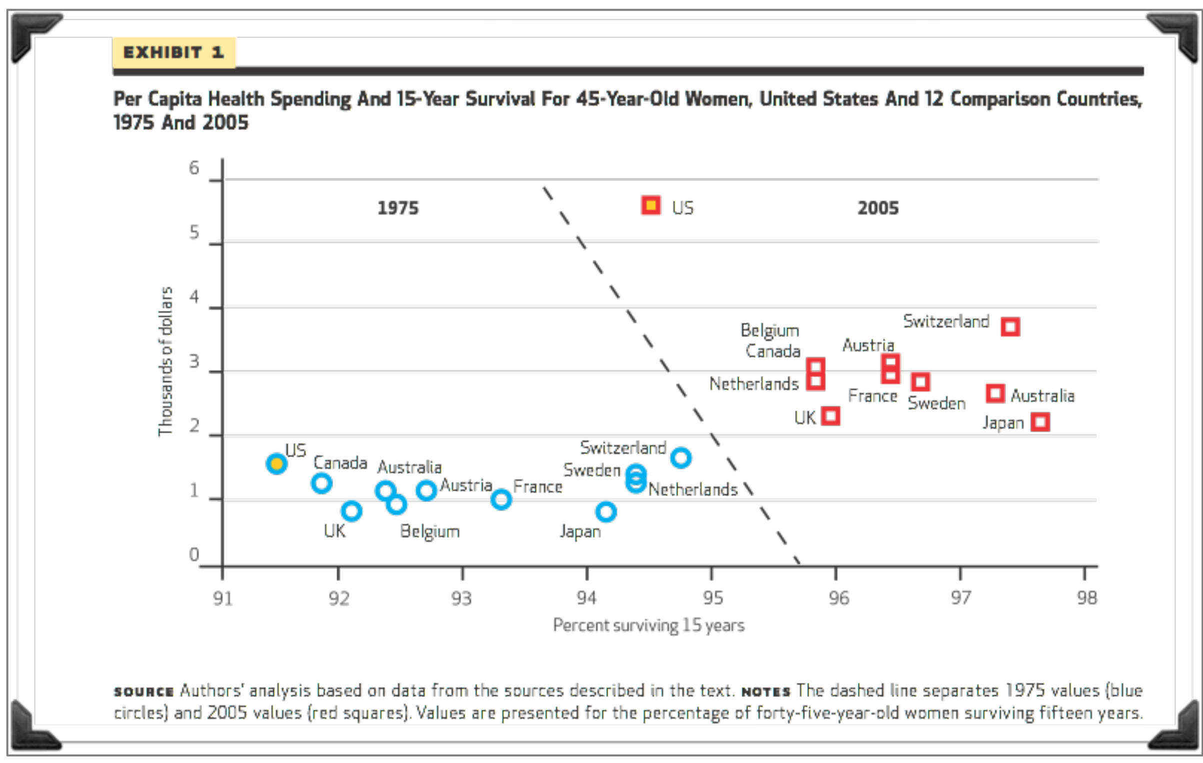


Figure 27 - 15-year survival for 45-year-old women USA and 12 comparators (from Muennig 2010)

A fundamental feature of the USA health system is not only its insurance-based character, but also that there is currently no systematic coverage applied to the whole population. Thus, as of 2008, approximately 15% of the USA population did not have comprehensive health coverage (Krugman 2009). Although this population cohort will have access to emergency medical care, arguably this feature of the system distorts investment away from preventative care, in favour of more expensive treatment for more serious health conditions. This distortion may be further amplified by a smaller, but well-resourced population cohort who can afford expensive specialist care, even where such care has limited supporting evidence. Thus, provider organizations seeking to maximize financial gain invest more heavily in expensive specialist hospital care, as there may be more limited incentives to develop more ‘upstream’ primary and secondary prevention or screening initiatives. The USA provides a further example of resource allocation and the role of something resembling public sector commissioning in the UK. Thus, the US programmes of Medicare (health insurance coverage for the elderly) and Medicaid (coverage for those on social security benefit) are state funded care programmes. Evidence exists to show that whilst the other funding streams of

healthcare in the US have seen significant recent cost growth, that of Medicaid has seen largely flat growth (Chandra 2013) as demonstrated in the following graph.

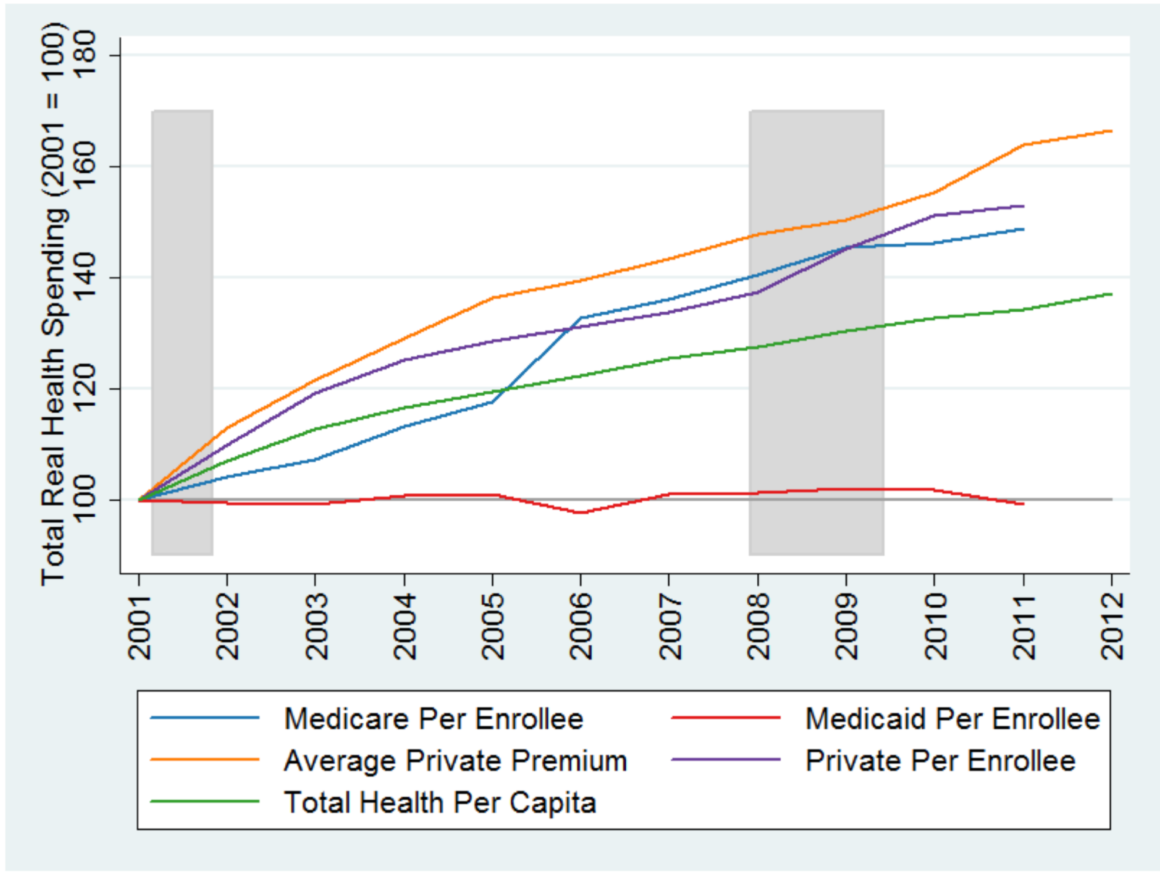


Figure 28 - US health spending by funding type from Chandra 2013

At the time of writing it is unclear if the Patient Protection and Affordable Care Act (often abbreviated to Affordable Care Act) will lead to a substantial improvement in the overall health of the US population (Rak 20130).

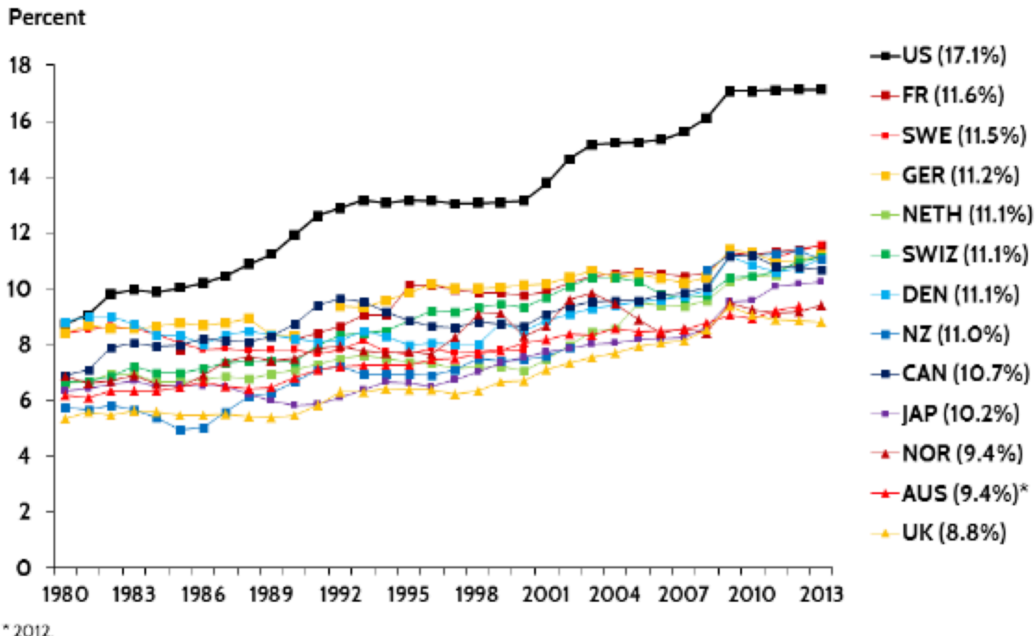
One of the complexities of evaluating different health systems is distinguishing what is commissioning, as other systems may look very different from the NHS. However, it may be possible to distinguish functions that resemble the system of commissioning in the UK. Indeed, arguably the relatively unique feature of the UK health system is a socialized system of planning and purchasing (commissioning) and a socialized system of care delivery, through what may be considered as largely nationalized hospitals, community, and primary care. But other countries may have systems that do contain elements consistent with commissioning. Examples of this are briefly described below.

- Canada has a 'single-payer' system that provides comprehensive healthcare purchased by public funding, with very low administrative costs (Klein 2007, Krugman 2009).

- France and Germany provide a form of commissioning, with largely public funding, but through funding of insurance companies or “sickness funds”. Systems of co-payment and individual private additional insurance provide greater choice than the Canadian or British systems. But at higher administrative costs (Klein 2007, Krugman 2009).
- Veterans’ Health Administration (VHA) provides a form of commissioning within the USA that resembles elements of European or Canadian commissioning. However, its obvious limitation is its exclusive access to former military personnel (Klein 2007).

Analysis by the Commonwealth Fund (Squires and Anderson 2015) shows the pattern of international healthcare spending. This demonstrates a consistent trend amongst developed nations of reducing growth in healthcare spending as a consequence of the 2008 economic slump. This shows the UK spending as still much lower than many comparative nations.

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



* 2012
Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.
Source: OECD Health Data 2015.

Figure 29 - Figure 3 - Healthcare Spending a % of GDP from Squires and Anderson 2015

Furthermore, it shows the UK as being only one of two countries in the group of developed nations with a real-terms negative growth rate in the post-slum period.

Table 22 - Comparative Healthcare Spending (from Squires and Anderson 2015)

Exhibit 2. Health Care Spending, 2013

	Total health care spending per capita[e]	Real average annual growth rate per capita		Current health care spending per capita, by source of financing[e,f]		
					Private	
		2003-2009	2009-2013	Public	Out-of-pocket	Other
Australia	$4,115[a]	2.70%	2.42%[c]	$2,614[a]	$771[a]	$480[a]
Canada	$4,569	3.15%	0.22%	$3,074	$623	$654
Denmark	$4,847	3.32%	-0.17%	$3,841	$625	$88
France	$4,361	1.72%	1.35%	$3,247	$277	$600
Germany	$4,920	2.01%	1.95%	$3,677	$649	$492
Japan	$3,713	3.08%	3.83%	$2,965[a]	$503[a]	$124[a]
Netherlands	$5,131[d]	4.75%[d]	1.73%[d]	$4,495	$270	$366
New Zealand	$3,855	6.11%[b]	0.82%	$2,656	$420	$251
Norway	$6,170	1.59%	1.40%	$4,981	$855	$26
Sweden	$5,153	1.82%[d]	6.95%[d]	$4,126	$726	$53
Switzerland	$6,325[d]	1.42%[d]	2.54%[d]	$4,178	$1,630	$454
United Kingdom	$3,364	4.00%	-0.88%	$2,802	$321	$240
United States[e]	$9,086	2.47%	1.50%	$4,197	$1,074	$3,442
OECD median	$3,661	3.10%	1.24%	$2,598	$625	$181

[a] 2012. [b] 2002-2009. [c] 2009-2012.
[d] Current spending only; excludes spending on capital formation of health care providers.
[e] Adjusted for differences in the cost of living.
[f] Numbers may not sum to total health care spending per capita due to excluding capital formation of health care providers, and some uncategorized spending.
Source: OECD Health Data 2015.

The consistent achievements of high-quality (if not necessarily *highest* quality) health outcomes from the NHS driven UK health system may indicate the potential for overall efficiency from a largely publicly funded healthcare system. However, it is also necessary to consider the wider picture of 'care' that needs to consider not only healthcare but also social care. Thus, the combined picture of care delivery provides a less severe assessment of the USA against comparative countries whilst maintaining the sense of higher priority for care funding in nations such as France and Sweden.

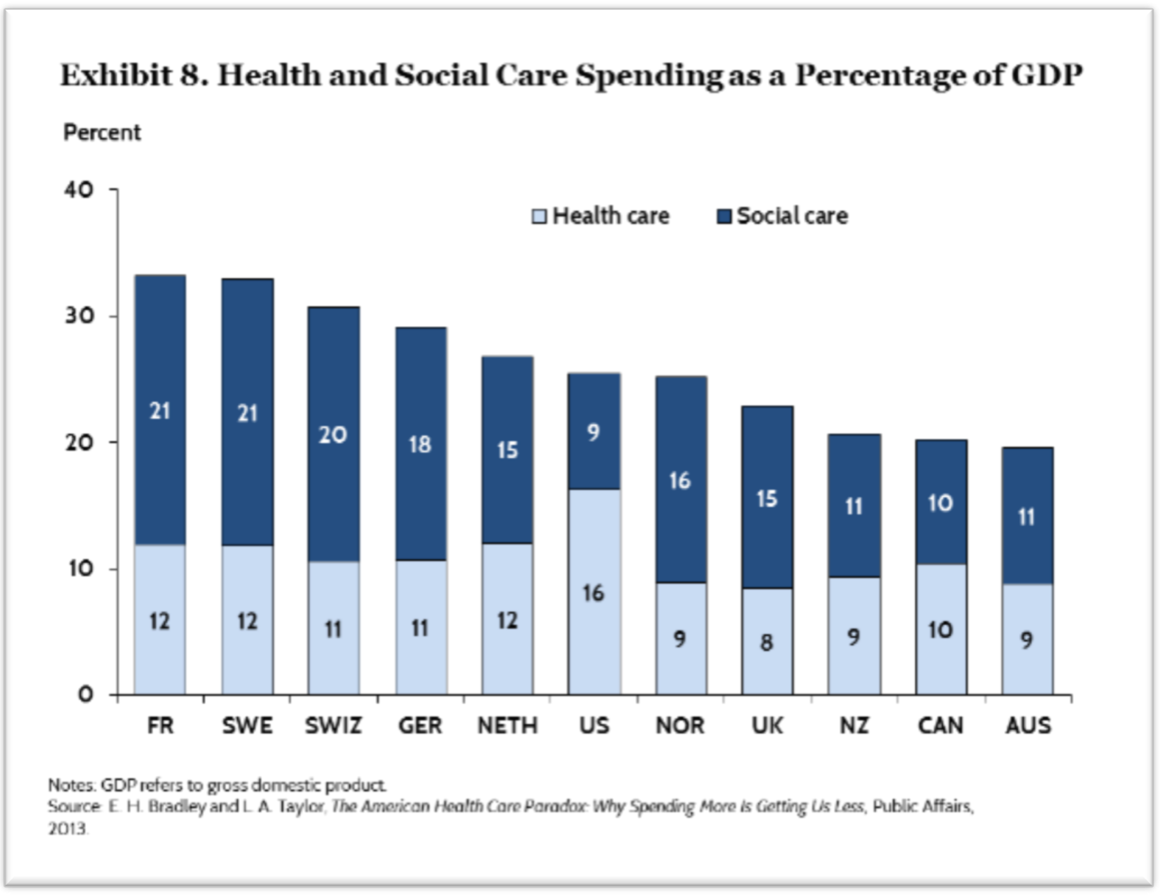


Figure 30 - Health and social care spending as % of GDP from Squires and Anderson

As discussed, the outcomes emerging in the USA from the impact of the Affordable Care Act (Rak 2013) are unclear: however, the development of initiatives such Accountable Care Organizations (ACO) is likely to see the establishment of systems that may compare more obviously with UK style focus on population health and managing need.

The comparative health analysis may present the following, tentative, conclusions:

- Increased healthcare funding may often be associated with improvements in life expectancy, but continued improvement will not be linear.
- The overall shape of healthcare systems, particularly its degree of population coverage and degree of focus on health improvement, will have a significant influence on health outcomes.
- Publicly funded healthcare can achieve good health outcomes and higher value for money by restricting access to marginal benefit health interventions.
- High-cost specialist hospital care may improve individual health outcomes, but the benefits at a population level are less certain.

Despite the difficulties of comparing health systems, the international evidence appears to confirm there are benefits to some form of healthcare population strategy within a form of healthcare resourcing. This may be achieved by a process consistent

with the NHS definition of commissioning although there may be many potential models. Furthermore, comprehensive access to care requires fitting healthcare usage within a limited, indeed increasingly limited, resource envelope. Consequently, achieving value for money from healthcare is a strategic issue: arguably for NHS commissioning the major strategic objective.

Appendix 2 – A Short Organizational History of the NHS

Introduction

This section provides a brief summary of the NHS from the perspective of its major organizational reconfigurations within their political policy context. More detailed history of the NHS can be found from Webster (2002), whilst Timmins (1996) provides a broader overview of the emergence of the UK welfare state, including the NHS.

Conception from Beveridge to Bevan 1942 to 1948.

The emergence of the modern welfare state in the UK does not have one single starting point. Various early attempts at forms of social welfare and 'safety nets' have been observed. But the point where, arguably, the modern form of a welfare state appears as a coherent concept may be seen as a range of initiatives and papers emerging in World War 2 (Timmins 1996). The most comprehensive statement as to a new type of state organized welfare was the Beveridge report in 1942 (Kynaston 2007), targeting the 'five giants of evil', want, disease, ignorance, squalor, idleness. Arguably this was a critical step in developing a political consensus across parties for a general welfare state. This led to many of the reforms seen in the post-war Attlee government (1945-51), including the development of the NHS (Kynaston 2007).

Early Years, 1948 to 1962 - Provision not Commission

The Labour Government and its Health Minister Aneurin Bevan established the NHS despite opposition from the medical establishment and votes against its introduction by the Conservative Party (Kynaston 2007). This period was primarily concerned with establishing the service and creating one 'free at the point of need' from existing health services. Thus, the overall strategy of the period may be seen as bringing the disparate parts of existing healthcare under one service with some common standards. But there may have been relatively little focus on an *intentional* strategy for service development, and arguably commissioning in its current form was not explicitly evident.

1951 is an important milestone for the purposes of analysis of systems for resource allocation, as it was the date Bevan resigned from the Cabinet due to the introduction of prescription charges for dental care and spectacles (Kynaston 2007). Although the specific issues at the time involved wider financial pressures (primarily the Korean War) it also reflected the growing financial pressure of a comprehensive, largely free at the point of need, healthcare system. Throughout this period cost growth outstripped financial forecasts and the early view of initial investment to make people well and then a smaller ongoing top-up to maintain health was proven to be completely erroneous ("The NHS proved spectacularly more expensive than expected" Timmins (1996, p. 157). Some of the first inklings about the need for decisions on resource allocation came within 18 months of the service being established (Bevan commenting, "I

shudder to think of the ceaseless cascade of medicine which is pouring down British throats at the present time." (Timmins, 1996, p. 131).

Maturity 1962 to 1974 - Planning and reorganization

This period saw a shift of focus towards the estate of the NHS and a greater focus on planning. Enoch Powell's time as Health Minister produced the Hospital Plan, signaling the emergence of what may be considered the modern District General Hospital for populations of 125,000 or greater (Timmins 1996). As with many NHS plans, the costs of the programme were to prove significantly larger than the initial prediction. This shift to a more strategic intention on service planning with some deliberate statements as to future design and configuration (the concept of the District General Hospital (DGH) being of strategic significance) was more obvious turn towards an approach closer to modern commissioning. Thus, the service, now established, had to look to its future and how it managed it resources. The Powell era may be seen as the first coherent attempt to manage NHS capital at a strategic level and recognized the lack of both investment and planning in major NHS capital (Webster 2002).

An important and arguably necessary element in the emergence of increased strategic focus may have been the establishment of a credible and sustained senior management at the top of the NHS. This provided focus, leadership, and the ability to effectively negotiate with the Treasury (Webster, 2002, p. 61). Similarly, as the NHS has been part of the Department of Health infrastructure and a large proportion of the overall public sector, it has at times had an 'organization within an organization' status. In the view of Webster (2002) the increasing status of healthcare as a government priority was accompanied by more senior figures occupying positions at the helm of the DoH with a consequent result of a larger share of public spending coming to healthcare.

Health Authorities 1974 to 1983

Something closer to the modern concept of commissioning initiated in this period: with the establishment of Regional and Area Health Authorities (RHA and AHA). Furthermore, the creation of the Resource Allocation Working Party (RAWP) was an attempt by central government to shape how resources were allotted across the system and reflected a belief that the existing resource allocation did not correspond to health need. The development occurred alongside extension of wider public sector spending controls such as cash-limits to the NHS, administered by the new RHAs and AHAs (Webster 2002). The structural re-organization was in retrospect one of an increasingly frequent process of NHS re-structuring.

Thatcher and Griffiths 1983 to 1989

The Thatcher administrations (beginning in 1979) commissioned two reports from Roy Griffiths (previously a senior figure in the Sainsbury's supermarket chain) (Timmins 1996, Webster 2002). The decade saw an attempt to use more open market

mechanisms in the service (through initiatives such as competitive tendering) and the introduction, particularly within the hospital sector, of ‘general management’. The end of this period and the appearance of Kenneth Clarke as Health Secretary appeared (in some authors’ views such as Timmins 1996) to herald an end to considerations for widespread privatisation of the NHS. Griffiths (Webster 2002) highlighted the perceived lack of management and accountability ('who was in charge') with the result of a focus less on how services were planned and delivered and more on the structure of the system and the relationship between those paying for services and those delivering.

Emergence of the internal market 1989 to 1997

This period saw the introduction of the internal market and the ‘purchaser-provider split’ between those with responsibility for purchasing (commissioning) healthcare and those delivering it. This formal split has been in place, in different guises, in the NHS from this period until the current day. In the 1990s government policy was influenced in part by foreign experts, such as Enthoven (Timmins 1996), who encouraged a move towards systems that were either actually based on, or mirrored, insurance type funding (the reference point often being the USA). The evidence for such systems either improving health outcomes or reducing cost was limited (Timmins 1996), but the drive towards privatisation of public services working as virtual markets was part of government policy: NHS policy thus reflected this drive.

The purchaser-provider split was accompanied by (and in part required) the emergence of NHS Trusts as more autonomous provider bodies. Although hospital Trusts were still part of the NHS and remained nationalized institutions within a state-run, tax funded system, they were now established as statutory bodies in their own right. This status included the formal production of published annual reports and audited annual accounts. After the introduction of hospital trusts there then saw the establishment of GP fundholding. This provided GP practices with direct responsibility for elements of NHS funding, again as an element of trying to make the NHS operate more like a traditional market (Timmins 1996).

The NHS Plan 1997 to 2010

Although the Labour Government was critical of the internal market it did not abandon the purchaser-provider separation. Primary Care Groups (PCGs) replaced GP Fundholding, but the function remained broadly the same, if allowing less obviously direct benefits to GP practices themselves (Timmins 2008). However, the NHS Plan was a more clearly centrally driven programme of health improvement, with a nationally mandated set of performance targets. This period saw significant growth in NHS spending (average annual growth in the period of 6%) with increases in capacity driving down waiting times and improving outcomes. But despite financial growth the NHS contained many organizations that were financially challenged (Timmins 2008).

This period also included an energetic attempt to grow private sector involvement in

healthcare. Although partly successful, the private provision established was relatively limited and despite the government's ambition to have up to 40% provided by the private sector (Mulholland 2006). From some perspectives the government in this period was more active in establishing NHS internal markets, as the period saw: the creation of Foundation Trusts, in theory with greater autonomy than NHS Trusts and allowed to secure their own private financing; and the introduction of a national pricing system (Payment by Results).

Liberating the NHS 2010 to 2015

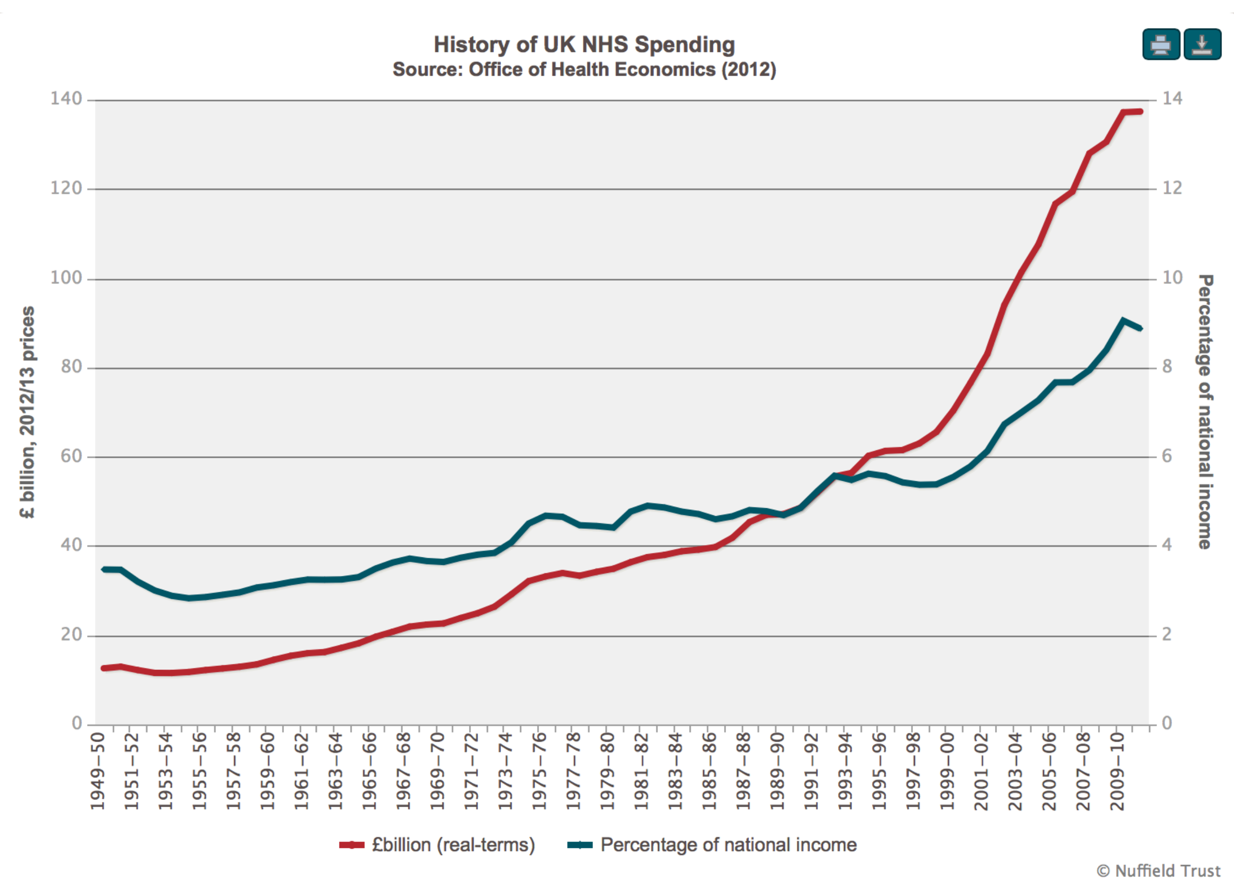
As in the years of the early 1990s the reforms introduced from the 2010 White Paper (Department of Health 2010) were not directed primarily at how healthcare was to be delivered, but rather as to how service redesign and particularly commissioning should be conducted. The direction was for a clinically led commissioning system, leadership provided largely through GPs. The aim of the policy was to promote 'bottom-up' service redesign driven by local clinicians responsive to their patients. The policy seemed most consistent under the stewardship of the Secretary of State considered as its parent, Andrew Lansley. Early versions of the annual NHS guidance (previously called the operating framework) emphasised bottom-up redesign and 'assumed liberty'. But the planning round of 2014-15 produced guidance 90 pages long with a return to top-down instructions, targets, and what may see a return to centralised strategic thinking not dissimilar to the Labour NHS Plan.

The 5 Year Forward View (5YFV) (NHS England 2014) emerged as the strategy document describing NHS intentions for the period to 2020, receiving a level of support from all of the major political parties (demonstrated in policy statements made during the 2015 General election). This also appeared to signal a return to a more directive and prescriptive approach to NHS policy than contained within Lansley's 'assumed liberty'. The case study was undertaken in the aftermath of the 5YFV with NHS organizations assessing how the latest stage of NHS strategy will be implemented.

Appendix 3 – A Financial History of the NHS

In addition to documenting the history of the NHS with a perspective on commissioning, it may be useful to briefly document the history from the perspective of its finances. In large part commissioning is a process of resource allocation and therefore, finance is a significant feature of the whole commissioning process. The financial context of commissioning may be seen as a major influence on the dynamics of NHS decision-making.

The historic pattern of NHS spending from 1949 to 2010 is demonstrated below (Crawford and Emerson 2012):



The chart demonstrates growth in actual spend and as percentage of national income (measured as Gross Domestic Product from OHE 2009). (Arguably the pattern of the graph overestimates the growth in later years, as the left scale is in actual £ spent providing an apparent sense of exponential growth in later years. Thus, the percentage of national income may be the more relevant measure.) Appleby et al. (2009) describes a number of features and trends of NHS spending:

- Spending has tended to increase consistently over the life of the NHS.
- Although it has increased as a proportion of GDP this has not been uniform growth
- UK spend on healthcare has been consistently lower than the European average as a percentage of GDP

- The Labour government of 1997-2010 had a deliberate target of increasing the proportion of national wealth spent on health
- Despite this growth UK spending has remained below its richer European comparators (France and Germany)
- The UK spend on healthcare is largely through the NHS with a much lower private sector healthcare spend.

There appear to be no periods in the whole NHS history where actual health spend failed to increase. There is a brief period in the early 1950s where the real-terms (inflation adjusted) NHS spend decreased. This appeared at a time from 1950 where the NHS introduced limited charging for services (such as prescription charges). Although both Labour and Conservative administrations from the 1950s and 1960s either introduced or did not completely abandon limited charging, neither party showed any enthusiasm for more widespread charging and move away from the basic tenet of an NHS ‘free at the point of need’.

The overall pattern of growth of the NHS and allocated to periods of political rule is summarised by Appleby (2009):

Time period/administration	Fiscal years	Average annual real change (%)
Whole period	1950/1-2010/11	4.04
20th century	1950/1-1999/2000	3.48
21st century	1999/2000-2010/11	6.56
Conservative	1951/2-1963/4	3.02
Labour	1964/5-1969/70	4.34
Conservative	1970/1-1973/4	5.50
Labour	1974/5-1978/9	3.58
Conservative	1979/80-1996/7	3.21
Labour	1997/8-2010/11	5.70

Sources: HM Treasury (2009); OHE (2009); authors’ calculations.

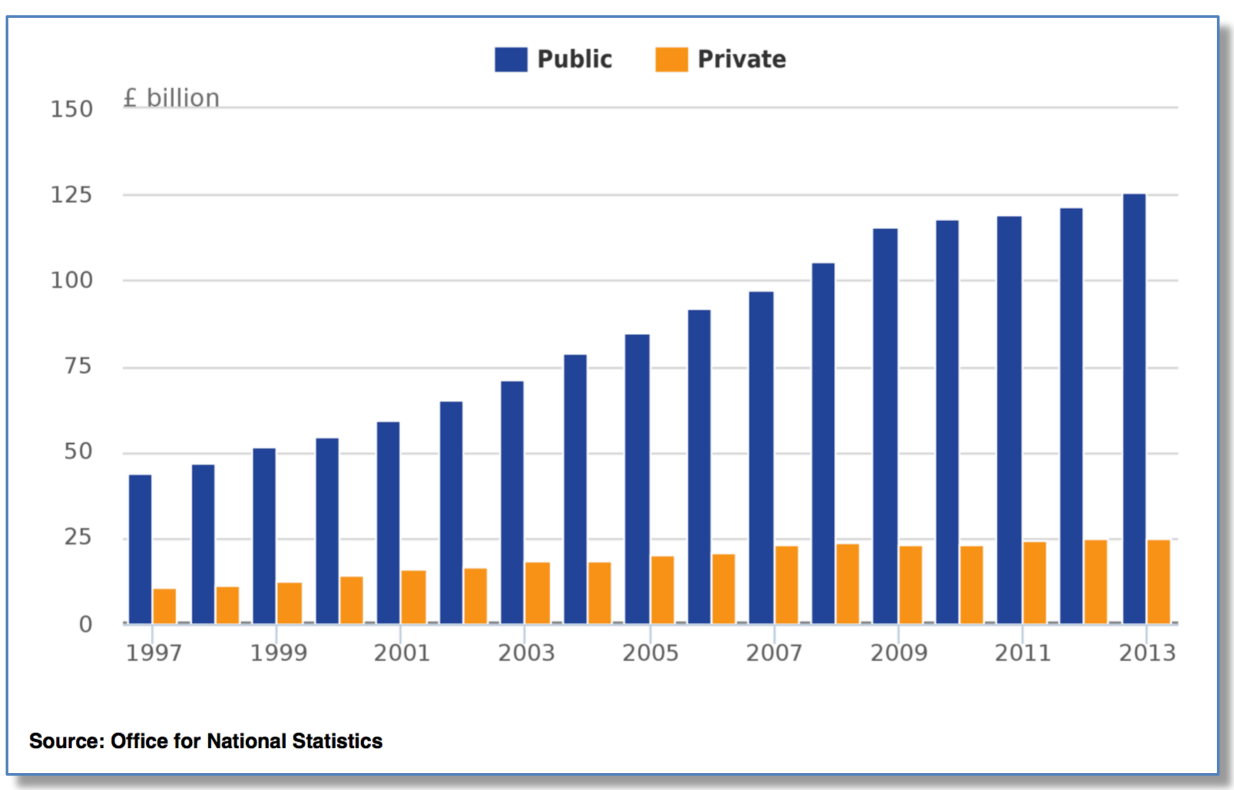
Thus, there was a degree of overall consistency across governments until the later part of the Labour administration of 1997-2010. The most dramatic rise in real-terms growth was in the current century. The period from 2000-2010 saw the growth in NHS spending support significant increases in hospital capacity, in part driven by the high-quality but expensive Private Finance Initiative (PFI). This growth may be seen as a step-change in funding growth and concomitant growth in service capacity. However, the implementation of new workforce policies (such as the European Working Time Directive) resulting in new contractual and payment frameworks also came at considerable cost. Mainstream media opinion in the wake of the 2008 financial crisis assumed a consensus of over-inflated and excessively funded public services, of which the NHS is part (Wren-Lewis 2015). But academic economic opinion (see Wren-Lewis 2013) does not universally support the assertion of profligate public sector financing in this period and consequently it may not necessarily be assumed that the

NHS was over-funded.

Throughout its history the NHS finances show not merely trends in financial performance but also contextual patterns that have, in part, informed commissioning strategies. There has been (since the very early days) an acceptance of the need for limited charging but limited to specific items of service such as drug prescriptions and sight testing. (Kynaston 2007). There has been and remains an unwillingness to charge for mainstream healthcare access (for example, attendances at a GP of A&E department). This is despite evidence of both differences in international comparisons being attributed to charging (Monitor 2014).

The principle of 'free at the point of need' may be seen to promote expectations of access. Thus, the increase in demand for care resulted in lengthy waits for elective care by the mid 1990s (Thorlby and Maybin 2010). Responses of successive governments included a focus on performance targets to reduce waits and investment to increase capacity. However, it may be seen that improvements in access have increased expectations as to shorter and shorter waiting times and a desire for more convenient access. All of this improvement in access to care came at a significant financial cost (Thorlby and Maybin 2010).

The limited level of private healthcare has been constant for most of the NHS history. The increase in public funding in the NHS from the late 1990s occurred at a time where private healthcare expenditure also increased, albeit at a slower rate than the rise in NHS expenditure. The respective growth in public and private sector healthcare expenditure is shown below (source ONS 2015): as of 2013 public sector funding equated to £125.5 billion and private sector £25.1 billion. (Private sector calculations include private healthcare spend by individuals, through private medical insurance and spend from NGOs such as registered charities.)



Source: Office for National Statistics

Attempts to increase the level of private funding and of private provision have had limited effect (ONS 2015). Little serious consideration has been given to the introduction of personal insurance-based services, or more widespread privatisation. Indeed, limited suggestions of greater involvement of a wider market of healthcare provision have sometimes been met with aggressively negative responses (Lafond 2016).

The emergence of the Five Year Forward View (5YFV) (NHS England 2014) occurred at a time of significant financial challenge for the NHS, within a wider programme of austerity level reduced public spending. The 5YFV included an explicit case for additional NHS funding above its recent historic levels. (Spending rose slightly above inflation from 2010-2015, but only by a very small degree.) This requirement for greater increases in resources reflected both: the higher than core inflation growth in healthcare costs; and the comparative reduction in healthcare spending as a proportion of GDP seen in the UK since the start of the financial downturn in 2008 (Lafond et al. 2016).

Appendix 4 – Sample Interview Questions

1. Please provide a brief description of the issue under scrutiny from your perspective?
2. Did you have any pre-conceptions about the issue for decision?
3. What evidence informed your views in support of the decision-making process?
4. How important was personal experience of the services under consideration compared to the presence of empirical evidence?
5. Did the decision-making process in the CCG change your opinions of the services under consideration?
6. Was the eventual decision outcome close to what you expected at the outset of the process?
7. What were the greatest influences on your decision-making in the process?
8. Did you observe common interest groups emerging through the decision-making process?
9. Did some decision-makers have more influence in the process?
10. Did you perceive there was something everyone was responsible for in the process?
11. How would you like CCG decision-making to change in the future?

Appendix 5 – Discourse Analysis of data codes

The method used in analysing the language in the coded data was the discourse 'building tasks' described by Gee (2010):

- Significance
- Practices
- Identities
- Relationships
- Politics
- Connections
- Sign system and knowledge

Significance is when language is used to "render something significant or insignificant," (Gee 2010, p.17).

Practices are "social recognized and institutionally or culturally supported endeavour that usually involve sequencing or combining actions in certain ways" (Gee 2010, p.17).

Identities are how language is used when we are "taking on a certain role or identity," (p 18).

Relationships are how language is used to express relationships "we have, want to have, or are trying to have" with others (Gee 2010, p.18). What relationship is the piece of language seeking to enact or reflect?

Politics is "the use of language to build a perspective on social goods," (Gee 2010, p.19): this being is something described as inadequate or adequate, good or bad, for a social group.

Connections are "the use of language to render something connected or relevant to other things," (Gee 2010, p.19): "How does this piece of language connect or disconnect things?" (Gee 2010, p.19).

Sign Systems and Knowledge are how language and certain sign systems "privileged over others" (Gee 2010, p.20).

Thus, we use the Gee typology to analyse the coding groups, with each coding category referenced to the discourse tasks. This analysis assesses how the codes relate to the framing environment and the three levels in the conceptual framework.

Table 23 - Discourse analysis with building tasks of improvement codes

Improvement codes	
Building Task	**How used in the discourse**
Significance	The significance of these codes was in establishing the clinical justification for both moving to a more radical

	service change and for how the previous attempts at incremental changes had been unsuccessful.
Practices	The codes were used as a practice to describe the need to establish improved services for patients. They were practiced as a primary reason for change, regardless of practical problems of implementation or associated risks.
Identities	The codes were seen to identify those who were strongest in favour of service improvement and considering both current services and relationships with current providers as inadequate.
Relationships	These codes were strongly used to form and reinforce relationships and may have been some of the main discourse supporting coalitions in support of tendering.
Politics	In terms of social goods these codes see the role of the current service delivery (and consequently the role of the service provider) as having a negative social impact.
Connections	The codes connected to the need to improve services in the first place and may be seen as some of the most important primary driving concepts for the subject of the case study.
Sign system and knowledge	These codes privileged the position of clinical decision-makers in the process, due to their experience of front-line clinical services.
Framing level	As the codes were driven in part from strong personal reflections, they operated primarily at the micro level.

Table 24 - Discourse analysis of risk codes

Risk codes	
Building Task	**How used in the discourse**
Significance	The significance of the codes was the potential threats to corporate objectives and sustainability. Although there were risks discussed on not making more significant changes (and in not using tendering) but the majority of the risk codes were those relating to the risks of using tendering.

Practices	The codes appeared to be used a practice of 'restraining' the views of others, in particular the tender coalition as a means of tempering the impact of the emotional codes.
Identities	The codes identified most obviously the professional executive officers on the Governing Body.
Relationships	The codes helped establish the relationships between those who may be thought to be more concerned with risk, and those that may conform to the risk aversion side of the prospect theory spectrum.
Politics	These codes were explicitly political, in relating to the impact on other organizations and considering the impact on wider health policy, as against assessing the qualities of the service under consideration only.
Connections	The connections of the codes were with wider elements of corporate risk.
Sign system and knowledge	The codes prioritised the role of risk as a decision-making factor and emphasised the broader decision-making context and thus required knowledge, with less emphasis on the quality issues of the service itself.
Framing level	These codes operated primarily from the meso and macro levels, referencing legal guidance, financial consequences, and political relationships.

Table 25 - Discourse analysis of corporate process codes

Corporate process codes	
Building Task	**How used in the discourse**
Significance	The codes were significant in relating to corporate governance and procedures, suggesting whether decisions, actions, or behaviours are corporately acceptable.
Practices	These codes were used as supporting codes that add weight to another code or position. Thus, they may be either restraining or driving codes, but will not drive a decision outcome in themselves.
Identities	The codes identified with practitioners across the process but tended to be the preserve of the professional officers.

Relationships	The codes supported existing coalitions or relationships but did not appear to establish relationships themselves.
Politics	These codes were implicitly political, with particular reference to the external regulatory framework in the NHS.
Connections	The codes connected to themselves as a web of corporate processes.
Sign system and knowledge	Codes show the signs of compliance with rules and established norms and also imply a recognition of understanding of existing knowledge in processes.
Framing level	These codes operated at the meso level

Table 26 - Discourse analysis of behaviour codes

Behaviour codes	
Building Task	**How used in the discourse**
Significance	These codes may be seen as similar to the corporate codes. The corporate codes tended to describe how decision-making 'should' happen (that is following rules and regulations, for example); the behaviour codes describe how decision-making 'does' happen in practice. The significance was in framing decision-making towards established or normative practice.
Practices	These codes, particularly the Nortondale code, were used to amend preferences that allowed pragmatism and built consensus.
Identities	The codes identified how individuals would and did behave in the process and allowed the behaviour of decision-makers to be reconciled with the implications of corporate processes.
Relationships	The codes reinforced existing relationships and sought to accommodate relationships within the decision process.
Politics	The codes were political within the context of internal politics of the CCG. The Nortondale code did recognise the potential political impact of the process on the politically sensitive issue of Notlam Hospital.

Connections	The codes connected to the other coding groups, in particular aligning the groups to the Improvement theme, without disenfranchising a sub-group.
Sign system and knowledge	The sign system was of accommodation of priorities and behaviours within the group.
Framing level	This was primarily at the Meso level but referenced elements of the Macro frame.

Table 27 - Discourse analysis of stakeholder codes

Stakeholder codes	
Building Task	**How used in the discourse**
Significance	The significance of theses codes was in aligning arguments to both add force ("x supports this option") and to define bounds of acceptability ("x believes we cannot or should not do this option")
Practices	These codes were used as supporting codes that add weight to another code. They may be either restraining or driving codes.
Identities	The codes showed how decision-making groups identified with the wider healthcare community.
Relationships	The codes were primarily regarding external relationships and how the CCG affected its major partnerships.
Politics	The political impact was of how it impacted on external relationships and sought external permissions for decision.
Connections	The connections were to identify a stakeholder group and then it links it to another code.
Sign system and knowledge	The sign system was of external permissions and approval.
Framing level	The framing level connected Meso and Macro levels but was primarily Macro.

Table 28 - Discourse analysis of service design codes

Service design codes

Building Task	How used in the discourse
Significance	The significance of the codes was in relation to the detail of services under consideration and how they may change.
Practices	These were seen as foundation codes and referenced previous discussions and policies in the CCG on how healthcare should develop.
Identities	The codes showed how decision-makers identified with improvement and how they saw services changing in time.
Relationships	The codes were primarily concerned with service content and less to with relationships, although the stakeholder views on service design were recognised.
Politics	The codes appeared apolitical.
Connections	The connections were between different groups within the process recognising their priorities for service change.
Sign system and knowledge	The sign was of system improvement
Framing level	Primarily at the micro level.

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Endnotes

[1] "The interpretation of fiction is undeniably do-able, with certain uncontroversial results. First, the fleshing out of the story, the exploration of 'the world of Sherlock Holmes,' for instance, is not pointless or idle; one can learn a great deal about a novel, about its text, about the point, about the author, even about the real world, by learning about the world portrayed by the novel. Second, if we are cautious about identifying and excluding judgments of taste or preference (e.g., 'Watson is a boring prig'), we can amass a volume of unchallengingly objective fact about the world portrayed. All interpreters agree that Holmes was smarter than Watson; in crashing obviousness lies objectivity." Daniel Dennett (1992, p.80)

[2] Interpretation and generation of consensus may be further complicated by the imprecision of information. Wright (2003, p.1) describes the ubiquity and usefulness of vagueness:

> Anyone must agree that vagueness pervades the lexicon of natural languages: almost everything we say is expressed in vague vocabulary. It is a little more controversial, but presumably true, that this is unavoidable: that a language stripped of vague expressions would suffer not merely in point of usefulness—often, a vague judgement is exactly what we need— but in its very expressive power. (We need concepts, for instance, of rough impressions, of casual appearances, and of circumstances in which a precise predication—say, "is more than six feet tall"—may justifiably be made on the basis of rough-and-ready observation; and we need to be able to express these concepts.)

Accepting the place and usefulness of vagueness may not necessarily mean its appearance within strategic decision-making is always helpful!

[3] In the UK General Practitioners (GPs) working as community physicians are sometimes referred to as 'family doctors' in part as often an individual GP will have members of a whole family on their caseload.

[4] Bhaskar (1978) makes a similar point if from the reverse perspective. Thus, for critical realism, Bhaskar's theoretical approach and the methodology used in the thesis, there are different perspectives, but recognising views of the same external reality (Bhaskar 1978, p.31):

> If changing experience of objects is to be possible, objects must have a distinct being in space and time from the experiences of which they are the objects. For Kepler to see the rim of the earth drop away, while Tycho Brahe watches the sun rise, we must suppose that there is something that they both see (in different ways).

Thus, the different views of the decision-making battlefield will be different, but always of the same event and process, regardless of the divergence of interpretation.

[5] Winter (1989, p.vii) is dismissive of the quote attributed to Confucius that, "a fool learns from his own mistakes – a wise man learns from the mistakes of others". Winter thinking that one's own learning is often much richer than that seen merely from observation. One is also tempted to ask Confucius that if the whole population was indeed wise, whose mistakes would there be to learn from!

[6] "Finally, I believe that strategic thinking is a necessary but greatly overrated element of business success. If you know how to design great motorcycle engines, I can teach you all you need to know about strategy in a few days. If you have a Ph.D. in strategy, years of labor are unlikely to give you ability to design great new motorcycle engines." (Rumelt 1996, p.110)

[7] Porter's earlier NEJM paper A Strategy for Health Care Reform — Toward a Value-Based System (Porter, NEJM 2009) does provide a strategy for healthcare, but primarily how applied to the USA and principally in relation to its funding and resourcing system through changing the system of insurance. It is not obviously a generic healthcare strategy that could be applied to other countries or systems.

[8] Thus, Andrews et al. (2006, p.58) state "Only one of the hypotheses for strategic action is supported by the empirical results. Organizations that move into new markets by identifying and serving new users are more likely to perform well. This can be seen as the most radical and innovative of the five strategic actions that we have identified, and it is consistent with the positive sign on the prospector variable." Again, this may be a more realistic option for Local Authorities, with a broad service portfolio and the ability to increase income, and less applicable to the NHS, particularly CCGs where access to new markets and income growth is very limited.

[9] The project uses the definition of sociology from Watson (2003, p.3):

> The study of the relationships which develop between human beings as they organize themselves and are organized by others in societies and how these patterns influence and are influenced by the actions and interactions of people and how they make sense of their lives and identities.

[10] Thus, it may be considered the default concept of decision is that of an event: a judgement assumed to be identifiable to a date or series of dates. Intuitively this appears to be the closest to the definition provided in the literature review above. However, the complexity of strategic decisions suggests they are rarely taken over very short time scales, and tend to involve a web of analysis, debate, and multiple conferences. As such it may be more helpful to consider strategic decisions as processes: thus, our definition, in this dimension, is that of a *judgemental process* to achieve an objective. This concept of decision as process is consistent with the author's previous research (Cox 2012) where of the three case studies studied, it was difficult to establish a specific point of decision for at least two of the three, and for all the start and finish of the processes took a number of months. A yet further dimension extends the thinking of Weick (for example Weick 2001), where the 'decision' is considered to be primarily a rationalisation and sense-making of actions taken at the outset. Thus, in this definition, the main work of any decision process is to justify, explain, and help those involved make sense of what is being done.

The uncertainty as to the precise form of decision is no monopoly of management decision-making. Libet (1983) conducted experiments on neurophysiology showing a difference in neurological activity suggesting the preparation for physical actions, measured through the readiness potential, happens before a conscious mind initiates the action. Thus:

> *It is concluded that cerebral initiation of a spontaneous, freely voluntary act can begin unconsciously, that is, before there is any (at least recallable) subjective awareness that a 'decision' to act has already been initiated cerebrally. This introduces certain constraints on the potentiality for conscious initiation and control of voluntary acts.* (Libet 1983, p. 1*)*

This was initially interpreted as a challenge to free will and to how decisions are made. The literature relating to and subsequent research generated by Libet is significant, and the original conclusions and implications have been challenged. A more balanced view that attempts to reconcile the various parts of the neuro-scientific research is the view that 'decision' may not necessarily be an event, or at least not *only* an event. Thus, it may be helpful to reconcile the multi-dimensional view of decisions through an assessment that:

> *When we look closely at a person's conscious decisions, we discover that this quest for spatio-temporal precision breaks down…We restore power…to the self by*

recognizing that its duties are distributed in both space and time in the brain. (Dennett 2003, p. 255)

Therefore, we may helpful approach decisions not as phenomena requiring different competing definitions (which may be mutually exclusive) but rather phenomena existing in a distributed, multi-dimensional social space.

[11] Simon (1978, p.2) states that economic rational man is “a maximizer, who will settle for nothing less than the best”. Furthermore, he quotes a noted figure in defending the economic rational model, Gary Becker, as stating that the rational decision model extends to the most mundane decisions of life: “he would read in bed at night only if the value of reading exceeds the value (to him) of the loss of sleep suffered by his wife” (Simon 1978, p.2).

[12] Schutz (1943) further states the implications of definition of rational choice.

> This postulate implies:
> (a) Knowledge of the place of the end to be realised within the framework of the plans of the actor (which must be known by him, too).
> (b) Knowledge of its interrelations with other ends and its compatibility or incompatibility with them.
> (c) Knowledge of the desirable and undesirable consequences which may arise as by-products of the realisation of the main end.
> (d) Knowledge of the different chains of means which technically or even ontologically are suitable for the accomplishment of this end, regardless of whether the actor has control of all or several of their elements.
> (e) Knowledge of the interference of such means with other ends or other chains of means including all their secondary effects and incidental consequences.
> (f) Knowledge of the accessibility of those means for the actor, picking out the means which are within his reach and which he can and may set going.

[13] In Tversky and Kahneman (1981) Participants were asked to *"imagine that the U.S. is preparing for the outbreak of an unusual Asian disease, which is expected to kill 600 people. Two alternative programs to combat the disease have been proposed. Assume the exact scientific estimate of the consequences of the programs are as follows."*

The first group of participants was presented with a choice between programs: In a group of 600 people,

- Program A: "200 people will be saved"
- Program B: "there is a 1/3 probability that 600 people will be saved, and a 2/3 probability that no people will be saved"

72 percent of participants preferred program A (the remainder, 28%, opting for program B).

The second group of participants was presented with the choice between the following: In a group of 600 people,

- Program C: "400 people will die"
- Program D: "there is a 1/3 probability that nobody will die, and a 2/3 probability that 600 people will die"

In this decision frame, 78% preferred program D, with the remaining 22% opting for program C.

Programs A and C are identical, as are programs B and D. The change in the decision frame between the two groups of participants produced a preference reversal: when the programs were presented in terms of lives saved, the participants preferred the secure program, A (= C). When the programs were presented in terms of expected deaths, participants chose the

gamble D (= B)
Tversky and Kahneman (1981) described the celebrated and oft cited piece of psychological research into decision-making; since referred to as the 'Asian Disease Problem' (ADP). This has been instrumental in developing the modern theses of framing in decision-making. Pinker (2007) has described the ADP as the 'gold standard of framing' and is a frequent reference point for understanding differential approaches to risk. For Kahneman and Tversky the ADP is part of the programme of research and discussion for their wider concept of Prospect Theory (Kahneman and Tversky 1979). The fundamental principle for PT is that decision-makers are: risk averse for gains (they seek to hold on the sure-thing and avoid riskier attempts to gain more if they involve possible loss); and risk seeking for losses (they seek to risk further loss to avoid regaining what is already lost). Bless et al. (1998) provide an example where the repetition of the research problem from ADP produces a similar result to the original: however, when the problem is re-stated as a statistical one, the outcome changes. Bless et al. (1998) conclude this is an example of the impact of 'context cues'. It may be debated as to whether 'context cues' are merely a form of 're-framing' or whether frames themselves have an inevitable contextual dimension. If Goffman's (1974) initial description of framing as the *organization of experience* is accepted, then the frame cannot be seen in isolation. Thus, it may be considered that decision-makers arrive at the point of decision with their own framing (either individually or as a group). This pre-frame may be important in shaping the decision frame as to 'loss' or 'gain'. Within the negotiated order, the group discussion and context will create the evaluation of what is 'loss' or 'gain'. Furthermore, the background knowledge of individuals (or groups) may influence not only the loss-gain dimension but also pre-existing experience may influence the option choice itself. Thus, Pinker (2007) suggests doctors (such as those participants in the original ADP) may treat the option of 'save 200 lives' as implying 'save at least 200'. Thus, option A then becomes potentially differential to Option B in statistical outcome. Their equivalence depends on an almost exact match between the outcomes of the two options treated iteratively over a series of occasions. If risk averse option A is treated not as 200 lives saved but as 200+ lives saved it becomes more attractive still. As option B in its best-case scenario (all lives saved) can only ever save 600 lives, then it only assumes comparative effectiveness if the saves all lives one time in three is matched against a literal option A of only 200 saved.

[14] "man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning." (Geertz 1973, p. 5)

[15] *Advocatus Diaboli* "Advocate of the Devil" or "Devil's Advocate". A popular title given to one of the most important officers of the Sacred Congregation of Rites, established in 1587, by Sixtus V, to deal juridically with processes of beatification and canonization. His official title is Promoter of the Faith *(Promotor Fidei)*. His duty requires him to prepare in writing all possible arguments, even at times seemingly slight, against the raising of any one to the honours of the altar. The interest and honour of the Church are concerned in preventing any one from receiving those honours whose death is not juridically proved to have been "precious in the sight of God". Prospero Lamertini, afterwards Pope Benedict XIV (1740-58), was the Promoter of the Faith for twenty years, and had every opportunity to study the workings of the Church in this most important function; he was, therefore, peculiarly qualified to compose his monumental work "On the Beatification and Canonization of Saints," which contains the complete vindication of the rights of the Church in this matter, and sets forth historically its extreme care of the use of this right. No important act in the process of beatification or canonization is valid unless performed in the presence of the Promoter of the Faith formally recognized. His duty is to protest against the omission of the forms laid

down, and to insist upon the consideration of any objection. The first formal mention of such an officer is found in the canonization of St. Lawrence Justinian under Leo X (1513-21). Urban VIII, in 1631, made his presence necessary, at least by deputy, for the validity of any act connected with the process of beatification or canonization.

[16] The performance of decision-makers in certain situations ay be improved not merely by the use of groups, but also decision-making models. Meehl's (1954) early study comparing expert clinician with statistically generated decision-making outcomes has been replicated across a number of studies (see Dawes et al. 1989) to conclude that the use of models and algorithms appear to provide consistently better decision-making for clinical decision-making than the use of individual clinical experts. That said the models themselves are the product of experts, but groups of experts agreeing a systematic approach which may be less influenced by decision-maker bias than the decision-making of individual experts in a clinical setting. Dana and David-Stober (2016) suggest that research into actuarial models optimizes data in favour of the actuarial models and thus underestimate clinician decision-making. Dawes et al. (1989) concluded, at least at the time of writing, that despite the strength of the research, the use of actuarial models had "limited impact on everyday decision-making" (Dawes et al. 1989, p.243).

[17] March was one of the co-authors of the original Garbage Can paper (Cohen et al. 1972) and elements from the earlier work (Cyert and March 1962) such as variable attentional focus and the shifting nature of goal setting and prioritization are present in the later paper.

[18] The graph of health spend compared to life expectancy as provided in Appendix 1 demonstrates a logarithmic curve of improved life expectancy against health spend (usually accompanying a similar increase in a country's economy relative to comparators). Le Fanu (2000) in describing the declining impact of modern healthcare in terms of improving mortality, infers the period for significant improvements in life expectancy through healthcare intervention may be over. Subsequent improvements may see smaller and smaller gains.

[19] See Appendix 1.

[20] Shibuya (2011) summarises a number of the reasons for the apparent cost benefit efficiency of the Japanese healthcare system. One area of cost containment appears to be the much longer lead time for the introduction of new drugs and devices in Japan. Such new interventions will often be of drugs and devices on patent, and consequently may come at a premium cost. Thus:

> In Japan, there are substantial delays in the approval and introduction of new health technologies, including drugs, devices, and vaccines. New drugs took about 3·7 years after first world application before market launch in Japan during 1999–2003. This long period compared with delays in other developed countries is attributable to the longer processes required for undertaking clinical trials, delay in filing new drug applications in Japan, longer approval process by Japan's regulatory authority, and tight price regulation that dampens incentives for pharmaceutical companies to enter the market.
>
> The delay is even longer for new devices in Japan. For example, Japan's approved implantable artificial heart has been replaced with newer second-generation devices in other countries. As a result, the device used in Japan has disappeared from the global market, and the latest devices are not available to Japanese patients with end-stage heart failure. (Shibuya 2011, p.1268)

[21] The Muennig and Glied (2010) review of USA healthcare concludes, "rising health spending may be choking off public funding on more important life- saving programs... At current spending levels, investments in public health, education, public safety, safety-net, and

community development programs may be more efficient at increasing survival than further investments in medical care."

[22] Pinker (2011, p.588-589) describes the more detailed view of different narratives:

> The Perpetrator's Narrative: The story begins with the harmful act. At the time I had good reasons for doing it. Perhaps I was responding to an immediate provocation. Or I was just reacting to the situation in a way that any reasonable person would. I had a perfect right to do what I did, and it's unfair to blame me for it. The harm was minor, and easily repaired, and I apologized. It's time to get over it, put it behind us, let bygones be bygones.
>
> The Victim's Narrative: The story begins long before the harmful act, which was just the latest incident in a long history of mistreatment. The perpetrator's actions were incoherent, senseless, incomprehensible. Either that or he was an abnormal sadist, motivated only by a desire to see me suffer, though I was completely innocent. The harm he did is grievous and irreparable, with effects that will last forever. None of us should ever forget it.

[23] In a later paper Lord et al. (1984) conduct research that concludes bias can be effectively countered by encouraging participants to actively consider opposite and alternative positions.

[24] Bhaskar (1978) describes what he sees as the necessary approach of transcendental realism (critical realism) as being the appropriate realist position in dealing with *open* systems. Thus, positivism and empirical realism (in Bhaskar's term) provides causal explanations effectively within closed systems. That is those where most factors and variables are known and where possible controlled, for example, in laboratory experiments in chemistry. In much of science, however, situations are not controlled and clearly defined: thus, they are *open* systems. This would appear to apply to all of social scientific exploration.

[25] Roy Bhaskar (1978) is considered a major original contributor to the development of critical realism (Johnson and Duberley 2000). Bhaskar (1978), despite being seen as the parent of critical realism, has preferred the term *transcendental realism* rather than critical realism. Thus, transcendental realism is seen to avoid the pitfalls (in Bhaskar's view) of empirical realism (encompassing positivism) and transcendental idealism (encompassing various forms of interpretivism).

[26] Wittgenstein being one author suggesting causality may be a 'superstition':
From Wittgenstein's Tractatus Logico-Philosophicus:

> "5.135 In no way can an inference be made from the existence of one state of affairs to the existence of another entirely different from it.
> 5.136 There is no causal nexus which justifies such an inference
> 5.1361 The events of the future *cannot* be inferred from those of the present.
> Superstition is the belief in the causal nexus.
> 5.1362 The freedom of the will consists in the fact that future actions cannot be known now. We could only know them if causality were an *inner* necessity, like that of logical deduction. - The connexion of knowledge and what is known is that of logical necessity.

[27] Bhaskar (1978) defends the concept of induction suggesting that it can be justified, but dependent on certain criteria being met. He is thus critical of Popper's rejection of induction as not the scientific method, but also of an interesting defence of induction from Strawson

(1963) that induction is such a central part of the scientific method it needs no separate explanation.

[28] Anderson (2006) contrasts this approach with what he describes as "evocative autoethnography" which is seen as being more emotionally based, closer to autobiography, and often reflecting a postmodernist methodology.

[29] The workforce risks of the tender option were considered by some participants to increase as if the tender resulted in a change of provider, staff currently employed within a service would be transferred to a new provider under the TUPE regulations. This could include transfer to a non-NHS provider. Although TUPE would protect employment terms and conditions, some staff may worry about future terms and conditions and access to the NHS pension scheme. Even if the impact on actual terms and conditions may be small, the perceived change may be seen to be unsettling. Conversely, there was anecdotal information regarding staff leaving due to low morale. Although this was stated in the meeting and the referenced engagement events suggested staff wanted to see changes in the services, no statistical information was provided to show whether staff departures were happening at a greater or lesser rate than normal staff turnover.

[30] As an interesting and possibly relevant anecdote, the author remembered the behaviour of a senior hospital manager in a performance review meeting. At the start of the meeting the forum chair, the Hospital CEO, circulated the meeting agenda. Before he could start to work through it the General Manager (largely at the meeting to account for his division's poor performance) place an alternative agenda on top of the CEO's agenda and said, 'before we begin the meeting can we just deal with some of our issues first?' Slightly taken aback, the CEO accepted the proposal. The meeting time worked through the GM's 'agenda' until there was no time to do the 'formal' agenda. All the performance issues were actually covered, but according to the frame of the GM, not the CEO. Inevitably the GM had a much easier time explaining poor preforming service after telling everyone how good other parts were. Consciously or unconsciously this was a masterly example of controlling a meeting to meet your needs, and assuming control at the outset. Whether the CEO recognized what had happened to him was unknown.

[31] Throughout the text the term 'managed change' refers to an approach of trying to achieve the desired outcomes through a process of negotiation with existing providers that would avoid a formal open market tender procurement.

[32] NOTLAM GP was present during Meeting 4 but they had lost their voice due to illness and did not actually speak in the session.

[33] Continuing Healthcare is a term describing care provide to those with very complex, severe, and ongoing care needs which are fully funded by the NHS.

[34] Although an NHS commissioning organization may not be directly liable to deficits sitting with a Foundation Trust, the FT would likely want to increase funding from its local NHS commissioner to help reduce (or eliminate) a deficit. As such any NHS financial pressure was treated as a 'system pressure' and had to be considered in any strategic thinking.

[35] Since the introduction of the NHS reforms in 2013 and by the time of the case study the NHS had a relatively complicated regulatory system. NHS England having responsivity and oversight for the commissioning organizations (CCGs); NHS Improvement responsibility for NHS provider organizations such as hospital and mental health providers; the Care Quality Commission having responsivity for safety and quality of care delivery including General Practice and social care providers.

[36] Notlam the main population centre with 20,000 of the Nortondale overall CCG population of circa 30,000. Nortondale district extended into parts of a neighbouring CCG the residents of whom also used the community hospital.

[37] "Suppose both you and another person are given sealed envelopes with amounts of money that neither of you knows anything about except that one of them is either twice as large or twice as small as the other one. Would you prefer to keep your own envelope or rather trade it with the other player?" (Navon 2013, p.4)

[38] Strategic assessment tool assessing a number of critical contextual influences – Political Economic Social Technological Legal Environmental.

[39] Toulmin (1964) describes six parts to logical arguments (data, claim, and warrant being the primary elements of the structure.

Data: The facts or evidence used to prove the argument
Claim: The statement being argued (a thesis)
Warrants: The general, hypothetical (and often implicit) logical statements that serve as bridges between the claim and the data.
Qualifiers: Statements that limit the strength of the argument or statements that propose the conditions under which the argument is true.
Rebuttals: Counter-arguments or statements indicating circumstances when the general argument does not hold true.
Backing: Statements that serve to support the warrants (i.e., arguments that do not necessarily prove the main point being argued, but which do prove the warrants are true.)

[40] Media Richness Theory (MRT) (Daft et al. 1987) asserts that knowledge transfer through information can be most effective when the information delivery provides the appropriate level of 'richness' to manage ambiguity of information content. Where information has high 'equivocality' (that is complex and needing a high level of interpretation) the use of delivery methods considered to be 'rich' (essentially those of face-to-face communication) will provide more effective communication.

[41] The origins of shibboleth being a Hebrew word contained in the Bible, literally meaning 'ear of wheat', was a dialect function that enabled distinctions to be made between friend and foe (McNamara 2012). McNamara (2012) discusses the role of shibboleth in Derrida's language analysis. Thus, "the shibboleth necessarily acts as a two-edged sword, that inclusion always carries with it the potential for exclusion, that its potential for justice is simultaneously a potential for injustice, leads Derrida to speak of 'the terrifying ambiguity of the shibboleth, sign of belonging, and threat of discrimination" (McNamara 2012, p.570).

[42] Pinker (2018, p.359) goes on to state:

> The anthropologist John Tooby adds that preposterous beliefs are more effective signals of coalitional loyalty than reasonable ones. Anyone can say that rocks fall down rather than up, but only a person who is truly committed to the brethren has a reason to say that God is three persons but also one person, or that the Democratic Party ran a child sex ring out of a Washington pizzeria.

[43] This is famously described in Wittgenstein's (1967) consideration of language games and examples of how difficult it is to provide a precise definition for terms such as 'game' which are dependent on the context within which they are used. Interestingly Clegg et al. (2006) cite earlier work by Clegg (1975) researching how language is used within the 'hard contracting'

of the building contracting industry, where there may seem to be little scope for interpretation. Au contraire says Clegg (2006, p.295-296):

> Contractual specifications, typically, are large and complex bodies of documentation. Not only are there the documents on which the work is bid but there is also associated 'bill of works' comprising detailed consultants' reports and associated documents. In an ideal world these would exist in an absolute and seamless correspondence of all detail from one document to another such that no document ever contradicted another or was in conflict with it. Given the vast amount of paper - comprising detailed specifications, reports, and projections - associated with the relatively complex construction projects, that there actually is such correspondence is a large assumption to make. Many hands, at many times, with many distinct skills, produce the papers. More often than not there will be points of ambiguity or even disagreement between them. The precise meaning of them is not stipulated in the documents themselves. In Wittgenstein's terms there is no meta-rule that provides the rules for how the meaning embedded in documents should be interpreted.

[44] 'Harmonious' here may be a somewhat misleading term, as the dynamic struggles of ideas may rarely produce harmony. The authors may be implying more *effective* than harmonious.

[45] Hayek (1945, p. 521) states:

> Today it is almost heresy to suggest that scientific knowledge is not the sum of all knowledge. But a little reflection will show that there is beyond question a body of very important but unorganized knowledge which cannot possibly be called scientific in the sense of knowledge of general rules: the knowledge of the particular circumstances of time and place. It is with respect to this that practically every individual has some advantage over all others because he possesses unique information of which beneficial use might be made, but of which use can be made only if the decisions depending on it are left to him or are made with his active cooperation.

[46] Mercier and Sperber (2011, p.72) further state, "People who have an opinion to defend don't really evaluate the arguments of their interlocutors in a search for genuine information but rather consider them from the start as counter arguments to be rebutted." Nevertheless, their assessment was, "Human reasoning is not a profoundly flawed general mechanism; it is a remarkably efficient specialized device adapted to a certain type of social and cognitive interaction at which it excels" (ibid).

[47] Winter (1989) describes reflexive analysis as learning where the view is 'bent back': thus, reflection is general consideration; reflexion self-analysis and consideration of one's own actions. See the methodology chapter for a more extended discussion on reflexivity, and the reflexive critique chapter for its application in the project.