

Sheffield Hallam University

Decision-making in English Clinical Commissioning Groups: A Mixed Methods Study

SIBANDA, Mpumelelo

Available from the Sheffield Hallam University Research Archive (SHURA) at:

<http://shura.shu.ac.uk/26110/>

A Sheffield Hallam University thesis

This thesis is protected by copyright which belongs to the author.

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given.

Please visit <http://shura.shu.ac.uk/26110/> and <http://shura.shu.ac.uk/information.html> for further details about copyright and re-use permissions.

**Decision-making in English Clinical Commissioning Groups:
A Mixed Methods Study**

Mpumelelo Sibanda

A thesis submitted in partial fulfilment of the requirements of
Sheffield Hallam University Sheffield Business School
for the degree of Doctor of Business Administration

October 2019

Candidate Declaration

I hereby declare that:

- a. I have been enrolled for another award of the University, or other academic or professional organisation, whilst undertaking my research degree. I was an enrolled student for the following award:

Name of award: Master of Science in Project Management

Awarding body: Salford University

- b. None of the material contained in the thesis has been used in any other submission for an academic award.
- c. I am aware of, and understand the University's policy on plagiarism and certify that this thesis is my own work. The use of all published or other sources of material consulted have been properly and fully acknowledged.
- d. The work undertaken towards the thesis has been conducted in accordance with the SHU Principles of Integrity in Research and the SHU Research Ethics Policy.
- e. The word count of the thesis is 74,807.

Name	<i>Mpumelelo Sibanda</i>
Date	<i>October 2019</i>
Award	<i>DBA</i>
Faculty	<i>Sheffield Business School Business and Management</i>
Director(s) of Studies	<i>Dr Richard Breese</i>

Abstract

This research primarily investigated the Clinical Commissioning Groups (CCGs) in the English NHS to identify factors influencing effective decision-making as perceived by General Practitioners (GPs) with formal roles in CCGs. A study by the British Medical Association (BMA) (2014a) revealed that GPs at practice level felt that CCGs were developing policies that restrict efficient delivery of health care. As such, I developed a hypothesised conceptual model demonstrating factors at play in the decision-making process, which I tested using Partial Least Squares Structural Equation Modelling (PLS-SEM). Alongside, informed by the conceptual model, was the qualitative strand, with the data that I analysed under interpretative phenomenological analysis (IPA). Quantitative and qualitative data were collected simultaneously through a survey using a questionnaire in a convergent parallel mixed methods design, underpinned by a philosophical position of pragmatism. Data was collected in 2017. Research sample consists of 73 GPs in the UK.

The hypothesis testing results show that *GP Proportion* has a significant and positive effect on *Decision-making Process Effectiveness*. Similarly, the effect of *GP Influence* has been found to be significant and positive on *Satisfaction*. In contrast, the effect of *GP Influence* on *Decision-making Process Effectiveness* has been found to be insignificant. This result is also observed regarding the effect of *GP Influence* on *Member Practice Wishes Met*. Five key themes were identified from the qualitative data analysis – namely, (1) Financial, focused on decisions influenced by financial concerns, (2) Bureaucracy, centred on decisions influenced by the bureaucratic hierarchy, (3) Clinical, to do with decisions that were perceived as having clinical implications, (4) Workplace culture, focused on behavioural patterns affecting decision-making within the organisation, and (5) CCG role, based on the way the role of CCGs was understood by member practices and the way that engagement of member practices was achieved by the respective CCGs.

The results contribute to theory and practice. Regarding practice, notwithstanding the intended autonomy for the CCGs, which was aimed at improving patient care by aligning health care commissioning decisions with local needs, structure alone appears not enough to deliver effectiveness, as perceived by GPs. The proportion of GPs was found to be a relevant factor, while leadership and local CCG level culture, coupled with communication and governance, are also important. Finance was found to be significant, with many concerns about CCG policies attributed to this factor. On contribution to theory, the general observation is that the CCGs appear to be moving from professional to bureaucratic organisational model (Mintzberg 1979), thereby threatening the purported autonomy.

This study also revealed new information on the formal roles that GPs occupy in CCGs, as previous research showed limited awareness in this regard (Checkland et al. 2016). Information gathered on committee memberships and the positions GPs occupy highlights the complexity and diversity of GP roles in CCGs.

Key words:

Clinical commissioning groups, CCGs, Governing Body, organisation, organisational structure, decision-making, effective decision-making, centralisation, decentralisation

Acknowledgements

First, I want to express my sincere gratitude to my supervisors, Dr Richard Breese, Director of Studies, and Professor Ilfryn Price. I am forever indebted to the tireless and patient support and guidance that you gave me. A special thanks to my friend, Dr Victor Samwinga, for motivating me to keep going even though at times I felt like letting go. I want to thank my statistician friends, Dr Jabulani Sithole and Noreen Chitate, who supported me with some of the principles in statistics as I prepared for my quantitative data analysis. Big gratitude also goes to the following, who helped me with proofreading; (1) Elizabeth Johnson, a fellow doctoral student, (2) Johnson Mukanganiki, a dear friend of many years, and (3) Dr Lucas Mafu, my amazing one-time high school teacher, who is now not only a friend to me but a brother. I would also like to thank Lucy Hind, a classmate in this journey, who nurtured us like a mother with tact and skill, instilling confidence in the cohort to soldier on. To my friends, Edward Kunonga and Patrick Mashiri, thank you for being a calming and empowering voice during this process. Not forgetting my brother in law, Isaac Chipswa, who always bolstered me with 'tons' of enthusiasm, which made the process feel worthwhile.

To my parents, thank you for the way that you brought us up, setting an excellent example for us to be industrious. To my brothers and sisters, thank you for the supportive words and influence that you imparted, which gave me stability. I would like to especially recognise my younger sister, Ntandoyenkosi, whose passion and dedication in academic undertakings is a positive force which challenged me and kept me on my feet. To my uncle, Modecai Madlela, your attitude towards work, and towards anything really that your hand finds to do, has always inspired me to aim higher. Thank you.

In a very special way, I would like to recognise my wife and children for their support, patience, and longsuffering during my studies as I spent much of my time away from them. You have grown to accept and live with the long-overdue DIY chores that I have been procrastinating due to lack of time. Thank you, my darlings; I appreciate your love and support.

Above all, I thank God for His mercies and grace in the pursuit of this doctoral programme. He has been my biggest inspiration, and my faith is greatly strengthened. I am exiting this course feeling more confident.

Table of Contents

Candidate Declaration	ii
Abstract	iii
Acknowledgements	v
Table of Contents	i
List of Figures.....	x
List of Tables	xiii
Abbreviations.....	xv
CHAPTER 1 INTRODUCTION	1
1.1 Contextual Background	1
1.1.1 Policy objectives and the context of CCGs	3
1.2 Rationale of the research	4
1.3 Research aims, objectives and questions	6
1.4 Scope and key assumptions.....	7
1.4.1 Delimitations of scope	7
1.4.2 Key assumptions.....	8

1.4.3	Access limitations	8
1.5	Methodology	9
1.6	Thesis structure	9
CHAPTER 2	LITERATURE REVIEW.....	11
2.1	Introduction	11
2.2	Key Concepts.....	12
2.3	Organisational structure and associated factors on decision-making	13
2.3.1	A brief history of organisational theory	13
2.3.2	Organisational structure.....	16
2.3.3	Organizational culture	18
2.3.4	Mintzberg’s models	21
2.3.5	Centralised organisational structures.....	23
2.3.6	Decentralised organisational structures.....	28
2.3.7	Leadership and governance.....	38
2.3.8	Communication	41
2.4	CCGs – What research has revealed.....	42
2.4.1	The question of autonomy	42

2.4.2	Finance.....	43
2.4.3	Member practice engagement.....	44
2.4.4	Conflicts of interest	45
2.4.5	CCG roles occupied by GPs	46
2.4.6	Summary of Previous research findings and knowledge gaps	47
2.5	Conceptual framework – CCGs and organisational structure	48
2.5.1	Independent latent variables	50
2.5.2	Dependent latent variables	51
2.5.3	Conceptual model.....	54
2.6	Summary.....	54
CHAPTER 3	RESEARCH DESIGN.....	56
3.1	Introduction	56
3.2	‘Philosophical position’ and methodological stance	56
3.3	Research methodology.....	58
3.3.1	Data collection: Survey	64
3.3.2	Why survey?	65
3.3.3	Epistemological Implications	66

3.3.4	Study authentication and generalisation	70
3.3.5	Research population and sampling	72
3.4	Measurement of variables.....	76
3.5	Data collection	77
3.5.1	Structure and design of the questionnaire.....	77
3.5.2	Survey questions.....	84
3.5.3	Ethical considerations.....	93
3.5.4	Pilot study	94
3.5.5	Questionnaire distribution	99
3.5.6	Effort on eliciting high response rate	103
3.6	Data analysis methods.....	104
3.6.1	Quantitative data analysis	104
3.6.2	Qualitative data analysis.....	125
3.6.3	Interpretation	132
3.7	Conclusion.....	133
CHAPTER 4	RESULTS AND DISCUSSION	134
4.1	Introduction	134

4.1.1	Response rate	134
4.2	Quantitative Results	135
4.2.1	Quantitative study strand: Descriptive statistics.....	135
4.2.2	Quantitative study strand: Inferential analysis	176
4.3	Qualitative Results.....	196
4.3.1	Data familiarisation	198
4.3.2	Discovering themes	198
4.3.3	Abstraction and integration of themes – Question.....	205
4.4	Conclusion.....	217
CHAPTER 5	CONCLUSION	219
5.1	Summary of the research	219
5.1.1	Recap of research problem	220
5.1.2	Recap of research methodology.....	220
5.1.3	Summary of research findings.....	222
5.1.4	Concluding remarks	241
5.2	Theoretical contributions	242
5.3	Implications for practice	243

5.3.1	Confirmatory implications	244
5.3.2	Conflicts of interest	244
5.3.3	Time factor.....	244
5.3.4	Bureaucracy	245
5.3.5	Knowledge vacuum	245
5.4	Research limitations	246
5.4.1	Response rate	246
5.4.2	Scope of leadership roles	247
5.4.3	CCGs' geographical locations information	247
5.4.4	Use of questionnaire in a phenomenological method	248
5.4.5	Quantitative data analysis	248
5.5	Recommendations for future research	249
REFERENCES.....		253
APPENDICES.....		282
Appendix 1	Email Communications with BMA	282
Appendix 1.1	Request for BMA's advice and assistance in proposed research: 18 February 2016	282
Appendix 1.2	BMA's Reply: Request for advice and assistance in proposed research: 18 February 2016.....	284

Appendix 1.3	Request for BMA Press Release Email Trail	285
Appendix 2	Communications with CCGs	290
Appendix 2.1	Freedom of Information Act 2000 – Information Request for GPs’ Email Contacts	290
Appendix 2.2	FOI Request – CCG Details as in December 2016	292
Appendix 2.3	Invitation to take part in pilot study: 10 & 14 April 2017.....	348
Appendix 2.4	Invitation to pilot study reminder: 24 April 2017.....	350
Appendix 2.5	Replies collection to pilot study ‘entreaty’ email.....	351
Appendix 2.6	Hard copy letter announcing forthcoming electronic based survey: 22 May 2017.....	355
Appendix 2.7	Stockton CCG complaint email: 23 May 2017	356
Appendix 2.8	Email seeking confirmation from DoS if my study is legitimate: 24 May 2017.....	357
Appendix 2.9	Good idea to introduce yourself: 27 June 2017	358
Appendix 2.10	Happy to take part in the survey: 25 May 2017	359
Appendix 2.11	CCG refusal to take part in survey	360
Appendix 2.12	Invitation to take part in survey: 04 June 2017	360
Appendix 2.13	Instructed not to open weblinks by IT: 05 June 2017	362
Appendix 2.14	Response from unconventional email address category: 05 June 2017	363

Appendix 2.15	Reminder invitation email: 20 June 2017	363
Appendix 3	Ethical considerations.....	365
Appendix 3.1	Research Ethics Committee approval email.....	365
Appendix 3.2	Head of Research Ethics email about IRAS.....	367
Appendix 4	PLS-SEM Path Model Assessment	368
Appendix 4.1	Outer Model Assessment	368
Appendix 4.2	Inner Model Assessment	372
Appendix 5	Data Analysis Concepts.....	375
Appendix 5.1	Qualitative Data Analysis: Hermeneutic phenomenology concepts.....	375
Appendix 5.2	Qualitative Data Analysis: Reflexivity	376
Appendix 6	Data Dictionary	378
Appendix 6.1	Data Dictionary: Format 1 Analysis Assigned Categories and Codes	378
Appendix 6.2	Data Dictionary: Format 2 Analysis Assigned Categories and Codes	383
Appendix 7	Statistics Tables	397
Appendix 7.1	Question 3 CCG Roles Distribution	397
Appendix 7.2	Question 4b Various CCGs Committees	403

Appendix 7.3 Question 13 Unfriendly Decisions to GP Profession 411

Appendix 7.4 Question 14 Reasons for Unfavourable Decisions to GP Profession..... 414

Appendix 7.5 Question 17 Mechanisms to Curb Domineering Persons..... 416

Appendix 7.6 Question 20 GPs’ Additional Views on Local CCG Decision-making Practices 425

Appendix 7.7 Question 22 Member practice Engagement 430

Appendix 7.8 Question 4b. Please list the “other committee(s)” that you sit on 441

List of Figures

Figure 1.1 Relationship structure: NHS England, CCGs, and GP Practices (Source: Author’s own 2019, unpublished)	4
Figure 1.2 Research design outline.....	9
Figure 2.1 Timeline of organisational theories.....	15
Figure 2.2 Organisational structure elements relations.....	17
Figure 2.3 Three levels of culture (Adapted from Schein (2017)	19
Figure 2.4 Mintzberg’s models of organisational structure	22
Figure 2.5 PCT commissioning and reporting lines	25
Figure 2.6 The relative importance of managerial skills at different managerial levels	27
Figure 2.7 A continuum of control over the decision-making process (Adapted from Mintzberg 1979).....	29
Figure 2.8 Buckinghamshire CCG Governance Structure	33
Figure 2.9 Somerset CCG Governance Structure.....	34
Figure 2.10 CCG commissioning and reporting lines.....	35
Figure 2.11 CCGs Decision-making Conceptual Model (Source: Author’s own 2019, unpublished)	53
Figure 3.1 Methodology - A connecting link between epistemology and methods	58
Figure 3.2 Pragmatic approach methodological framework versus traditional approaches	58
Figure 3.3 Convergent parallel mixed-methods approach.....	60
Figure 3.4 Questionnaire landing page (Source: Survey questionnaire).....	79
Figure 3.5 Consent statement (Source: Survey questionnaire)	79
Figure 3.6 Example of long answer text (Source: Survey questionnaire).....	80
Figure 3.7 Example of short answer text (Source: Survey questionnaire)	81
Figure 3.8 Recommendations on when to use PLS-SEM or CB-SEM.....	106

Figure 3.9 SEM Model Ecosystem Illustration	111
Figure 3.10 CCGs Final Phase PLS-SEM Path Model (Source: Author’s own 2019, unpublished)	112
Figure 3.11 CCGs Early Phase PLS-SEM Path Model (Source: Author’s own 2019, unpublished).....	115
Figure 3.12 A Two-step PLS-SEM Path Model Assessment	118
Figure 3.13 Final Phase CCGs Decision-making Conceptual Model	121
Figure 3.14 Qualitative Data Statistical Analysis Approach (Source: Author’s own 2019, unpublished).....	127
Figure 3.15 Qualitative data analysis steps (Adapted from Benner 1994).....	131
Figure 4.1 Respondent’s professional background breakdown (Source: Analysis of survey data).....	135
Figure 4.2 Length of time with local CCG (Source: Analysis of survey data)	138
Figure 4.3 GP CCG Roles Distribution by Code (Source: Analysis of survey data).....	140
Figure 4.4 Number of Roles Measure per GP (Source: Analysis of survey data).....	141
Figure 4.5 Committee Involvement Status (Source: Analysis of survey data)	143
Figure 4.6 CCG Various Committees (Source: Analysis of survey data)	144
Figure 4.7 Number of Committees Measure per GP (Source: Analysis of survey data).....	147
Figure 4.8 Voting membership status (Source: Analysis of survey data)	147
Figure 4.9 CCGs’ Governing Body sizes (Source: Analysis of survey data)	149
Figure 4.10 CCGs’ Governing Body sizes (Source: Checkland et al. 2016)	149
Figure 4.11 Governing Body decision-making approach (Source: Analysis of survey data)	150
Figure 4.12 GP membership proportion in Governing Body (Source: Analysis of survey data).....	151
Figure 4.13 GP Level of influence measure in Governing Body (Source: Analysis of survey data)	153
Figure 4.14 Measure: Local Governing Body is dysfunctional (Source: Analysis of survey data)	154
Figure 4.15 Measure: Few strong personalities influence GB decisions (Source: Analysis of survey data).....	155
Figure 4.16 Measure: Some GB members yield their views easily (Source: Analysis of survey data)	156

Figure 4.17 Senior authority influence measure (Source: Analysis of survey data).....	157
Figure 4.18 Unfriendly decisions measure (Source: Analysis of survey data).....	158
Figure 4.19 Reasons for unfriendly Decisions to GP Profession (Source: Analysis of survey data)	159
Figure 4.20 Unfriendly Decisions Perceived Impact (Source: Analysis of survey data).....	160
Figure 4.21 Unfriendly decisions to GP profession by codes (Source: Analysis of survey data)	161
Figure 4.22 Domineering Persona Checks (Source: Analysis of survey data).....	163
Figure 4.23 My CCG Decisions Reflect Members' Wishes (Source: Analysis of survey data)	165
Figure 4.24 Local CCG Decision-making satisfaction measure (Source: Analysis of survey data).....	166
Figure 4.25 Unfriendly Decisions versus Satisfaction (Source: Analysis of survey data)	167
Figure 4.26 Additional comments: Decision-making satisfaction Format 1 (Source: Analysis of survey data)	169
Figure 4.27 Is my local CCG GP led measure (Source: Analysis of survey data).....	170
Figure 4.28 Declining GP representation in CCGs (Source: Rosser 2018)	171
Figure 4.29 Accountable Officer professional background (Source: Analysis of survey data).....	172
Figure 4.30 Other: Accountable Officer Background (Source: Analysis of survey data)	173
Figure 4.31 Path model illustration	178
Figure 4.32 Early Phase PLS-SEM Path Model (Source: Author's own 2019, unpublished)	180
Figure 4.33 Reflective versus Formative models.....	181
Figure 4.34 Final Phase PLS-SEM Path Model (Source: Author's own 2019, unpublished)	183
Figure 4.35 Path model results summary.....	184

List of Tables

Table 3.1 Email Address Count by Type	76
Table 3.2 Type of questions in the questionnaire (Source: Survey questionnaire)	80
Table 3.3 Outline of questions	85
Table 3.4 Descriptive statistics for model characteristics (Adapted from Hair et al. 2012).....	110
Table 3.5 CCGs Final Phase Path Model Sources and Instruments List.....	112
Table 3.6 CCGs Early Phase Path Model Sources and Instruments List	116
Table 3.7 A list of criteria used in this study to evaluate outer path models.....	119
Table 3.8 A list of criteria used in this study to evaluate inner path models	120
Table 4.1 Participants' Demographic Information Outline (Source: Analysis of survey data)	136
Table 4.2 Question 3 Format 2 Analysis Example: 4 roles per GP (Source: Analysis of survey data)	141
Table 4.3 Question 3 Format 2 Analysis Examples: 5 or more roles per GP (Source: Analysis of survey data).....	141
Table 4.4 Question 4b List of CCG committees	145
Table 4.5 Domineering persona checks code list (Source: Analysis of survey data).....	163
Table 4.6 Correlation Status Description.....	166
Table 4.7 Additional comments: Decision-making satisfaction code list (Source: Analysis of survey data).....	169
Table 4.8 Correlation matrix (Source: Analysis of survey data)	174
Table 4.9 Correlation matrix interpretation (Source: Adapted from Hinkle et al. 2003)	174
Table 4.10 Early phase model (Reflective): Reliability and validity test affected indicators.....	181
Table 4.11 Early phase model (Formative): Validity test affected indicators	182
Table 4.12 Reflective outer model: Composite Reliability evaluation	185
Table 4.13 Reflective outer model: Convergent validity evaluation	185

Table 4.14 Reflective outer model: Heterotrait-monotrait evaluation.....	186
Table 4.15 Formative outer model: Variance inflation factor evaluation.....	186
Table 4.16 Final phase model: Description of indicators	187
Table 4.17 Inner model: R-Square evaluation.....	188
Table 4.18 Inner model: Effect size	189
Table 4.19 Inner model: Prediction relevance	189
Table 4.20 Inner model: Significance of path coefficients	190
Table 4.21 Hypotheses 1 to 3 results	192
Table 4.22 Hypotheses 4 results - Indirect effects	194
Table 4.23 Outline of qualitative data questions	197
Table 4.24 Themes for unfriendly decisions.....	198
Table 4.25 Themes for reasons of unfriendly decisions.....	199
Table 4.26 Themes for aspects local CCG good at.....	200
Table 4.27 Themes for aspects local CCG not good at	201
Table 4.28 Themes about curbing domineering personalities.....	203
Table 4.29 Themes about decision-making satisfaction	204
Table 4.30 List of themes.....	205

Abbreviations

ACO	Accountable care organisation
AO	Accountability Officer
APMS	Alternative Provider Medical Services
AVE	Average variance extracted
BBC	British Broadcasting Corporation
BMA	British Medical Association
BMJ	British Medical Journal
CB-SEM	Covariance Based Structural Equation Modelling
CCG	Clinical Commissioning Group
CG	Clinical Guidelines
CMG	Clinical Management Group
COI	Conflict of interest
CSC	Care Staff Committee
CV	Curriculum Vitae
CVD	Cardiovascular
DoH	Department of Health
ENT	Ear, nose, and throat
EPEC	Empowering Parents, Empowering Communities
F&P	Finance & Performance
FT	Foundation Trust
GB	Governing Body
GMS	General Medical Services
GP	General Practitioner
H _A	Alternative Hypothesis
H ₀	Null Hypothesis
HTMT	Heterotrait-monotrait
IBE	Inference to the Best Explanation
IFR	Individual Funding Request
IGP	Integrated Governance and Performance

IM&T	Information Management & Technology
IPA	Interpretative phenomenological analysis
IRAS	Integrated Research Application System
JLEB	Joint Locality Executive Board
LMC	Local Medical Committee
MSK	Musculoskeletal
MTMM	Multitrait-multimethod matrix
NED	Non-Executive Director
NHS	National Health Service
NHSCB	NHS Commissioning Board
NHSCC	NHS Clinical Commissioners
NHSE	NHS England
NHSI	NHS Improvement
NHST	Null hypothesis significance testing
OOH	Out-of-hours services
PCCC	Primary Care Commissioning Committee
PCT	Primary Care Trust
PLS-SEM	Partial Least Squares Structural Equation Modelling
PLT	Protected Learning Time
PMS	Personal Medical Services
PRUComm	Policy Research Unit in Commissioning and the Healthcare System
PTE	Pulmonary thromboendarterectomy
REC	Research Ethics Committee
REM	Remuneration
SHU	Sheffield Hallam University
SMI	Standards for microbiology investigations
STPs	Sustainability and transformation plans
UK	United Kingdom
VIF	Variance inflation factor

CHAPTER 1

INTRODUCTION

1.1 Contextual Background

“Clinical Commissioning Groups (CCGs) in England, a flagship of the government’s health reforms, have failed to deliver overall improvements to patient care or involve more GPs in the running of services” (British Medical Association 2014a). This comment was made by the British Medical Association (BMA) following their survey in April 2014 of 1,393 General Practitioners (GPs) in the English National Health Service (NHS). The study discovered that, in general, the GPs were not happy about the policies produced by the CCGs as they felt that some of those policies restricted them from efficiently performing their function in the health care service of the English National Health Service (NHS). In this respect, some of the BMA’s findings are,

- 1. Almost three out of ten GPs believe their local CCG has introduced policies that have adversely affected their ability to care for patients.*
- 2. Barely one in ten GPs feels that they have been given more freedom to make clinical decisions for their patients.*
- 3. Despite being members, almost two-thirds of GPs feel they either have little influence over their CCG or are told what to do by the CCG rather than being asked to contribute their views.*

(BMA 2014a)

These findings implicate decision-making, a concept which this thesis centres on and extensively examines in the context of CCGs. As well as being crucial to any organisational success, effective decision-making also ensures the continued existence of the organisation. The structure under which an organisation operates influences the organisation’s decision-making routines (Jacobides 2007). In this thesis, I primarily consider structure from the perspective of organisational decision-making rather than the composition of how staff jobs are connected. Given this, decision-making in the NHS, a public service body (NHS England [Open Government Licence v3.0]), typically takes place within a hierarchical arrangement, a regular occurrence in the public sector

organisations (Ljungholm 2014). Decision-making in such contexts is usually fraught with low levels of autonomy, and a high degree of 'red tape', resulting in the "managers' endeavors [being] obstructed by structural forces that are beyond their control" (Ljungholm 2014, p.43). Even so, the literature explores how centralisation and decentralisation at the macro as well as micro-levels can be employed to moderate the harmful effects of 'red tape', occasioned by hierarchy (Kim et al. 2014; Mintzberg 1979). I view centralisation and decentralisation from the position of Mintzberg (1979, p.181), which is "exclusively in terms of power over the decisions made in the organization". As intimated above, to understand the influence of structure along with associated processes, I chose to investigate decision-making in the CCGs, as set out in the Health and Social Care Act 2012 (United Kingdom Government 2012). A review of the literature indicates that the knowledge base lacks awareness of effective decision-making, as perceived by the GPs, under the NHS's decentralised CCGs, a gap that the current study sought to fill. Additionally, investigation of the CCGs was of interest because previous research had identified limited awareness of what the GPs do in their respective local CCGs and the roles that they occupied (Checkland et al. 2016; McDermott et al. 2015).

CCGs were created to rid the English primary health care sector of the 'red tape' by decentralising decision-making for secondary and community commissioning to the local level, a phenomenon which McDermott et al. (2017, p.4) describe as "decision making closer to the patient". Meanwhile, The King's Fund (2018, p.2) describes this move as "intended to 'liberate professionals and providers from top-down control'". Even so, as mentioned at the opening of this Chapter, a study by BMA (2014a) discovered that the GPs at practice level blamed the CCGs for producing policies that they perceived as hindering efficient service delivery within the primary health care sector in the English NHS. The study centred on the GPs since they were the intended key decision-makers but were apparently unhappy. Interest was specifically on those with formal roles in the CCGs where the criticised policies are formed as those GPs could give insight into how decision-making is conducted.

1.1.1 Policy objectives and the context of CCGs

The stated objective at the launch of CCGs was to devolve power to the clinicians such as GPs, consultants, and nurses, so that they could directly run health care services at the local level, thereby enabling them to improve patient care and increase accountability (NHS England 2015; Talbot 2014; United Kingdom Government 2012). GPs were intended to lead the system. The CCGs' structure "was intended from the beginning to be "bottom up"" (Checkland et al. 2016, p.2), with no provision for a central blueprint. The relationship between the CCGs and GP Practices was intended to be on a "membership organization" basis which was enforced by law where the GP Practices subscribe as members of their local CCG, thus becoming known as member practices (Checkland et al. 2016; Naylor et al. 2013). Figure 1.1 demonstrates this relationship.

In the new arrangement, NHS England was designated to directly commission primary care services at GP Practice level while the CCGs were to commission secondary and community care services on patients referred by the GP Practices. Also, the CCGs were charged by law to support GP Practices in quality improvement (Naylor et al. 2013; NHS Commissioning Board 2012a). The supportive roles for the GP Practices that the CCGs were set to fulfil included the development of policies which could impact the way primary care "referral and prescribing decisions" are made at GP Practice level. At the same time, the GP Practices were directed to "adhere to commissioning decisions made by the CCG" (Naylor et al. 2013, p.14). Further details about the CCGs in terms of legal status, GP Practice representation, and the degree of diversity of CCGs structures (especially for decision-making) allowed by law, are provided in Chapter 2.

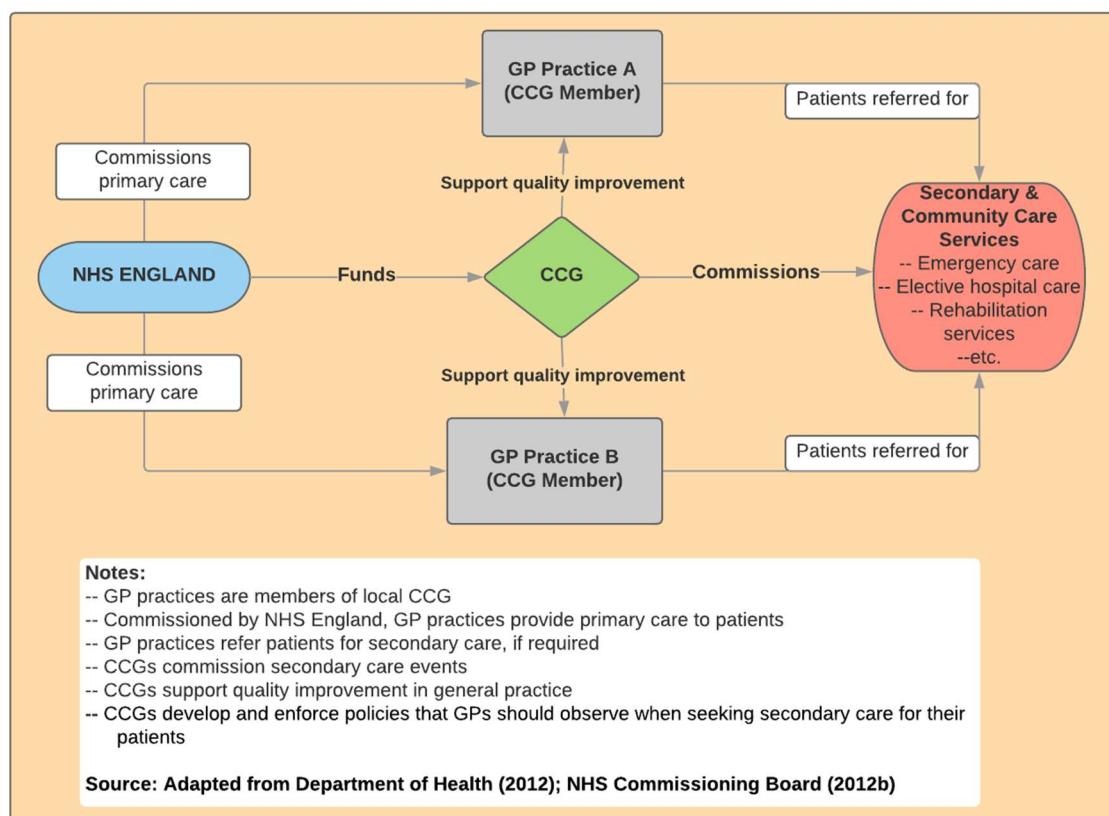


Figure 1.1 Relationship structure: NHS England, CCGs, and GP Practices (Source: Author's own 2019, unpublished)

1.2 Rationale of the research

There are three reasons which supported this research. The principal reason pertained to the BMA study described above. Recent research, however, suggests a shift in the general climate within the CCGs wherein the concerns outlined in the findings by the BMA (2014a) seem to be getting redressed. In this regard, Robertson et al. (2016, p.6) discovered that “CCGs have developed a range of strategies to work more closely with general practice”. All the same, in this current research I intentionally decided to establish the factors influencing the perceived effective decision-making process following the findings of the BMA (2014a), as there is a gap in the knowledge base in that respect. The next element that motivated the study related to the formal roles that the GPs occupy in the CCGs. Research has indicated that CCGs are complex organisations comprised of diverse structures with different methods of task delivery for both internal and external purposes (McDermott et al. 2015). While the system was designed to be led by the GPs, the inherent complexity makes it so difficult to determine what roles individual GPs occupy. Considering this, McDermott et al. (2015, p.30) suggested that “asking what the role of GPs is or should be in CCGs is a complex

question with as many answers as there are CCGs". In the same vein, Checkland et al. (2016, p.2) recommended further empirical exploration of CCGs to gain "a clear understanding of their internal structures and procedures". For this reason, the current study sought to investigate the roles that the GPs occupied in their CCGs and the kind of service that they delivered in that capacity.

Lastly, the conceptual structure of the CCGs appealed to a long-held personal, passionate regard, which is decentralisation of authority. The creation of CCGs was underpinned by this tenet in which autonomy of secondary and community health care commissioning was conferred to the local level (McDermott et al. 2017; Checkland et al. 2016; United Kingdom Government 2012). At the inception of this study, I had worked in the NHS in different capacities which covered clinical, technical, and leadership roles for nearly 15 years. Notwithstanding, CCGs were, and had always been, at 'arms' length' from my core professional business. CCGs appealed to me because of the contexts that I worked under. My engagements, particularly technical tasks, were routinely run under a structure called Scrum, an agile framework for managing projects, which shares principles that parallel decentralised and flat organisational configurations. For this thesis, it will suffice to portray Scrum approach as a decentralised formation at micro-level which is light in weight of bureaucracy and typically operating by providing "a simple "inspect and adapt" framework" (Hossain et al. 2009, p.175). It is worth stressing, nonetheless, that decentralisation in the context of the CCGs' commissioning decisions is different from decentralisation set to a project team as decision-making in CCGs is set at a higher level – that is, it is strategic rather than operational.

There are three reasons for investigating the GPs' views in this study. First, the key reason was to maintain consistency with previous studies on the type of participants. These include Checkland et al. (2016), McDermott et al. (2015), British Medical Association (2014a), and other numerous studies by King's Fund and Nuffield Trust. The second reason emanated from the understanding that the GPs were intended to lead the CCGs, thereby raising a desire to hear directly from them about their experience and opinions regarding CCGs' decision-making structures and processes. Lastly, I wanted to understand what the GPs do precisely in the roles that

they occupy to add to existing knowledge from previous research (Checkland et al. 2016; McDermott et al. 2015).

1.3 Research aims, objectives and questions

Research aims:

1. **Primary aim:** To explore decision-making profiles and associated processes within the CCGs to identify factors influencing effective decision-making, based on GPs' views.
2. **Secondary aim:** To discover the formal roles occupied by the GPs in the CCGs.

To achieve the primary and secondary aims, I identified the below outlined research objectives, respectively, along with the related complementary research question for the primary aim.

Primary Aim Objectives:

1. To explore the experience of GPs participating in the decision-making process in CCGs.
2. To investigate the way the Governing Bodies function.
3. To identify actions in the continuum of the CCGs' decision-making process that are conducive to support perceived effective decision-making.
4. To identify actions in the continuum of the CCGs' decision-making process that are not helpful in perceived effective decision-making.

Research Question:

How do the GPs with roles to perform in the CCGs explain and describe their experience regarding decision-making at their local CCGs;

- i. During the decision-making process, and
- ii. Once the decision-making process has concluded and the decisions have been made?

Secondary Aim Objectives:

1. To establish the formal roles that the GPs occupy in CCGs.
2. To clarify the tasks that the GPs deliver in their formal roles in the CCGs.

1.4 Scope and key assumptions

This section describes three aspects that were conceived to have the potential to affect the scope of my research. Discussed first are the delimitations in which the criteria for this study were set. This is followed by the key assumptions upon which this study was based. Next, are the access limitations, which were limitations that were foreseen but out of the researcher's control, thereby presenting possible weaknesses to the study (Simon 2011). There is another section on limitations, referred to as 'Research limitations', towards the end of the thesis in Section 5.4. The difference in the research limitations is that the limitations described in that section were not foreseen beforehand and were only discovered as the research progressed.

1.4.1 Delimitations of scope

There were two delimitations of scope that I conceived at the inception of the study – namely, the scope of the study in the fieldwork and the scope on the type of decision-making committees to be considered for investigation. The scope of the study was set to embrace all the CCGs in England regardless of the individual sizes. The target population in that context was set to be the GPs, owing to their function in the CCGs. The criterion for inviting the participants to the study was that GPs were to be contacted by email only. As such, I contacted only those GPs whose email addresses I received from their local CCGs following the request that I made as detailed in Chapter 3, Section 3.3.5. Consequently, if a CCG refused to supply the email addresses of its GPs or suggested a different means of communication than email, no communication was to be made to any of the GPs affected. No invitation was to be sent to the participants by post. This inevitably introduced sampling bias, described in Chapter 3, Section 3.3.5. I did not put any effort to correct biases introduced by sampling and other population-related parameters like coverage bias, a position that I pragmatically adopted, seeing that such a position is generally recognised by research practitioners involved with non-probability convenience samples, which this study was (American Association for Public Opinion Research 2013).

Regarding the scope on the type of decision-making committees to be considered for investigation, I planned to focus on the Governing Body, specifically. There are two reasons for this. Firstly, regardless of the variation in structure and format of committees across the different CCGs, all the CCGs are mandated in statute

to have a Governing Body committee. Secondly, a Governing Body committee was designed to be the top decision-making committee where the CCG decisions are made and/or ratified. More about the internal structures and associated dynamics of the CCGs is discussed in Section 2.3.6.1.

1.4.2 Key assumptions

The first assumption was that the sample which was invited to take part in the study was representative of the GP population with formal roles in the CCGs. This is because the CCGs constitute a distinct population, so it should be possible to assess the representativeness of respondents using statistical methods. The second assumption was about the belief that the respondents were probably going to answer the questions candidly since the survey was anonymous and confidential, an assurance which was explained in the questionnaire. The third assumption had to do with the authenticity of the study, that is – if the study addressed a real problem recognised by the participants, and whether the study could get proper answers to the problem. A pilot study was performed to verify this assumption. The pilot study candidates not only concurred with the study but also enhanced the scope of the questions by making suggestions to cover some aspects which were not initially included in the questionnaire.

1.4.3 Access limitations

There was one main limitation that this study faced which was foreseen right from the onset. The limitation concerned the accessibility of the target population. GPs are ‘notoriously’ known to be busy people, an observable occurrence which was commonly spoken about on the news prior and after the launch of the research. For example, in March 2015 the BBC News published a news item about how GPs were overstretched due to a shortage of doctors (BBC News 2015). The article mentioned how this phenomenon put pressure on the system thereby forcing some of the GPs to leave the profession while precluding the prospective applicants from taking up the profession as they viewed it as an “unglamorous” occupation. To mitigate this challenge (accessibility), I devised a strategy to make the study appealing to the potential respondents as much as was practicable. The course of action that was planned was to advertise the study on standard media of communication to the

medical professionals in general, the British Medical Journal (BMJ) and the BMA Newsletter. More details about how this progressed are in Chapter 3, Section 3.5.6.

1.5 Methodology

A general survey was performed on CCGs using an electronic questionnaire. The process encompassed both quantitative and qualitative study strands running simultaneously. To develop a useful outcome, several phases were involved, which included choosing the target population, picking a sample, determining the suitable analysis methods to analyse the data (quantitative and qualitative) that were collected, piloting the study, carrying out data collection, and performing data analysis. The key tenet of the methodology – that is mixing, was performed at the analysis phase in Chapter 4 and the interpretation phase in Chapter 5. More detail on the procedures that were followed is given in Chapter 3. Figure 1.2 summarises the design which guided this research.

Philosophical position: Pragmatism	<i>Quantitative study</i> – Underpinned by post-positivism <i>Qualitative study</i> – Underpinned by interpretive phenomenology
Theoretical lens	Social sciences: Organizational decision-making structure
Methodological approach	Mixed methods
Methods: Data collection	<i>Quantitative strand</i> - Survey <i>Qualitative strand</i> - Survey
Methods: Data analysis	<i>Quantitative strand</i> - Partial Least Squares Structural Equation Modelling (PLS-SEM) <i>Qualitative strand</i> – Guided by Interpretive phenomenological analysis (IPA)

Figure 1.2 Research design outline

1.6 Thesis structure

The rest of this thesis is set out as follows. Chapter 2 builds a theoretical foundation upon which the research was based by reviewing the relevant literature. The research design, which includes methods associated with gathering, analysing, and interpreting the data, is presented in Chapter 3. As well as analysing the data collected from the

fieldwork, Chapter 4 discusses the findings reached in this study, comparing them with the existing knowledge. Conclusions, implications, recommendations, and limitations are described in Chapter 5.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter builds a theoretical foundation upon which the research was based. While the primary aim of the study rested on identifying the factors influencing the perceived effective decision-making process within the CCGs, this was contextualised on the theoretical background of organisational structure, a concept considered in this thesis from the standpoint of organisational decision-making as opposed to relationships within staff hierarchies. Specific interest was on decentralisation, viewed from the position of Mintzberg (1979, p.181) in which this concept is exclusively considered “in terms of power over the decisions made in the organization”. As such, the organisational decision-making structure and the influence that it has on the decision-making process is explored in this chapter. Other associated factors that may influence the efficacy of the decision-making process – factors like organisational culture, leadership, and communication, are also considered.

Firstly, an outline of the key concepts underpinning the study is given in Section 2.2. Next, the organisational structure and associated factors are discussed in Section 2.3. Of specific interest in that discourse are concepts of centralised and decentralised organisational configurations which are explored in Section 2.3.5 and Section 2.3.6, respectively. The term configuration in this context is taken to denote arrangement of authority, whether it is centralised or decentralised. The concepts are considered at macro and micro-scale levels, evaluating their implication to the service delivery in the English primary health care sector. CCGs, the objects of interest in this study, are reviewed in Section 2.3.6.1, Section 2.3.6.2, and Section 2.4. As part of critiquing CCGs, a conceptual framework designed to understand decision-making structures and associated processes within the decentralised setting of CCGs is developed in Section 2.5. In this setup, latent variables of factors influencing an environment conducive to a GP-led decision-making process are identified, and the associated propositions are developed. As well as providing a basis for statistical hypotheses testing, the

conceptual framework was intended to inform the formulation of the qualitative questions to complement the research hypotheses.

2.2 Key Concepts

Organisational structure: There are multiple ways that organisational structure can be defined. For example, organisational structure can be understood to denote a “framework of the relations on jobs, systems ... people and groups making efforts to achieve the goals” (Ahmady et al. 2016, p.455). For this thesis, there are two standpoints from which I consider organisational structure. The first and primary position is organisational decision-making, as opposed to how staff jobs are connected. Organisational decision-making has broadly two configurations, centralisation and decentralisation (Mintzberg 1979). These are described in the next subsection. Secondly, I consider organisational structure in terms of the NHS, an organisation which involves complex inter-relationships between entities within it, which could also be considered as organisations in their own right, such as the CCGs, and indeed GP Practices. The thesis endeavours to formalise the structures assumed by the different NHS entities in line with the different organisational structure models discussed in the literature, specifically derived from Mintzberg’s theories (Mintzberg 1979).

Centralisation and decentralisation: alternatively referred to as centralised and decentralised configurations in this thesis, are viewed from the position of Mintzberg (1979, p.181), which is “exclusively in terms of power over the decisions made in the organization”. Simply put, centralisation denotes a context where decisions are made at one centre “and then implemented through direct supervision” (Mintzberg 1979, p.182). In contrast, decentralisation denotes a scene where decision-making “authority is spread out” (Huber & McDaniel 1986, p.581). It is important to note that centralisation and decentralisation are not mutually exclusive, but rather, they should be viewed as “two ends of a continuum” (Mintzberg 1979, p.185).

Decision-making: The literature and dictionaries give different perspectives on the term ‘decision-making’. For example, the Oxford Dictionaries define decision-making as “the action or process of making important decisions” (Oxford University Press 2018), while Mintzberg and Westley (2001, p.89) portray this concept as, “first

define the problem, then diagnose its causes, next design possible solutions, and finally decide which is best”.

Decision-making process: this thesis considers decision-making process as “a continuum of control” (Mintzberg 1979, p.188) in the act of decision-making. The process entails different steps where different actions are taken, as portrayed by Mintzberg (1979) in the continuum of control over the decision-making process where the steps range from “the original stimulus to driving the last nail [in the implementation of the decisions made]” (Mintzberg 1979, p.187). Section 2.3.6 demonstrates the entailed steps. Different factors can influence the outcome at any point in the process. For example, once a decision is made, it may need authorisation, at which point it may be blocked, changed, or approved.

Perceived effective decision-making process: this study considered any action that supports efficient delivery of health care service within the CCGs’ decision-making continuum as being ‘effective’. This view follows the concerns that the GPs raised about the decisions by the CCGs which were perceived as curtailing efficient service delivery in patient care (BMA 2014a). For this thesis, technicalities on how the predicted results are measured or tested will not be described, as the study was about the process as opposed to the specific decisions.

2.3 Organisational structure and associated factors on decision-making

This section centres on the review of organisational structure and associated factors which supported the scheme of the current study about understanding decision-making plus the roles occupied by the GPs in the CCGs. A brief background about the general history of organisational theory, which sets the contextual stage for organisational structure, is presented first.

2.3.1 A brief history of organisational theory

To adequately explain and address the issues linked to the concept of organisations, it is useful to define what an organisation is. There are numerous definitions of organisation, including the one by McAuley et al. (2014) which states that an organisation is a collection of people who gather to work towards a common purpose.

An organisation can also be described as a human network through which tasks are accomplished (Mosley et al. 2014). Alternatively, an organisation can be defined as “a group of people occupying different roles designed to achieve goals” (Anheier 2005, p.142).

Organisations of a business nature are differentiated from ordinary social activities by the fact that goals drive them. The activities that these organisations perform are structured with distinct lines of demarcation to make them unique from their environments (Anheier 2005). Additionally, these organisations usually have agreed on strategies that are designed to facilitate the efficient running of their affairs to achieve set objectives through "effective decision-making and coordination of the available resources" (Mosley et al. 2014, p.6). How these processes are implemented differs from one organisation to the other, a phenomenon that historically elicited enquiry from intellectuals who sought to understand “why organizations take the form they do and why they behave as they do” (Jensen 1983, p.319). This led to propositions that attempted to explicate different observed phenomena, giving rise to organisational theory (Hatch & Cunliffe 2006), which is basically “the study of how organizations function and [how] they affect and are affected by the environment in which they operate” (Jones 2013, p.8). Numerous organisational theories have been developed over time, as depicted in Figure 2.1.

The early 1900s organisations shown in Figure 2.1, explicated under the concept of classical theories advocated by intellectuals such as Frederick Winslow Taylor, Henri Fayol, and Max Weber, were perceived as being rigid and mechanistic (McAuley et al. 2014). This was due to the disproportionate emphasis on the organisation rather than the employees, in which, fundamentally, everything about the organisation was considered as a machine, including humans who were taken like different components of that machinery (Draft and Armstrong 2012; Shafritz et al. 2005).

Significant organizational theories	
	1900
	1911 Taylor - Scientific Management
Weber - Bureaucracy Model	1922
	1925 Fayol - Administrative Theory
Mayo - Hawthorne Studies	1933
	1954 Maslow - Hierarchy of Needs
McGregor - Theory X-Theory Y	1957
	1957 Tannenbaum-Schmidt - Continuum of Leader Behavior
Simon & March - Organizations	1958
	1961 Burns & Stalker - Management of Innovation
Blake-Mouton - Managerial Grid	1964
	1965 Woodward - Industrial organisation
McClelland - Achievement Theory	1965
	1966 Herzberg - Motivation-Hygiene
Likert - Systems 1-4	1967
	1967 Fiedler - Contingency Model
Olsson - Management By Objectives	1968
	1969 Hersey-Blanchard - Situational Leadership
Alderfer - Existence, Relationship and Growth	1972
	1974 House-Mitchell - Path-Goal
Vroom - Expectancy Theory	1976
	1980 Hackman & Oldham - Jodesign
Mintzberg - Organizational Design	1981
	1985 Schein - Organizational Culture
Senge - The Learning Organization	1990
	1991 Toyota - Lean
Martin - Culture in Organizations	1992
	1995 Weick - Sensemaking in Organizations
Whetter-Cameron - Empowerment	1995
	1997 Kotter - Leading Change
Fairholm - Values-Based Leadership	1998
	1998 Scott - Rational, Natural and Open Systems
Knowledge Society - Kolind	2001

Source: Adapted from Laegaard (2006)

Figure 2.1 Timeline of organisational theories

An evolution of the classical theories promoted by characters like Elton Mayo, Chester Barnard, and Hebert Simon ensued, leading to a fundamental change of underlying assumptions which saw an emergence of what became known as neoclassical theories (McAuley et al. 2014). These proponents sought to understand the best way to motivate employees. Focus was removed from the product to the human element. A

realisation of the importance of the human element was best understood from the Hawthorne experiments where the social factors like showing interest to the workers' well-being went a long way in boosting productivity (McAuley et al. 2014). Moreover, neoclassical theories proponents further argued that the purpose of the organisation was to serve human needs instead of vice versa (Shafritz et al. 2005). Viewed from a philosophical standpoint, the theories shifted from a positivistic orientation which characterised the classical theories to a subjective position in which many possible solutions could be construed about the same situation, depending on the assumptions and the understanding of the observer (Hatch and Cunliffe 2006). This may be possibly the reason for what appeared like an explosion of organisational theories after the era of classical theories.

From the timeline in Figure 2.1, theories that the current study embraced are “Weber – Bureaucracy Model”, “Mintzberg – Organizational Design”, and “Schein – Organizational Culture”. Aspects of Weber’s Bureaucracy significant to decision-making as applicable to the current study are discussed in Section 2.3.5., whereas the works of Mintzberg, specifically centralisation and decentralisation (Mintzberg 1979), were the theoretical lens through which this research was framed. On the other hand, Schein’s theory of organisational culture, discussed in Section 2.3.3, enhanced the appreciation of the research topic.

2.3.2 Organisational structure

Firstly, structure in this thesis is viewed primarily from the standpoint of organisational decision-making rather than the composition of how staff jobs are connected, as mentioned in Chapter 1, Section 1.1. Notwithstanding, it is worth mentioning that organisational structure, broadly speaking, is a topic portrayed from so many perspectives in the literature that some may be confusing. For example, discussing about centralisation and decentralisation within the mix of organisational structure, Mintzberg (1979, p.181) identified these concepts as being “the most confused ... in organizational theory”. One of the many different views portrays structure as an assortment of “relations between organizational elements” (Ahmady et al. 2016, p.455). In this vein, varied perspectives of the concept can be assumed based on two architectural dimensions, where relations can be established based on whether the dimension at issue is hard or soft (Janicijevic 2017; Ahmady et al. 2016). Hard

dimensions consist of jobs that, when grouped according to how they relate to each other, produce a construction of the formal organisational structure. Conversely, the soft dimensions are demonstrated in informal organisational structures seen in relationships such as social networks and organisational culture (Janicijevic 2017). The dynamics of these relationships and other associated dimensions are depicted below in Figure 2.2, a diagram adapted from a social network for business as it best illustrates a practical management perspective.

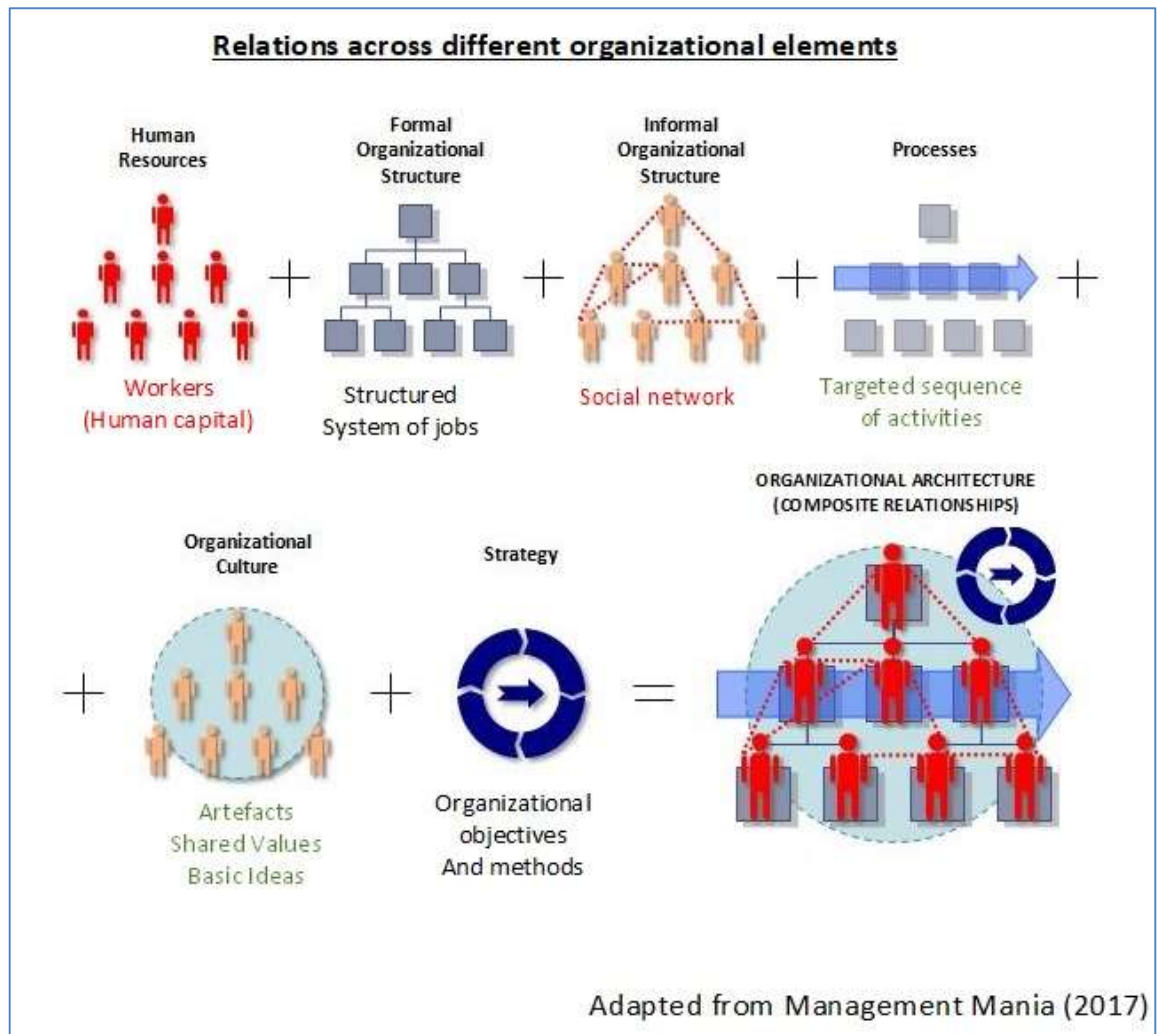


Figure 2.2 Organisational structure elements relations

There are many types of formal organisational structures discussed in the literature that organisations can assume. These include, but are not limited to, tall structures (Mosley et al. 2014; Fairtlough 2006; Kumar & Kant 2005; Ghiselli & Siegel 1972), flat structures (Rickards 2012; Langfred 2007; Meisel & Fearon 1999), heterarchical structures (Schumacher 2010; Dawson 2009; Fairtlough 2006; Crumley 1995), reverse

hierarchy structures (Mosley et al. 2014), responsible autonomy structures (Fairtlough 2006; Friedman 1977), and triarchy structures (Fairtlough 2006). Also, Mintzberg (1979) created models of organisational structure, described in Section 2.3.4, which are dominating the literature of “organizational structuring”.

Different formal structures described in the previous paragraph can be classed either as being centralised or decentralised when aligned with Mintzberg’s concepts of centralisation and decentralisation (Mintzberg 1979). These concepts, centralisation and decentralisation, underpinned this study, and in accordance with Mintzberg (1979, p.181), were considered exclusively “in terms of power over the decisions made in the organization”. In this respect, centralisation denotes a context where decisions are made at one centre “and then implemented through direct supervision” (Mintzberg 1979, p.182) while the decentralisation denotes a scene where decision-making “authority is spread out” (Huber & McDaniel 1986, p.581). As Mintzberg contends, centralisation and decentralisation are not mutually exclusive. Instead, they should be viewed as “two ends of a continuum” (Mintzberg 1979, p.185) where tagging of the organisation in the continuum is based on the dominant manifested occurrence of either centralisation or decentralisation characteristics. Centralisation and decentralisation are discussed at length in Section 2.3.5 and Section 2.3.6, respectively. Before that, a brief review of organisational culture is made from the viewpoint of its relevance in influencing decision-making within the matrix of the concept of organisational theory.

2.3.3 Organizational culture

In its simple definition, organisational culture is, “how things are done here” (Drennan 1990, cited in Belassi et al. 2007, p.14). However, the concept of culture is more profound than this, with Schein (2017) identifying it as being broad in breadth and depth, attended by numerous models. When considered from the standpoint of decision-making, Williams et al. (2018) portray the concept of culture as being minimally investigated in the health care literature. Notwithstanding, Williams et al. (2018, p.692) recognise “that culture shapes decision-making” albeit a lack of “evidence base on how this happens”. So, what is organisational culture? This thesis considers organisational culture through the lens of Schein (2017), who gives three levels in defining this concept, as depicted in Figure 2.3.

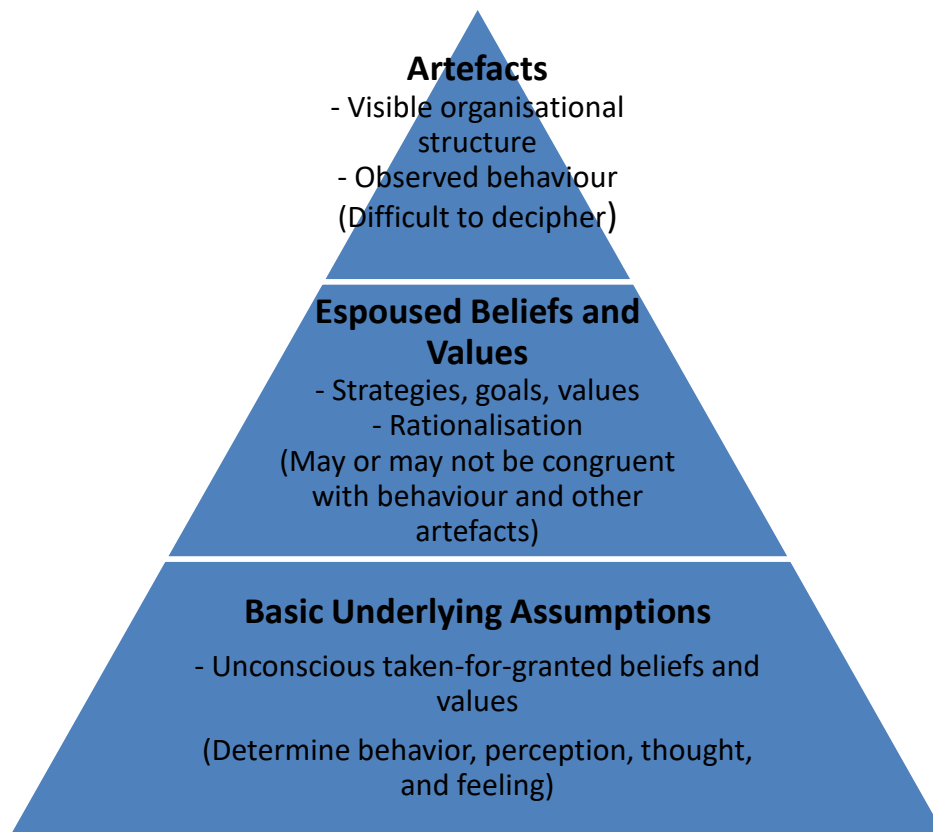


Figure 2.3 Three levels of culture (Adapted from Schein (2017))

The top level of Schein’s model of organisational culture is **Artefacts**, where discernible objects of the organisation are seen, like dress code or language style or even the structure of buildings. These artefacts are difficult to interpret though, as in trying to do so, someone may mistakenly apply their preconceived cultural beliefs which may be different from that of the organisation. The second level is **Espoused Beliefs and Values**, where standards and protocols about the behaviour of the organisation are defined, to represent the character of the organisation internally and externally.

A fitting example demonstrating Schein’s second level of culture from the context of CCGs and decision-making is here drawn from the Gloucestershire CCG. In 2014, Gloucestershire CCG purposed that, to maintain a high standard of the “NHS’s reputation locally”, they were going to promote an open culture between their organisation and the local population (Gloucestershire Clinical Commissioning Group 2014). This strategy was supported by the statement, “We want to: *‘ensure effective communication and engagement with patients, carers, community partners, the public and clinicians’ and be ‘accountable and transparent in our decision making’*” (Gloucestershire Clinical Commissioning Group 2014, p.2). The framework of this open

culture approach was set to encourage “equality” in an environment that enabled “‘Anyone and Everyone’ to have a voice”. To achieve this, Gloucestershire CCG aimed to “provide ‘Information and good Communication’, focus on ‘Experience’ feedback and undertake good ‘Engagement and Consultation’” (Gloucestershire Clinical Commissioning Group 2014, p.3).

Other attributes in the CCG context demonstrating Schein’s second level of culture are revealed on the baseline results of a study that North Durham CCG conducted which was focused on their culture (North Durham Clinical Commissioning Group 2013). Characteristics such as, (1) people feeling involved in the scheme and believing that they can make a difference (study found the CCG strong on this), (2) being clear about the “core values and the behaviour expected” (study found the CCG strong on this), (3) identification of leadership communication clarity (study found the CCG lacking on this), (4) the level of consistency and predictability (study found the CCG lacking on this), and (5) smarter approach to sharing information (study found the CCG lacking on this).

The third level of Schein’s definition of culture is **Basic Underlying Assumptions**. This is where the shared assumptions that manifest in unconscious behaviour from the organisation’s employees exist. This space operates under unwritten rules, which could be the reason that it is widely known as a soft dimension because of its informal nature (Janicijevic 2017). Basic underlying assumptions of culture may unwittingly affect the decision-making process by obscuring the way decision-makers “interpret environments and evaluate decision-making process” (Strutton & Carter 2013, p.2). Ultimately, “the rationality of decision-making processes” is undermined. Culture is one of the main factors that “highly experienced executives” acknowledge has an impact on decision-making. A report by McKinsey indicated that 72% of the executives “admitted their organizations’ top decision-making processes were as likely to be flawed as high quality” (Lovallo & Sibony 2010 cited in Strutton & Carter 2013, p.1) because of the influence that culture has on decision-makers. From the standpoint of the CCGs, organisational culture could impact decision-making in several ways, which include communication, GP member practice engagement, accountability, transparency, equality, consistency, and kindness.

While it is desirable for everyone in the organisation to understand their organisational culture, it is even more crucial for the leaders to embrace this phenomenon (Schein 2017). Failure to do this may result in resistance to development and change, from the employees (Schein 2017); thereby creating an environment that is “toxic” at work to all parties concerned. That kind of culture was an accusation levelled at Sheffield CCG, which was fraught with allegations of bullying (Collins 2019). Such culture can be characterised as “unhealthy” and “uncaring”, as was alleged by one of the employees in Sheffield CCG concerning their organisation.

2.3.4 Mintzberg’s models

Turning back to Mintzberg’s models in the structure of organisations, there are five that Mintzberg produced – namely, the simple model, the bureaucratic model, the professional model, adhocracy, and the divisionalized adhocracy (Mintzberg 1979). As stated earlier, for this thesis, technicalities of these models in organisational structuring will be kept to a minimum, with specific interest directed on the import that these structures have in influencing decision-making.

Simple model: the simple model is principally used in small organisational settings. Control in this setup is typically autocratic with the top manager making all the decisions and the support staff following the orders. The structure is basic with the roles of the support staff frequently overlapping and run under the direct supervision of the top manager. Features like formalisation do not exist. A distinct advantage of this structure is that it is highly adaptable to change, although it is inefficient.

Bureaucratic model: the bureaucratic model is highly formalised, typically found in mature organisations with workflows that are standardised and performed under predefined strict protocols, operating more like a machine. This model is characterised as being an epitome “of Weber’s (1947) ideal bureaucracy” (Lunenburg 2012, p.4). Decision-making is predominantly centralised, with little contribution from the operations staff, thus resulting in a tall chain of command.

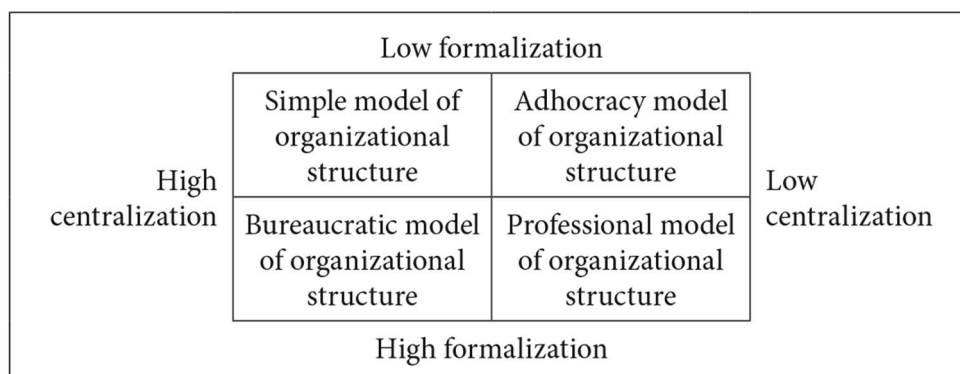
Professional model: this variant has a similar bureaucratic structure like the bureaucratic model, and is also highly formalised, in which “programmes, protocols, and procedures ... are prescribed in advance” (Janicijevic 2017, p.73). However, it differs from the bureaucratic model in that decision-making is consigned to

knowledgeable professionals who are experts in their fields. In this context, the experts are given operational autonomy; in that way typifying decentralised decision-making style. Basically, the professional model employs both vertical and horizontal styles in its approach.

Adhocracy: adhocracy model has similarities to the professional model in that decision-making is conferred to experts. However, in this background, there is no standardised blueprint of procedures that need to be followed. Experts have the entitlement to run intricate business processes, making decisions suited to the presenting needs, and using whatever innovative ways that they deem appropriate to address situations in hand. Formalisation in this model is very low, and so is centralisation.

Divisionalized adhocracy: the divisionalized adhocracy model is typically found in large organisations where the business is broken down into different divisions with specific management appointed to the respective units. This kind of structure usually is run under a centralised approach per divisional unit, with a tendency to resemble the machinist style of bureaucratic model.

Janicijevic (2017) grouped four of Mintzberg’s models into two classes based on their degree of centralisation and formalisation. The former classification is relative to the distribution of power over the decisions made in the organisation while the latter has to do with “the extent to which processes are covered by formal procedures and the extent of specialization and task standardization in the given structure” (Janicijevic 2017, p.74), as demonstrated in Figure 2.4.



Source: According to Mintzberg, H. (1979). *The Structuring of Organizational Structures*, Englewood Cliffs: Prentice Hall (cited from Janicijevic 2017, p.74)

Figure 2.4 Mintzberg’s models of organisational structure

The next sections look deeper into the concepts of centralisation and decentralisation, exploring these in broad general terms while at the same time specific application is made using two well recognised organisational structure examples derived from the NHS. These are the defunct Primary Care Trusts (PCTs) which were replaced by the CCGs, here being used to exemplify the centralised organisations, and the CCGs, here being used to illustrate the decentralised organisations. Arguments about PCTs and CCGs are, at this stage, made from the ideal theoretical perspective which originally underpinned the development of these models as opposed to the real-world scenarios, which are reviewed later, accordingly. Considered from Mintzberg's structuring of organisations models, the characteristics of the PCTs manifest the bureaucratic model while those of CCGs exhibit the professional model (Chapter 1, Section 1.1.1). The NHS has a high level of formalisation, as demonstrated by the decision-making structures, which are discussed in the next sections (Sections 2.3.5 and 2.3.6).

2.3.5 Centralised organisational structures

Whether a system is centralised or not depends on the way authority is wielded. Authority in this instance is taken to denote power, control, and accountability (Anheier 2005; Huber & McDaniel 1986) exercised "over the decisions made in the organization" (Mintzberg 1979, p.181). "If authority is closely held, the organization is said to be more centralized; if authority is spread out, the organization is described as more decentralized" (Huber & McDaniel 1986, p.581). Centralised designs are generally characterised by tall structures, also known as vertical structures in which the striking characteristic that they bear is "many levels of management" (Ghiselli & Siegel 1972, p.617). In other words, they are hierarchical. Hierarchy implies that the business is governed in layers, with those at the higher levels having more authority and responsibility than those at the lower levels (Mosley et al. 2014). In organisational theory, the traditional tall organisational structures fall under the classical theory where the classical theorists believe that a lack of hierarchy could mean the "loss of order, discipline, motivation and leadership" (Fairtlough 2006, p.5). While there has been a shift from the rigid conservative approach to hierarchical organisational configurations, many contemporary organisations still feature characteristics of this concept, specifically indicated by bureaucracy (McAuley et al.

2014) which is widely accepted in contemporary societies (Kumar & Kant 2005). The Business Dictionary (2018) defines bureaucracy as:

“A system of administration distinguished by its (1) clear hierarchy of authority, (2) rigid division of labor, (3) written and inflexible rules, regulations, and procedures, and (4) impersonal relationships. Once instituted, bureaucracies are difficult to dislodge or change.”

Max Weber conceived the concept of bureaucracy (Kumar and Kant 2005) which he modelled with protocols that had a rigid approach to ensure that everything in the organisation was done logically and orderly with employees directed by plainly described duties as well as rules and policies which stipulated their conduct while at work (Long-Crowell 2014; McAuley et al. 2014). This phenomenon led Weber to believe that if properly applied, bureaucracy would result in the most stable organisation (Long-Crowell 2014). Weber further believed that bureaucratic organisations are capable of handling more complex systems than those governed by traditional forms (Groth 2012).

Applied to the NHS, the PCTs model well-represented bureaucracy in the sense of decisions about “who plans and buys treatment for patients” (BBC News 2013b). Established in 2001, the PCTs were delegated with the duty of commissioning and looking after the primary health care, including community and secondary services in the NHS (Wilkin et al. 2001). The structure of this model was characteristically hierarchical (see Figure 2.5) with the PCTs making commissioning decisions for the GP Practices while at the same time they (PCTs) received strategic direction from the centre, represented by the Department of Health and the Strategic Health Authority. In this background, the managers predominantly controlled the decision-making processes as well as the GPs. Whereas the GPs were at the service delivery point, looking after the patients, they had little or no input to the decisions made by the PCTs on how they should function, as depicted in Figure 2.5. This diagram is an illustration by BBC News at the level of the layperson’s understanding (BBC News 2013a; BBC News 2013b).

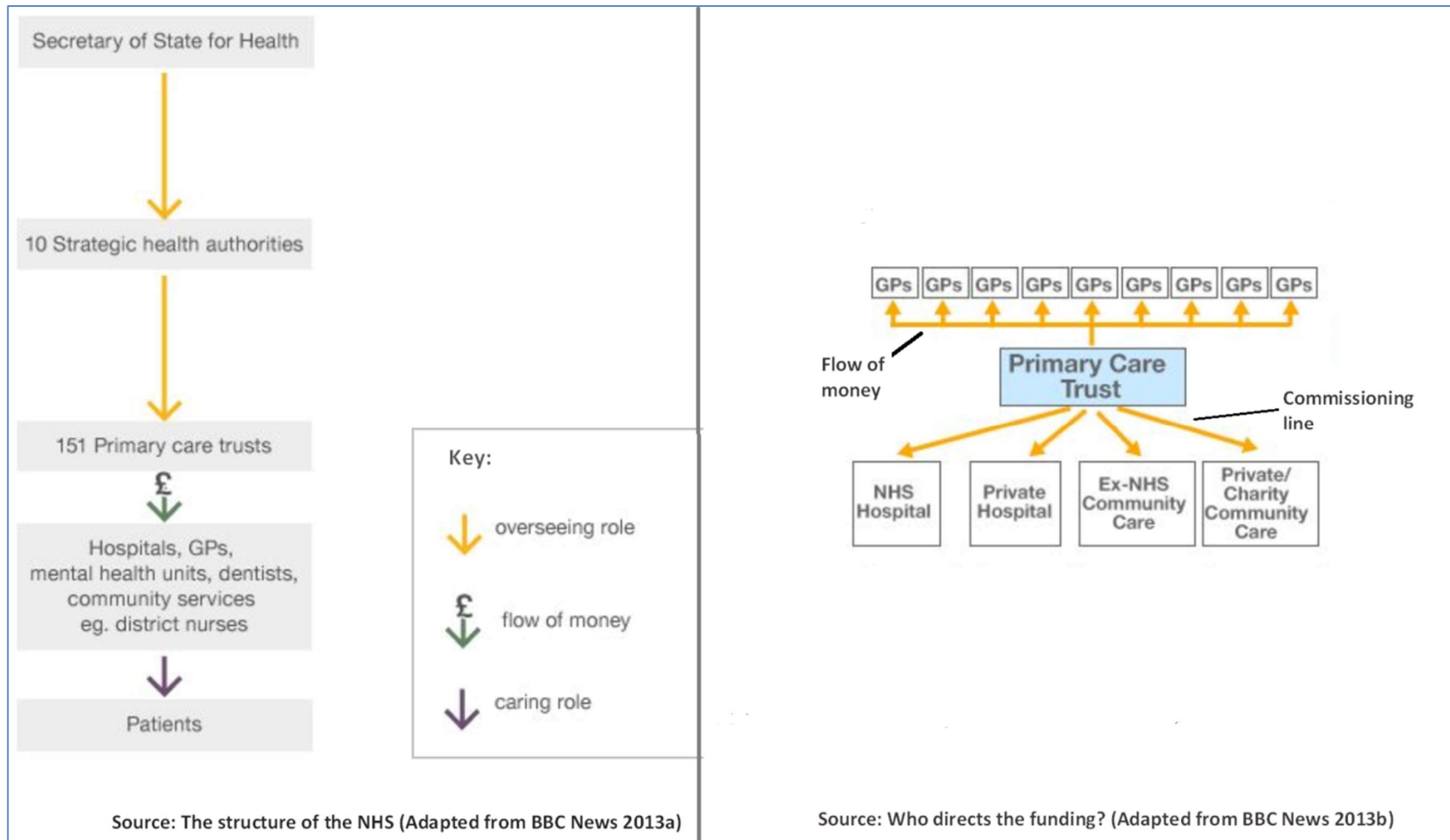


Figure 2.5 PCT commissioning and reporting lines

Studies report that in some instances, managers in the PCTs did not have good relationships with the GPs (Naylor et al. 2013). The way PCTs functioned was almost uniform across the board from one geographical location to the other because of the policies that controlled them from the top. For example, concerning funds allocation to their local populations, all PCTs used a method called the weighted capitation formula which enabled them “to commission similar levels of health services for populations with similar need” (Department of Health 2011, p.7). On the contrary, CCGs vary in structure and operation with no one CCG similar to the other (Checkland et al. 2016; McDermott et al. 2015).

One significant weakness that beset the PCTs, which is one of the leading reasons for the creation of the CCGs, was the lack of proper understanding of the needs of local patients, something which the CCGs were to remedy by involving “GPs from across their local area in the work [of commissioning]” (Robertson et al. 2016, p.20). The CCGs’ ethos is based on a “bottom-up” (Checkland et al. 2016) approach designed to meet the local needs of patients (Storey et al. 2018). This is different from the typical top-down arrangement characterising the bureaucracies. Lack of representation from the service delivery level in decision-making routines is a phenomenon generally recognised across bureaucracies. Often, in such settings, the top management’s depth and breadth of knowledge in specialist matters which may require expert knowledge may be deficient (Mosley et al. 2014). Typically, the level of specialist knowledge tends to be inversely proportional to the rank of seniority in the management hierarchy. This scenario is illustrated in Figure 2.6, which shows the “relative importance of managerial skills at different managerial levels” (Mosley et al. 2014, p.16).

As mentioned earlier, with regards to the PCTs scheme, the top management roles were typically occupied by non-medical personnel. Considering this, some experts argue for the expediency of involving relevant staff from the service delivery point in decision-making as they may be better qualified to determine whether the aspired “dreams” are achievable or not (Maughan 2010; Thompson 2010). This case is best illuminated using insights transferred from Maughan (2010), whose reasoning is set in a different context. Maughan (2010) claims that the exclusion of the relevant service delivery point personnel input to decision-making partly contributed to the

colossal failure of the infamous National Programme for IT (NPfIT) in the UK, which was designed to merge all patient records into a centrally managed repository across England (Parliamentary 2007). When the programme was abandoned in 2011 after running for almost ten years, the government had spent nearly £10 billion on it (Parliamentary 2013). A case in point here is about the importance of involving persons at the lower levels of the hierarchy if the perceived effective decision-making process is to be achieved.

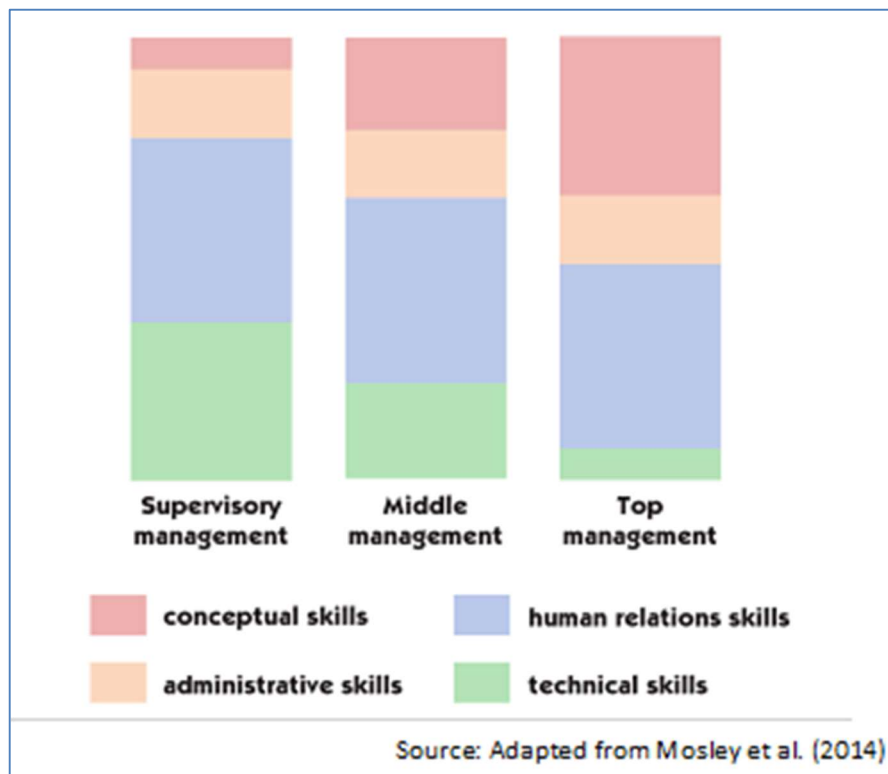


Figure 2.6 The relative importance of managerial skills at different managerial levels

Another line of thought about bureaucracies is that they are efficient in matters of reporting relationships due to their unambiguous and well-defined structures that, according to Fairtlough (2006, p.7), “make life easier”. Decisions are reached quickly, as few people are involved in the process. Those who are involved are arguably more experienced in making decisions (Hummon 1970). On the other hand, there is yet another salient drawback worth highlighting about bureaucratic schemes. Decision-makers are encouraged by the system to be “impersonal and rational” (McAuley et al. 2014, p.76), a phenomenon that Merton (1968 p.253, cited in McAuley et al. 2014,

p.76) bemoans for developing leaders who are “bureaucratic virtuosos” with an ill-defined view of the primary purpose of the organisation.

2.3.6 Decentralised organisational structures

As alluded earlier, decentralised organisations are, in this thesis, considered from the premise of decision-making authority, in line with Mintzberg’s position on this topic (Mintzberg 1979). Also, as mentioned earlier, all formalised organisational structures can be broadly classified based on the dominant manifested characteristics between the two ends of centralisation/decentralisation continuum (Mintzberg 1979). For example, adhocracy and professional models from the Mintzberg’s framework of organisational structuring exhibit more decentralisation than centralisation features, and therefore are viewed as decentralised configurations. While these structures may have some form of hierarchy, this phenomenon is a recognised feature in decentralised configurations as such is typically unavoidable in organisations of considerable size and complexity if chaos is to be avoided (Fairtlough 2006; Cooney 1997).

Another critical factor about decentralised configurations is their degree of formalisation, which, as pointed out earlier, is “the extent to which processes are covered by formal procedures” (Janicijevic 2017, p.74). As discussed earlier, adhocracies have low formalisation while the professional model has high formalisation. While the CCGs vary in many ways (Checkland et al. 2016; McDermott et al. 2015), they display high formalisation recognisable in processes covered by formal procedures that exist across the board. For example, (1) all CCGs should have a Governing Body, the highest authority for signing off decisions at CCG level (McDermott et al. 2015), (2) all CCGs are subject to an assurance framework where formal processes assessing the fitness of the CCGs in various factors are in place (NHS England 2016), and (3) CCGs are mandated by statute to formally support GP Practices in quality improvement (Naylor et al. 2013; NHS Commissioning Board 2012a).

Mintzberg points out three forms of decentralisation as being discussed in the literature, which, for the present thesis, technicalities thereof will be kept to a minimum. The first is known as “vertical decentralisation”, where the dispersal of decision-making power is exercised by delegating decision-making authority to the

staff at the lower rank in a vertical hierarchy. The second form is “horizontal decentralisation”. In this variant decision-making authority is not only the preserve of managers but may also be dispersed to the non-management staff. The third and final form of decentralisation refers merely to services that are physically dispersed.

There are further types of decentralisation from the standpoint of decisional powers alluded to by Mintzberg which this thesis will not describe as they were not relevant to this study. These are selective decentralisation and parallel decentralisation. Generally, whatever type of decentralisation that an organisation adopts, the decision-making process, in all cases, can be influenced at different stages of the process in one way or another. This situation is depicted in Figure 2.7 below, where a framework by Paterson (1969, cited in Mintzberg 1979) outlining different steps in the decision-making process is encapsulated.

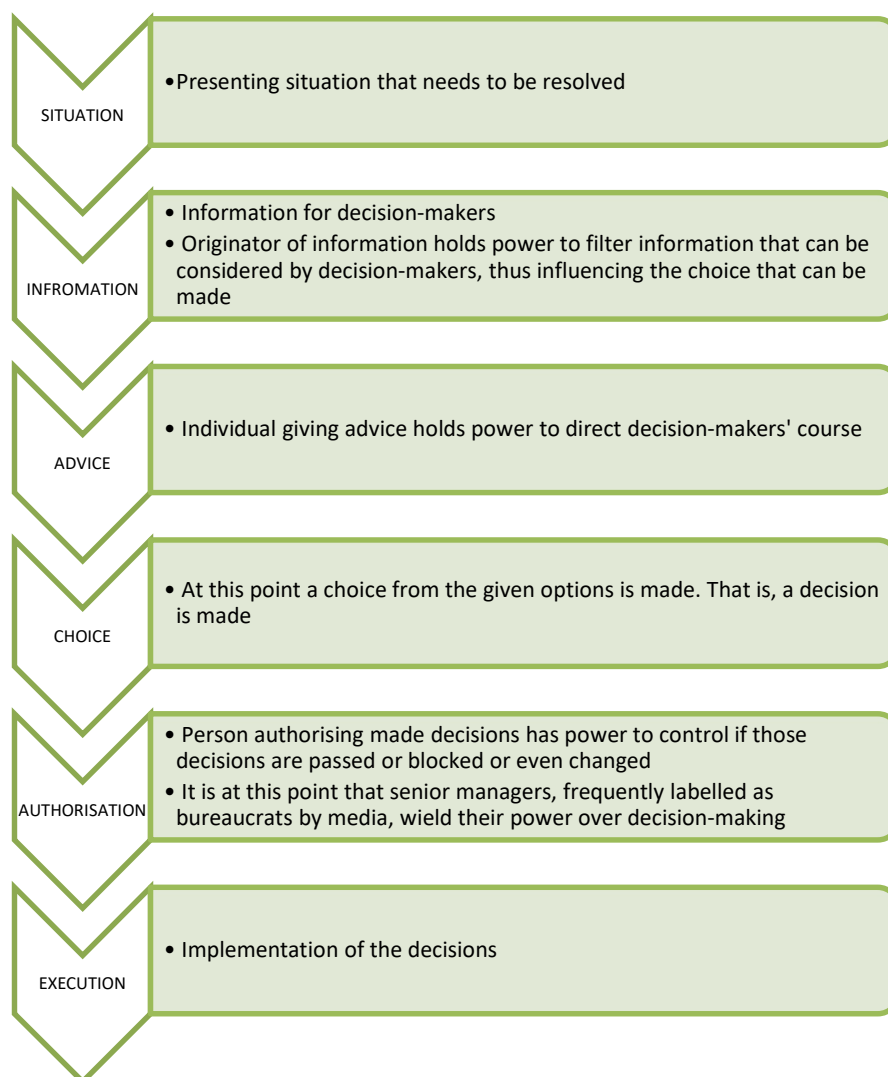


Figure 2.7 A continuum of control over the decision-making process (Adapted from Mintzberg 1979)

There are several reasons for decentralisation, with two main ones relevant to the current research topic being, (1) the ability for “the organization to respond quickly to local conditions” (Mintzberg 1979, p.183), and (2) because of complexity of specifics that can be barely understood by the top manager, it is useful to assign decision-making power to the persons “where knowledge is” (Mintzberg 1979, p.183). A third reason concerns motivation to the staff, particularly middle managers, which this approach could help them to prepare for higher responsibilities by enabling them to tap into their decision-making skills. The discussion will now centre on CCGs under the auspices of the theoretical concept of decentralisation.

2.3.6.1 Understanding the CCGs as decentralised bodies

As already mentioned above, the objective of creating CCGs was to decentralise authority by getting the system to be run at a local level by clinicians who know their local population’s needs, with the aim of improving patient care (Moran et al. 2017b; NHS England 2015; Talbot 2014; United Kingdom Government 2012). The King’s Fund (2018), an independent charitable entity with interest in health and care issues in England, summarised the government’s vision in these words:

“The reforms ... are intended to ‘liberate professionals and providers from top-down control’ and to locate the headquarters of the NHS ‘in the consulting room and the clinic’”. (The King’s Fund 2018)

The government’s literature describes the reforms as empowering the professionals by “giving them more autonomy” (Department of Health 2010, para 6.0, cited in Checkland et al. 2018, p.378). Andrew Lansley, the Health Secretary between May 2010 and September 2012, illustrated the professed autonomy bestowed on the CCGs in a letter that he wrote to the CCGs’ clinical and managerial leads (Lansley 2012). He drew attention to the freedom of operation designed for the CCGs, stressing that they could operate under any structure that they deemed appropriate, so long as it supported the outcomes of the NHS budget. Additional to autonomy, Lansley’s letter introduces, as well as illustrates, the concept of self-managing teams, where organisational members self-regulate (Rickards 2012). The phenomenon of self-managing teams with characteristics such as “freedom and discretion” (Langfred 2007,

p.885), has a bearing “in enabling rational decision-making” (Williams et al. 2018, p.691).

Building on from the idea that the CCGs’ structure denotes Mintzberg’s professional model, it is useful at this point to mention the hierarchy that the CCGs have in their decision-making routines. In this respect, of all the different decision-making units, the Governing Body is the highest authority (Checkland et al. 2016). In relation to the NHS as an organisation, the CCGs are part of a network of different schemes in the health care system comprising this wider organisation, the NHS. In this network, the CCGs are considered as organisations in their own right (Moran et al. 2017b; McDermott et al. 2015; Imison et al. 2011).

As discussed earlier, the decision-making process in decentralised structures is not only about the devolution of power to the decision-makers, but along with this, it is useful to be aware that the process of making decisions can be influenced at any point in the continuum of decision-making (see Figure 2.7). When viewed from this position (decision-making process continuum), CCGs can be regarded as being unique at micro-level in all the steps shown in Figure 2.7, in that they can control all those steps since they are self-managing entities which were granted autonomy to operate as they please. This means that they can collect their information from their local interested parties, they can analyse that information themselves, they can determine the best choice from the available options, they do not need to seek authorisation on the choice that they make, and they are the executioners of the made decisions. However, as will be seen later in Section 2.4, other players encroach those steps, in some instances, so much that the professed autonomy is negatively impacted.

Shifting the focus back to the self-managing teams, Langfred (2004) calls attention to a potentially ‘crippling’ weakness in these schemes concerning their decision-making practices, particularly for those teams with high cohesiveness and trust. Langfred claims that such teams are susceptible to “groupthink”, whereby the team can fall into the trap of “group decision biases” (Janis 1982, cited in Langfred 2004, p.386). To avoid being perceived as violating trust, some team members are likely to yield their views to their colleagues’ choices even if they may not agree with them. In this state, the team addresses “problems or issues as a collective group - no

matter what the facts are - instead of acting and thinking as individuals” (Pautz & Forrer 2013, p.1). To act otherwise may degrade the team’s unity, so they may think. In consequence, “People under groupthink begin to think alike and do not tolerate new ideas” (Wang & Wagner 2018, p.266), thereby, possibly, leading to sub-optimal decision-making. The literature refers to this kind of groupthink as negative groupthink (Pautz & Forrer 2013). There is also positive groupthink, a situation whereby a collective approach to a problem may produce better results than otherwise. For example, the team can “challenge each other with alternative strategies and solutions” (Pautz & Forrer 2013, p.3). Studies have shown that positive groupthink has produced better decisions in a group of non-experts than a group of experts (Solomon 2006, cited in Pautz & Forrer 2013).

Internal dynamics of the CCGs

To further understand the element of autonomy given to the CCGs, it is worth looking into the internal dynamics of these bodies as intended at their inception. To begin with, GPs with formal roles in their CCGs were designated to lead the system as they are the ‘vessels’ that deliver health care to the local communities, and hence should be better informed about the local needs (Checkland et al. 2016). All GP Practices were, by law, required to be a member of the local CCG, thereby making them be known as “member practices”. Member practices were set to be represented in different dimensions and different forms, depending on the CCG. As such, GP Practices have designated practice representatives who attend “meetings on behalf of the practice” (Naylor et al. 2013, p.12). The designated representative can either be “a GP or other health care professional, or, in some cases, the practice manager” (Naylor et al. 2013, p.12). As CCGs differ in structure and size, representation by respective practice personnel may be directly at CCG level or at a sub-committee level. As well as taking to the next committee level the interests of their local organs, the designated representatives are, in some instances, also held accountable for their practices. Naylor et al. (2013, p.14) best describe this scenario in the following words,

“Most of the engagement and decision-making is conducted through practice representatives, who are expected to act on behalf of their practice ... practice representatives will be held partially accountable for the behaviour of their practice colleagues ... to ‘ensure that their practice... adopts good practice as agreed by the group’”.

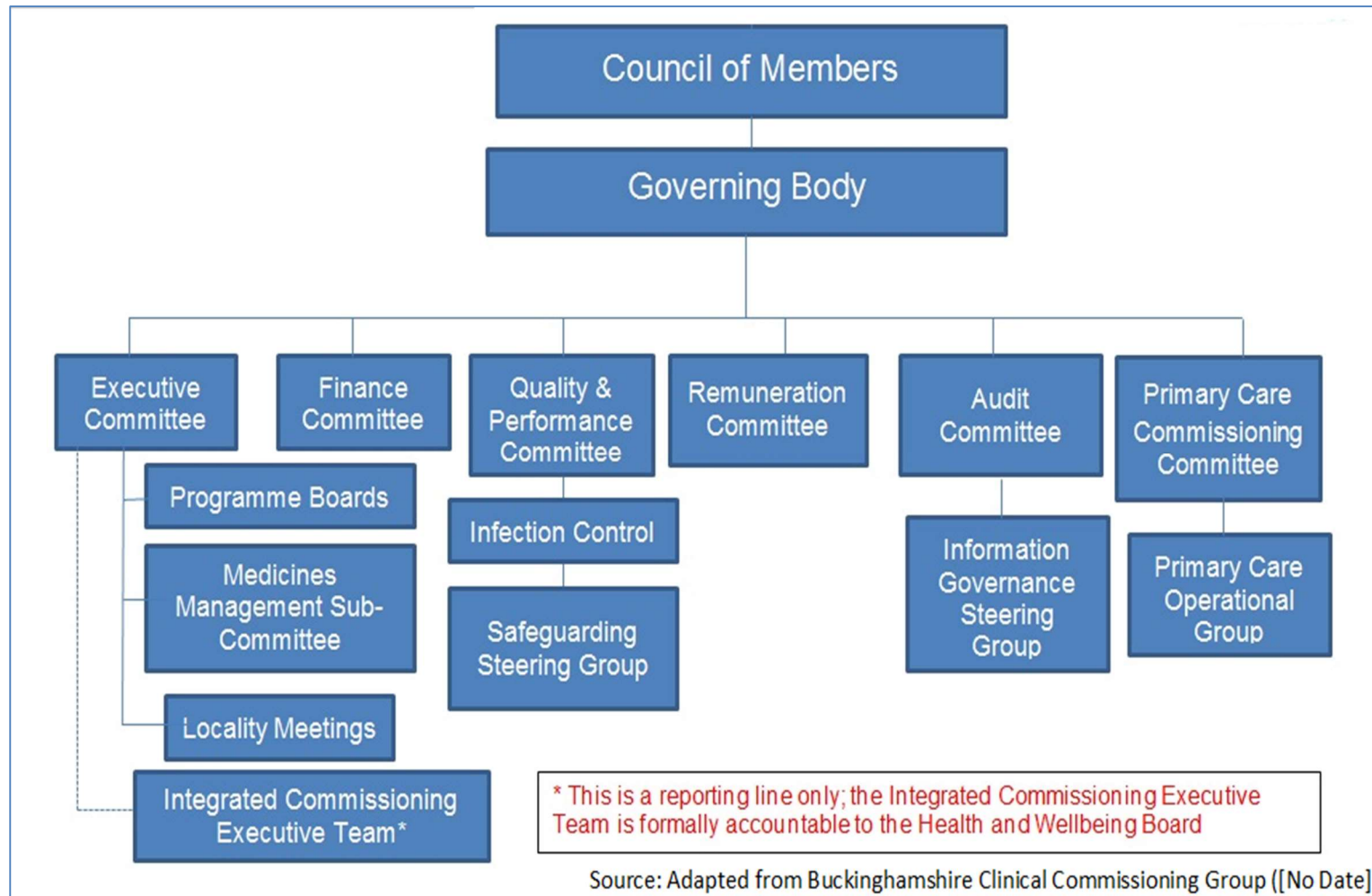
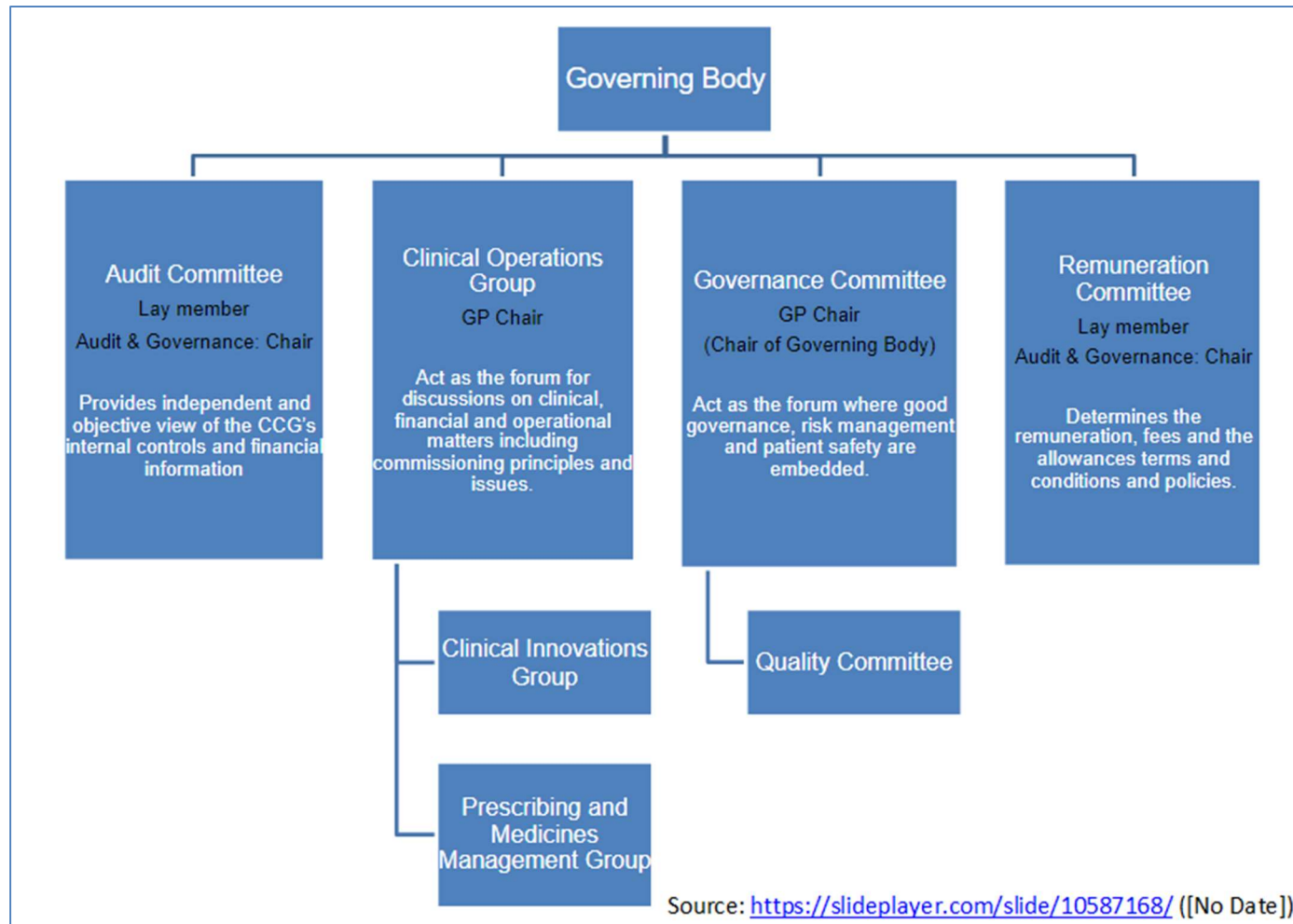
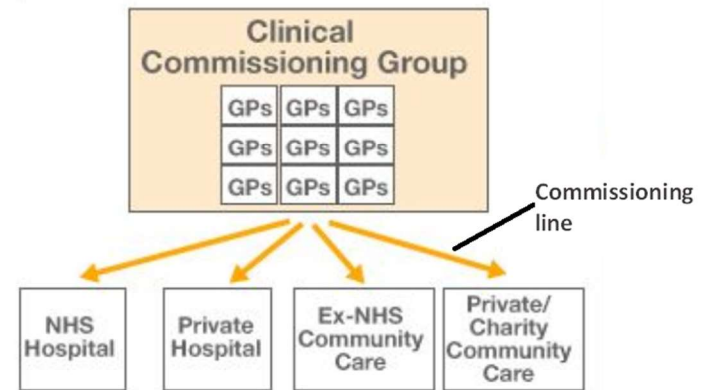
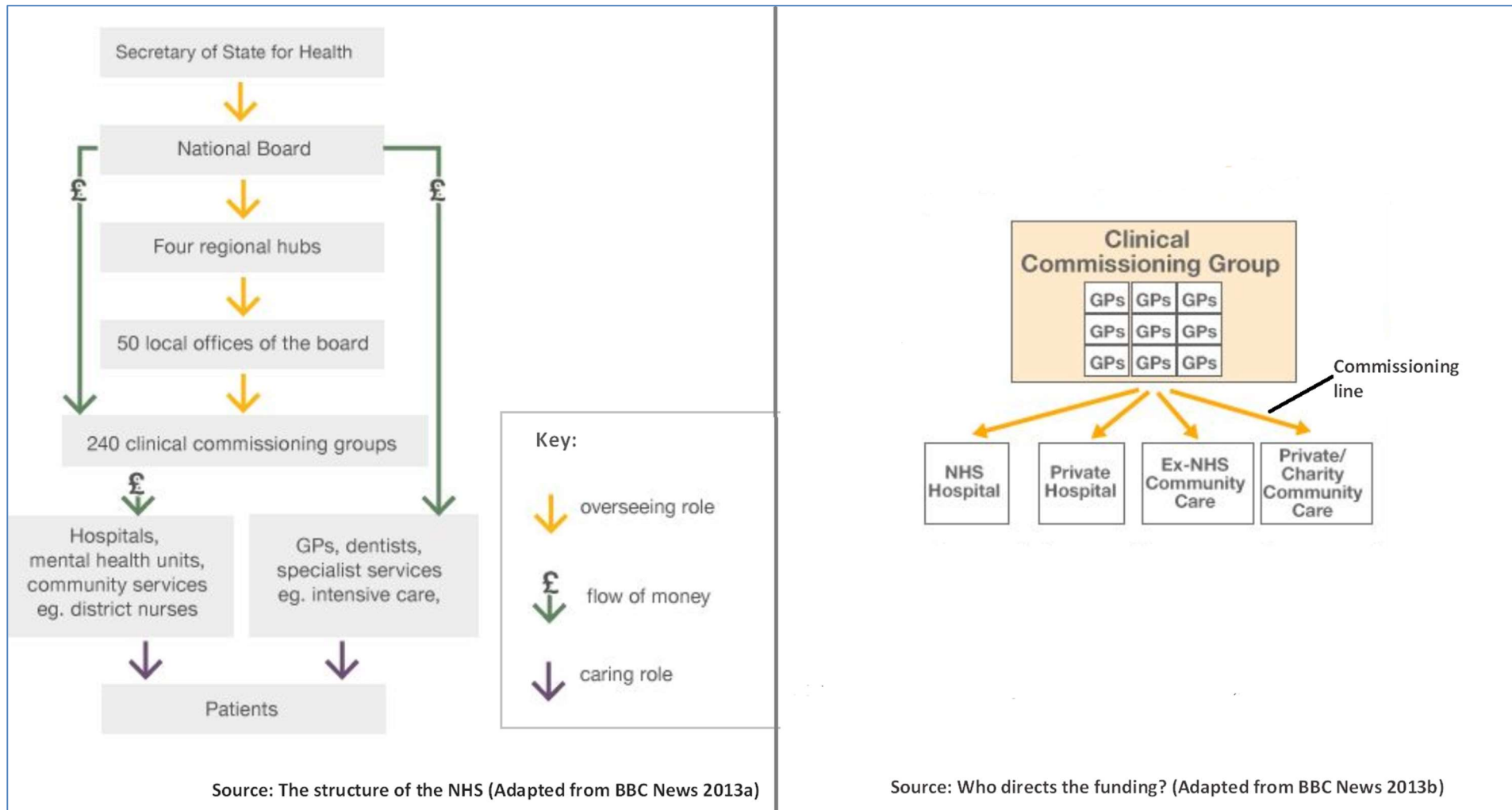


Figure 2.8 Buckinghamshire CCG Governance Structure

Figure 2.9 Somerset CCG Governance



Structure



Source: Who directs the funding? (Adapted from BBC News 2013b)

Figure 2.10 CCG commissioning and reporting lines

The authority with statutory responsibility for signing off decisions at CCG level is the Governing Body (McDermott et al. 2015), which is one of the three committees that every CCG is required to have under the Health and Social Care Act 2012. As hinted earlier, the top leadership of the Governing Body “was to be shared between an Accountable Officer (a GP or a manager) and Chair (clinical or non-clinical)” (McDermott et al. 2017, p.5). The other two committees mandated by statute are remuneration committee and audit committee. Outside these, individual CCGs were granted a prerogative to produce supplementary committees of any type and shape as they see fit. For example, Figure 2.8 and Figure 2.9 above illustrate two CCGs, Buckinghamshire CCG and Somerset CCG, with entirely different structures and hierarchies making up their committees.

One aspect about the CCGs worth pointing out is that, although these entities were created to operate autonomously in terms of commissioning routines, they were, nonetheless, made to be accountable to the central authority, NHS England. Reporting lines of this setup are shown above in Figure 2.10. There are several layers of hierarchy above the CCG level, as depicted in the diagram (Figure 2.10). This should not be construed as an inconsistency over the notion of CCGs being decentralised entities.

As explained earlier, centralisation and decentralisation are not mutually exclusive, but rather should be seen as two ends of a continuum (Mintzberg 1979). Instead of conflicting each other, the top-down (centralisation) and bottom-up (decentralisation) schemes can exist simultaneously in the same organisation, or network of organisations, to “serve complementary roles in the formation of operations strategy” (Kim et al. 2014, p.463). In this arrangement, the top-down approach operates at macro-level, outlining the overall organisation’s strategy – namely, goals and priorities, as well as allocating resources, whereas the bottom-up approach operates at micro-level fostering self-management in operational routines (Kim et al. 2014). That is, the operations strategy at service delivery point is informed by the way the operations staff perceive “the company’s direction, which may partially differ from top management’s [priorities]” (Kim et al. 2014, p.464). Mintzberg (1979, p.183) identifies this view as being one of the reasons to decentralise, as pointed out earlier, in which the specifics that the top management may barely understand are assigned to the persons “where knowledge is”. Applied to the CCGs, at macro-level

NHS England gives strategic direction along with the allocation of financial resources, as depicted in Chapter 1, Figure 1.1 (Department of Health 2012; NHS Commissioning Board 2012b). At micro-level, the CCGs were granted autonomy of self-management, already discussed in the previous paragraphs.

PCTs had a slightly similar hierarchical arrangement to the CCGs in which layers above the PCT level had an overseeing role, which included the stipulation of strategic direction (see Figure 2.5). The theoretical difference between the PCTs and CCGs is that commissioning decisions in the PCTs were made with no direct involvement of personnel from service delivery point (GP Practices) whereas, in the case of the CCGs, the service delivery point leads in decision-making. The former used a top-down approach while the latter was created from onset to be a bottom-up approach with no provision for a central blueprint (Checkland et al. 2016). The literature describes the PCTs as having a “history of diminishing clinical involvement” (Naylor et al. 2013, p.x), something which the creation of the CCGs was meant to redress.

In contrast to the initially intended purpose of the CCGs, which was getting commissioning decisions done at a local level and labelled as a service that knows the needs of the local population (described earlier in this section), the number of CCGs across England seems to be increasingly getting reduced through mergers and dissolutions. For example, just before launch in 2013, NHS England (2012) website listed a total of 212 CCGs across England. However, recently, the ‘GP Online’ website announced plans by NHS England to cut more than 75% of the CCGs through mergers or dissolutions citing the question of sustainability as the reason (Cook 2019). Already, at the time of writing of this thesis, several CCGs have been either merged or dissolved, with some sharing leadership as depicted on the map published by the Health Service Journal (Eddie 2018).

2.3.6.2 Bureaucracy and CCGs

At macro-level, the CCGs are subjected to schemes and policies meted through the arm of NHS England, requiring them (CCGs) to meet certain standards against which they are measured. For example, at the time when the current study was done, the CCGs were assessed against an assurance framework known as “CCG Improvement and Assessment Framework (CCG IAF)” (NHS England 2016). This framework centres

on “CCG’s performance in each of the indicator areas over the full year and balanced against the qualitative assessment of the leadership of the CCG” (NHS England 2016, p.9). Indicator areas that are assessed include patient health care – where conditions like “dementia” and “cancer” are evaluated, sustainability – in which factors like financial health and care models are appraised, leadership – in which aspects like “workforce engagement” and “CCGs’ local relationships” are considered.

At micro-level, while the CCGs are accountable to NHS England where they are assessed under stringent indicators described above, it is likely, and possibly inevitable, that the same ‘draconian’ measures may have a ‘domino effect’ on other circles outside the CCGs. For example, the CCG Governing Bodies are set to hold the GP “practices to account for individual commissioning decisions” (Imison et al. 2011, p.5), while they (CCGs), in turn, are held to account by NHS England. Could this be the reason the GP Practices blame the CCGs for making policies that are an obstacle to efficient service delivery (BMA 2014a)?

The scenario of bureaucratic clutches can be aggravated by the fact that CCGs’ top leadership roles of Accountable Officer and Chair are open to being occupied by non-clinical officers – that is, managers. These are strategic roles, so influential that the literature claims they have the power to steer the strategic direction of the local CCG (Storey et al. 2018). Opening these roles to the non-clinical persons raised eyebrows of the media, leading to one of the newspapers to publish an item about it contemptuously headlined, “Bureaucrats Return to Lead Doctors’ Groups” (Independent 2012). Because of the critical influence that leadership has, the next section reviews the concept of leadership, with application to the CCGs where relevant. Communication is then discussed from the context of the influence that it has on the decision-making process.

2.3.7 Leadership and governance

Williams et al. (2018, p.685) designate governance jointly with leadership as being “the modes of practice in relation to leading and managing the organisations within which the decision-making function is embedded”. Meanwhile, as well as seeing governance as being about “performance management relating to the actions associated with the decision”, Robinson et al. (2011, p.63) identify this concept with politics that enables

coalition-building by commissioners, that goes beyond formal lines of performance management. Robertson et al. (2011) contend that in so doing, the commissioners place themselves in a more amiable position that will not only legitimise them and make them acceptable to their stakeholders but will also set their decisions to be equally treated. In this thesis, I similarly view the concept of governance as Robertson et al. (2011).

Regarding leadership, interest in this thesis is focused on the CCGs' top leadership; a function shared between the Accountable Officer and the Chair (McDermott et al. 2017; Clinical Commissioning Board 2012a). Leadership is a "critical determinant of success" (Williams & Brown 2014, p.11). Persons appointed to these positions usually hold credentials of previous experience in a similar role and/or have an education that has prepared them for the role (Mumford et al. 2000). When viewed from this standpoint, the situation with the CCGs concerning leadership may be tricky. It is because the CCGs' leadership roles are not only occupied by managers, who usually get trained for this task but are also occupied by clinical personnel, who, by contrast, are not routinely trained for such responsibilities. One of the GPs in a recent study intimated this situation, commenting that, "I think the clinicians in those roles find it quite tough sometimes because it is not something that clinicians are trained for" (Storey et al. 2018, p.50).

Additional to the challenge of whether one has training or not in leadership, is a layer of complexity existing within the CCGs' scheme, which is service redesign. Regarding this, Storey et al. (2018, p.7) remark that "attempting to lead changes in service redesign across the complex boundaries in primary and secondary care is a very different challenge". To this effect, Storey et al. (2018, p.7) discovered that leadership within the service redesign context was 'spearheaded' "by informal leaders, as well as those occupying formal roles within CCGs". While CCGs were designed to be led by the GPs, and that the clinicians should be part of the leadership roles, studies have shown that, generally, there are fewer GPs in a leadership position in the CCGs than managers (Storey et al. 2018; Checkland et al. 2016). This observation can arguably be viewed as substantiating the allegation that was levelled by the Independent (2012) in its bulletin headed, "Bureaucrats Return to Lead Doctors' Groups".

Notwithstanding, Storey et al. (2018) identified obstacles to having a higher representation of GPs in leadership positions as being, (1) lack of time, a commodity that the GPs regularly complain about, (2) lack of capability – that is, GPs are not trained in leadership in general, (3) lack of influence. In this aspect, the GPs characterised the system as lacking autonomy because of control from the macro-level centre, organs like NHS England. As such, even if they were to try to steer the direction, their vision may not be realised, and (4) money, which the GPs complained about, citing that there was little incentive in that regard for them to take leadership roles.

One aspect of leadership, which this thesis does not explore in depth as it is outside the scope of discussion, is leadership style. There is, however, an element closely related to leadership style which is of interest to this study. It is destructive leadership, a leadership behaviour which the literature characterises as being a dark side of leadership (Conger 1990). This leadership behaviour is associated with connotations like “toxic leaders”, “intolerable bosses”, “petty tyrants”, and “bullies” (Einarsen et al. 2007, p.208). The literature claims that the consequences of destructive leadership behaviour are not only limited to the affected individual members of the organisation but also have wider “negative outcomes” on the organisation as an entity (Padilla et al. 2007). For example, could it be the case that the recently reported news which took place in the Sheffield CCG was because of destructive leadership behaviour? Health Service Journal, a news service covering the NHS, recently reported about how Sheffield CCG “is facing serious questions over its leadership and culture, amid bullying allegations” (Collins 2019). This followed the period after the appointment of a new Accountable Officer. It is reported that the environment was soured with a “breakdown in relationships” and suspension of senior staff. Former and current CCG employees are said to have described the culture in this CCG as “toxic”.

Contrary to the above leadership issues, Storey et al. (2018, p.6) discuss the need for leaders in the health service to be compassionate, thereby “keeping with the caring nature of the services provided in health”. Besides, whether clinical or non-clinical, the candidates for leadership should possess an attribute of influence, being one of the most expressive qualities (Coleman 1990, cited in Gronn 2002). The kind of

influence alluded to here is the one which is so contagious that some scholars regard it as being “mysterious chemistry... that causes some individuals to be followed and others to follow” (Lorsch et al. 1978, cited in McAuley et al. 2014, p.194).

2.3.8 Communication

Communication, a central tenet to the organisational well-being and success (McDermott et al. 2017), is here reviewed from the standpoint of centralised and decentralised organisational configurations with the influence that this concept has on the decision-making process highlighted. In centralised organisational configurations communication across different lines is typically unidirectional (Mosley et al. 2014; Huber & McDaniel 1986), thus slow to get through as the message has to traverse different layers (Business Case Studies 2015). Conversely, in decentralised configurations where layers are relatively fewer, communication is usually quicker (Powell 2002). Regarding decentralised structures fostering a bottom-up culture, like the way CCGs were intended to be (Checkland et al. 2016), insights transferred from public relations and management research studies indicate that about 70% of the vital information comes from the ‘grassroots’ (Stoffels 1994 cited in Park et al. 2014).

To achieve optimum communication, Grunig and Hunt (1984) proposed “the most effective way of communicating” that they named as “two-way symmetrical approach” (cited in Park et al. 2014, p.542). This method “uses communication to promote mutual understanding, resolve conflict, and establish respect between the organisation and its publics by encouraging communication symmetry” (Park et al. 2014, p. 542). It would be difficult to apply the principles of effective communication to centralised formations in a manner described in the two-way symmetrical approach as communication in these structures is typically one-way, in a top-down direction (Mosley et al. 2014; Huber & McDaniel 1986). Park et al. (2014, p.542) identify the communication style seen in centralised structures with what they term, “asymmetrical communication approach”. Grunig and Hunt (1984, cited in Park et al. 2014, p.542) characterised this communication style as being “selfish because the organizations in this approach assume that their interest or position is right or more important whereas that of publics is not”. Conversely, with symmetrical communication model fitting decentralised organisational structures like CCGs, employees are provided with “more opportunities for dialogue, discussion, and

discourse on issues” (ibid). Organisations fostering characteristics like communication openness are more predisposed to realising ingenuity and innovation from their staff whereas employees are likely to be dissatisfied at work if they feel that their organisations are poor at communication (Park et al. 2014).

2.4 CCGs – What research has revealed

This section looks at the real-life practical issues that occur within the CCGs as revealed by research. When considered from Mintzberg’s models of organisational structuring, the account from the previous studies demonstrates that the CCGs, in reality, straddle between the professional model and the bureaucratic model, with the perceived tendency supporting the latter, as will be gathered in the following sections.

2.4.1 The question of autonomy

To begin with, administration of the CCGs “was intended to be ‘bottom up’” (Checkland et al. 2016, p.1), structured in such a way that decision-making and policy formulation would be conducted at local level. In this context, GPs would lead, which is why given this reform The King’s Fund (2018) flagged that the NHS headquarters will be in the consulting room. Member practices would inform the CCGs about their wishes through appropriate channels that individual CCGs set up. Important as this scheme was designed to be, research has identified barriers to CCGs being wholly autonomous in decision-making matters to effectively meet local needs (Robertson et al. 2016). In fact, a study by Naylor et al. (2013, p.46) discovered that some GPs were sceptical about “the political narrative around local freedom and autonomy” and questioned if it would “manifest itself in reality”. There are too many constraining factors which suffocate the supposed autonomy both vertically and horizontally. Autonomy from the top-down administration, that is – at macro-level, is stifled by a “strict and prescriptive assurance regime” (Checkland et al. 2018, p.390) explained in Section 2.3.6.2. Research has revealed that some CCGs are disappointed by “the nature of the assurance regime, finding it to be hierarchical rather than collaborative or developmental” (Checkland et al. 2018, p.386).

Autonomy at micro-level – that is, locally, is restricted by the inherent complexity of local environments. The complexity in question concerns the abundance of organisations that the CCGs are not only accountable to but must also deal with to

fulfil their mandate. These include bodies such as “local authority Health and Wellbeing Boards”, “Monitor”, “local government Health Scrutiny Committees”, “Commissioning Support Units (CSUs)”, “System Resilience Groups”, “Urgent and Emergency Care Networks”, “Specialised Commissioning Collaboratives”, and “Sustainability and Transformation Plans”, as noted by Checkland et al. (2018). To this end, Checkland et al. (2018, p.389) argue that “CCGs’ freedom to act, even if they have formal autonomy from the centre, is likely to be limited by the need to co-ordinate, collaborate and interact with other local actors”. Another dimension of complexity in the same question of CCG’s operations is intrinsic to individual CCGs. Research has shown that “CCG structures and governance arrangements” (McDermott et al. 2015, p.5) are dissimilar from each other and are attended by a high degree of complexity. While all CCGs have, by statute, Governing Body, Audit, and Remuneration committees – outside these, it is not possible to tell with accuracy what other committees there are and who comprises them across different CCGs (Checkland et al. 2016; McDermott et al. 2015). Of concern in this diversity is ambiguity about what GPs should do, leading to discovery by research that some roles that the GPs occupy duplicate tasks of others under the same CCG due to a multiplicity of committees (McDermott et al. 2015). This complication is compounded by the cost implication to the CCGs owing to the value that the GPs’ time carries (McDermott et al. 2015). Additionally, research has revealed that CCGs are handicapped by budgetary deficits respecting the funds that they receive from the central government in contrast to the actual needs at local level (Drake 2016; Robertson et al. 2016), an issue described and detailed next.

2.4.2 Finance

While the CCGs were given authority to run their budgets, barely a few months following their launch, “the Health Service Journal (HSJ) reported that nine CCGs were forecasting large overspends in their first year of operation” (Wood & Heath 2014, p.10). At the time, it was argued that possibly the CCGs underestimated “how much of their commissioning budget would be transferred to NHS England for commissioning specialist services under the changes to the health system” (Wood & Heath 2014, p.10). At the time of writing of this thesis just over five years from the official launch of the CCGs, Healthcare Financial Management Association (HFMA), a UK charitable body “promoting the highest standards in financial management and governance in

healthcare” (HFMA 2018), revealed that “a total of 83 CCGs reported an overspend against plan at the end of quarter two” (HFMA 2017, p.3). The research that HFMA (2017) conducted yielded an assortment of discoveries regarding the financial health of the CCGs and the entire NHS. The chief finance officers and financial directors indicated matters such as high risk to their 2017/18 financial plan, unachievable 2017/18 budgetary control, and lack of confidence in making any savings. What is more, before the financial years just cited above, not long after the CCGs were launched, the Health Secretary is known to have conceded to the fact that the NHS was in its worst financial crisis (Mirror 2015).

Because the CCGs were granted freedom to operate as they saw fit, a possible consequence of this included the rationing of services, imposed to save money given the low funding levels that the CCGs generally faced as described above. For example, it was reported that Devon CCG had announced that it was going to restrict all routine surgery for obese patients and smokers as well as restrict all routine shoulder surgery for all patients (The Guardian 2015).

2.4.3 Member practice engagement

Another aspect that research has revealed is a lack of constant engagement that CCGs should have with member practices (Drake 2016; Robertson et al. 2016). While previous research indicated a higher rate of satisfaction about the way GPs felt regarding the level of engagement that they have with the CCGs when compared with the previous system of Primary Care Trust (PCT) (Robertson et al. 2014; Naylor et al. 2013), recent research has shown that CCGs struggle to engage “with all GPs in a local area” (Robertson et al. 2016). In a 2014 survey, 35% of the GPs without formal roles in the CCGs indicated that they felt they could influence decisions made by their local CCG whereas in a recent study only 20% could make the same claim (Bostock 2016). The most recent research suggests that the decline in member practice engagement could be due to practice workloads which “were impeding engagement with clinical leadership” (Storey et al. 2018, p.35). This corroborated the observation by McDermott et al. (2015, p.96) where concerns were raised “that GPs and other clinicians were too busy with their own practices and work to become engaged with the CCG”. Other possible reasons that Naylor et al. (2013) identified as being barriers to engagement are; first, the financial climate, which was perceived as being a limiting

factor to the GP Practices as some GPs did not see any value in spending time in commissioning matters, which they could use fruitfully on their main responsibility, thereby helping maintain good relationships with their patients. Secondly, communication was also found to be an issue. For example, relying on one person to act as a conduit between the CCG and the practice could be attended with delays in passing information. Also, there may be too much information from the CCG which overwhelms the practice staff, or simply that the information is provided in an un-understandable format to the GPs.

Studies have shown various ways that CCGs engage with their member practices. These include, (1) engagement “through quality assurance visits” (McDermott et al. 2015, p.83), in which focus is not so much directed on inspection than identification of areas where service could be developed, (2) “education and training” that involve a discussion of subjects such as the role of the CCGs and the function of the GPs with formal roles in the CCGs (McDermott et al. 2015), (3) direct ‘ad hoc’ telephone calls to the Governing Body members using a ‘hotline’ (Naylor et al. 2013); and (4) use of CCG websites to access information as well as giving feedback, in some instances (Naylor et al. 2013). Research has also revealed that CCGs have faced challenges in addressing conflicts of interest (Robertson et al. 2016), a subject reviewed next.

2.4.4 Conflicts of interest

Conflicts of interest, in the context of the CCGs relates to “GPs commissioning themselves or their practices to provide services” (Moran et al. 2017a, p.1), thus creating a risk that their “ability to apply judgement ... could be, impaired” (Moran et al. 2017a, p.1). This puts the GPs in a predicament that, when undertaking their CCG responsibilities, they are actively encouraged to disconnect from being providers to avoid a conflict of interest (Baird et al. 2016). It appears like the question of conflicts of interest is like an ‘elephant in the room’ for the CCGs, flagged repeatedly in different studies (Storey et al. 2018; Moran et al. 2017a; Holder et al. 2016; McDermott et al. 2015; Naylor et al. 2013). One CCG manager in a recent study remarked that the question of conflicts of interest was so huge that it worried him or her (Storey et al. 2018). Some of the points of interest on this question that different studies have discovered are discussed next.

A study undertaken by McDermott et al. (2015) not long after the CCGs were launched did not only identify concerns touching commissioning on the question of the conflicts of interest but also stated an additional dimension that the respondents mentioned, which was allocation of time to the GPs with formal roles in the CCGs for them to perform their CCG related tasks. That is, the respondents expressed concern that time allocated to them was not enough, thereby leading them to work on CCG work in the evenings and weekends. As a result, one GP is reported as having “left their practice entirely to take up a full time CCG role” (McDermott et al. 2015, p.108). In the same study, it was discovered that the conflicts of interest were labelled as being “one of the greatest risks” (McDermott et al. 2015, p.17). In a study published in 2016, it was discovered that 20% of the GPs expressed concern about their CCGs’ ability to efficiently handle the matter of conflicts of interest (Holder et al. 2016). In 2017, Moran et al. (2017a) dedicated their entire study on this topic of the conflicts of interest in which they stated that, because of the conflicts of interest, NHS England published guidance to help the CCGs to manage this issue. The latest at the time was revised guidance produced in 2016 which was said to be an improvement on the guidance produced initially in 2014. Moran et al. (2017a) reiterated the criticality of the subject of the conflicts of interest, which they claimed to have “gained renewed attention”. While the CCGs have set governance structures to manage the conflicts of interest, Moran et al. (2017a, p.12) contend that they are not adequate given that “simply disclosing an interest does not prevent GPs and practice managers from influencing discussions about primary care, which may undermine their public stewardship role”. A striking example substantiating the above argument can be drawn from the Crawley CCG where the Chair “breached a conflict of interest rule” (Clover 2019), as reported in the Health Service Journal (HSJ) bulletin. While this case did not directly concern commissioning decisions, it reflects the argument that “disclosing an interest does not prevent GPs” or managers from breaching the protocol. The case in question mentions that the Chair advocated “for a technology company that had paid his consultancy firm £35,000”.

2.4.5 CCG roles occupied by GPs

McDermott et al. (2015, p.30) suggested that “asking what the role of GPs is or should be in CCGs is a complex question with as many answers as there are CCGs”. This

viewpoint is supported by Drake (2016) who first references the NHS Commissioning Board (NHSCB) that provides a guideline of the roles that GPs should assume. Drake then goes on to mention that additional to the NHSCB guidelines, “there is scope for choice and variability in CCG roles and the mixture of clinical and non-clinical members” (Drake 2016, p.126), which could be the reason for this lack of awareness.

Another interesting thing about the GP roles is what research has shown regarding leadership positions. In this respect, research has revealed that many CCGs have experienced challenges in getting the GPs who are willing to serve in leadership positions (Storey et al. 2018). Instead, non-clinical managers have assumed these roles bringing along “hierarchical structures”, thereby leading to the persistence of “the centre-led influence” (Storey et al. 2018, p.xvii). The possible reasons for having relatively fewer GPs in the top leadership roles are delineated in Section 2.3.7, where a focused discussion on leadership is made.

2.4.6 Summary of Previous research findings and knowledge gaps

The BMA (2014a) pronounced that, “Clinical Commissioning Groups (CCGs) in England, a flagship of the government’s health reforms, have failed to deliver overall improvements to patient care or involve more GPs in the running of services”. At the time, the BMA’s study revealed that the GPs were not happy with the policies that the CCGs produced, which they felt were restricting them from efficiently performing their function of delivering health care service in the English NHS. To understand the CCGs and their decision-making routines which arguably produce what the GPs viewed as ‘hostile’ policies, a summary of the literature has revealed the following.

First, while at inception, the CCGs were originally intended to be autonomous, operating at a bottom-up style designed to effectively meet local needs (Robertson et al. 2016), studies have shown differently, as discussed in Section 2.4.1. This situation is exacerbated by the question of limited finances, reviewed in Section 2.4.2, that the CCGs must operate under yet at the same time being expected to deliver high quality services. Stifled autonomy and limited finances leads to questions as to whether the intended professional model (Mintzberg 1979) is happening in practice. Also revealed in the previous studies is a lack on the part of CCGs regarding constant member practice engagement which, consequently, may detach the CCGs from the local

services, as discussed in Section 2.4.3. Another striking phenomenon that studies have shown is the conflicts of interest, a factor which is a big challenge for many CCGs in their decision-making routines, as discussed in Section 2.4.4. While these factors may be viewed as contributing to the formulation of the policies that the GPs perceive as 'hostile', there appears to be a void in the knowledge base about the factors contributing to the effective decision-making process, as perceived by the GPs, a gap that the current study sought to fill. Besides, there is a limited understanding of what the GPs do in their respective local CCGs because of the variability in their roles, as discussed in Section 2.4.5, another gap that the current study also sought to fill.

The next section presents a conceptual framework where different elements gathered from the review of the literature are pulled together and then used to inform the direction of the study.

2.5 Conceptual framework – CCGs and organisational structure

In this section, a conceptual framework of decision-making structures and associated processes within the CCGs is developed. Here, latent variables of factors influencing an environment conducive to a GP-led decision-making process are identified, and the associated propositions are developed. As well as providing a basis for statistical hypotheses testing, the conceptual framework informed the formulation of the qualitative questions which related to the research hypotheses. To this end, six latent variables were derived from published studies done on CCGs cited elsewhere in this thesis (Checkland et al. 2018; HFMA 2018; Moran et al. 2017a; HFMA 2017; Checkland et al. 2016; Holder et al. 2016; Robertson et al. 2016; McDermott et al. 2015; BMA 2014a; Naylor et al. 2013). "Latent variables", also known as a latent constructs or unobserved variables (Lowry & Gaskin 2014; Carrascal et al. 2009; Henseler et al. 2009; Bozionelos 2003) represent concepts that cannot be measured directly but are estimated using proxies. In the interest of consistency, this thesis uses the term latent variable. Latent variables make it possible to model a complete estimate causal network simultaneously in which, for instance, "the effect of $A \rightarrow B$ can be estimated while also estimating the effects of $A \rightarrow C$ and $B \rightarrow C$, as well as the indirect effect of A on C through B " (Lowry & Gaskin 2014, p.125).

The six latent variables mentioned above that I produced are *Decision-making Process Effectiveness*, *Member Practice Wishes Met*, *Satisfaction*, *GP Influence*, *GP Proportion*, and *Higher Authority Control*. The first four were dependent latent variables, which means that their impact was causally influenced by another variable linked to them using the principle of causal relationships while the last two were independent, not influenced by an external variable. As such, theoretical propositions explaining the causal relationships were developed accordingly. Theoretical proposition in this sense refers to the research hypotheses – that is, a ‘high-level’ version of statistical hypothesis (Prethus & Munkvold 2016) in which “a functional statement of cause and effect (e.g. changes in X cause changes in Y; Y is a function of X)” (Lowry & Gaskin 2014, p.126-127) is used to describe the relationship.

While the preceding paragraphs in this section reference a phenomenon of causal relationships across different latent variables, it is essential to note that cross-sectional studies, such as the current research, do “not allow causality assertions. Causality in cross-sectional research can be only speculated” (Bozionelos 2003, p.7). Conversely, longitudinal and experimental studies provide relatively stronger causal relationships rationales (Bagozzi and Yi 2012). Considering this, Bozionelos (2003, p.7) advises that “to assign causality in cross-sectional investigations ample theoretical and background knowledge of the nature of the included variables is imperative”. The current study achieved this requirement through an in-depth review of literature about the phenomenon of study, presented in the previous sections in this chapter. This exercise helped to justify the assumptions about causality in the model. Even so, because of the uncertainty over the causality assertion, the theoretical propositions (hypotheses) that I developed were nondirectional, meaning that they were not suggestive of any direction of causality, but simply indicated that a difference exists (Brewer & Stockton 2010). In contrast, directional hypotheses, which are typically based on foreknowledge of the phenomenon being investigated, derived from sources such as past research, assert the direction of causality by use of key words such as “higher, lower, more, less, increase, decrease, positive, and negative” (Brewer & Stockton 2010, p.366).

2.5.1 Independent latent variables

GP Proportion: Related to the rest of the latent variables, was the question of the proportion of the GPs in the decision-making panels. Studies have shown that the GPs are perceived to be relatively less influential in meetings when compared to the managers (Holder et al. 2016; Naylor et al. 2013). As such, since GPs are perceived as being less influential in the Governing Body meetings, does the proportion of their numbers in the same platform have any significance on decision-making? This question prompted the creation of latent variable *GP Proportion* designed to empirically explore the bearing of the GPs' proportion in the Governing Body from the context of the current study. The feeling that, if the proportion of GPs is generally higher in the Governing Body, GPs' level of influence could possibly be augmented as well, led to the following theoretical proposition,

Proposition 1 (P1): A high proportion of GPs in the Governing Body committee will cause a difference in the level of GP influence.

Higher Authority Control: the conception of this latent variable was driven by two main aspects discussed in the literature concerning the CCGs directly and impliedly. These are the authority and control that leadership and bureaucracy have (McAuley et al. 2014; Williams & Brown 2014; Mintzberg 1979). The literature shows how influential leadership can be in steering the strategic direction of the organisation (McAuley et al. 2014; Williams & Brown 2014; Einarsen et al. 2007; Padilla et al. 2007; Gronn 2002). Regarding the CCGs, Storey et al. (2018) specifically mention the influence that the roles of the Chair and Accountable Officer have at local CCG level. What is more, it is possible that due to the "strict and prescriptive assurance regime" (Checkland et al. 2018, p.390) meted out by NHS England, explained in Section 2.3.6.2, leadership in various levels within the CCGs' spheres of operation could have no choice but extend such severe measures to their domains of operation in order to meet NHS England's requirements. As a result, the perceived decision-making process effectiveness along with the member practice wishes being met plus the degree of GP satisfaction about decision-making, may all be impacted. For this reason, I devised the following three propositions.

Proposition 2 (P2): Higher authority control in the Governing Body committee will influence the decision-making process effectiveness.

Proposition 3 (P3): Higher authority control in the Governing Body committee will influence the member practice wishes being met.

Proposition 4 (P4): Higher authority control in the Governing Body committee will influence the degree of GP satisfaction about decision-making.

2.5.2 Dependent latent variables

GP Influence: Closely related to the GP proportion, was another question that the current study developed to understand the degree of influence that the GPs had in decision-making routines. Although research has indicated that, in general, managers – that is, non-clinical officers, were more influential than GPs in the committee meetings (Holder et al. 2016; Naylor et al. 2013), it was useful to explore the same subject from the context of the current study. The premise of the argument in this study was that, since the CCGs were designed to be clinically led (Checkland et al. 2016; United Kingdom Government 2012; NHSCC [No Date]), with the GPs specifically named to lead the system, did the custodians of this responsibility wield enough influence proportionate with the ethos underpinning the CCGs? For this reason, the latent variable named *GP Influence* was created to evaluate the impact of the GPs' influence. Three propositions were developed to this end,

Proposition 5 (P5): The level of GP influence in the Governing Body will cause a difference in the effectiveness of the decision-making process.

Proposition 6 (P6): The level of GP influence in the Governing Body will cause a difference in member practice wishes being met.

Proposition 7 (P7): A high level of GP influence in the Governing Body will impact the degree of GP satisfaction about decision-making.

Decision-making Process Effectiveness: The current study aimed to identify factors influencing the perceived effective decision-making process. Any action that supported efficient delivery of health care service within the decision-making process continuum (Figure 2.7) of the CCGs was viewed as being 'effective'. As such, a method to estimate the effectiveness of the process would be useful, something which the

latent variable, *Decision-making Process Effectiveness*, was designed to do. The reflectance of the decision-making process effectiveness would essentially be captured using perceptual measures, represented by the observed variables, such as (1) The Governing Body is dysfunctional, (2) The Governing Body makes decisions unfriendly to the member practices, (3) Senior Authority veto decisions made by the Governing Body, and (4) other Governing Body members yield their decisions to those of their fellow board members.

Satisfaction: Following on from the BMA (2014a) study, described in Section 1.1, the general tone of the findings indicated that the GPs were not satisfied with the decisions that their CCGs made. As such, the current study sought to analyse GPs' satisfaction with decision-making, three years on from the BMA (2014a) study.

Member Practice Wishes Met: *Member Practice Wishes Met* latent variable was considered as a moderating variable between latent variables *GP Influence* and *Satisfaction* as well as *Higher Authority Control* and *Satisfaction*. A lack of fulfilment of member practice wishes was demonstrated by the grievances expressed in the BMA (2014a) research findings where sentiments such as limited "freedom to make clinical decisions" for the patients, "little influence over their CCG", and not being able "to contribute their views" were made. The assumption that the current study adopted was that, for GPs to be satisfied with the decisions made by their CCGs, they needed their wishes to be addressed. These included, giving them the freedom to make clinical decisions, giving them more influence over their CCGs, and allowing them to contribute their views. Meeting those wishes depended on the level of influence of the GPs who sat in the Governing Body where they could facilitate in getting those wishes realised. To this effect, Proposition 8 was developed.

Proposition 8 (P8): The level of GP influence and the higher authority control in the Governing Body will influence the scale of member practice wishes being met, thereby causing a difference in the degree of GP satisfaction about decision-making.

The propositions and latent variables were linked together to produce a conceptual model shown in Figure 2.11, and described in the next section.

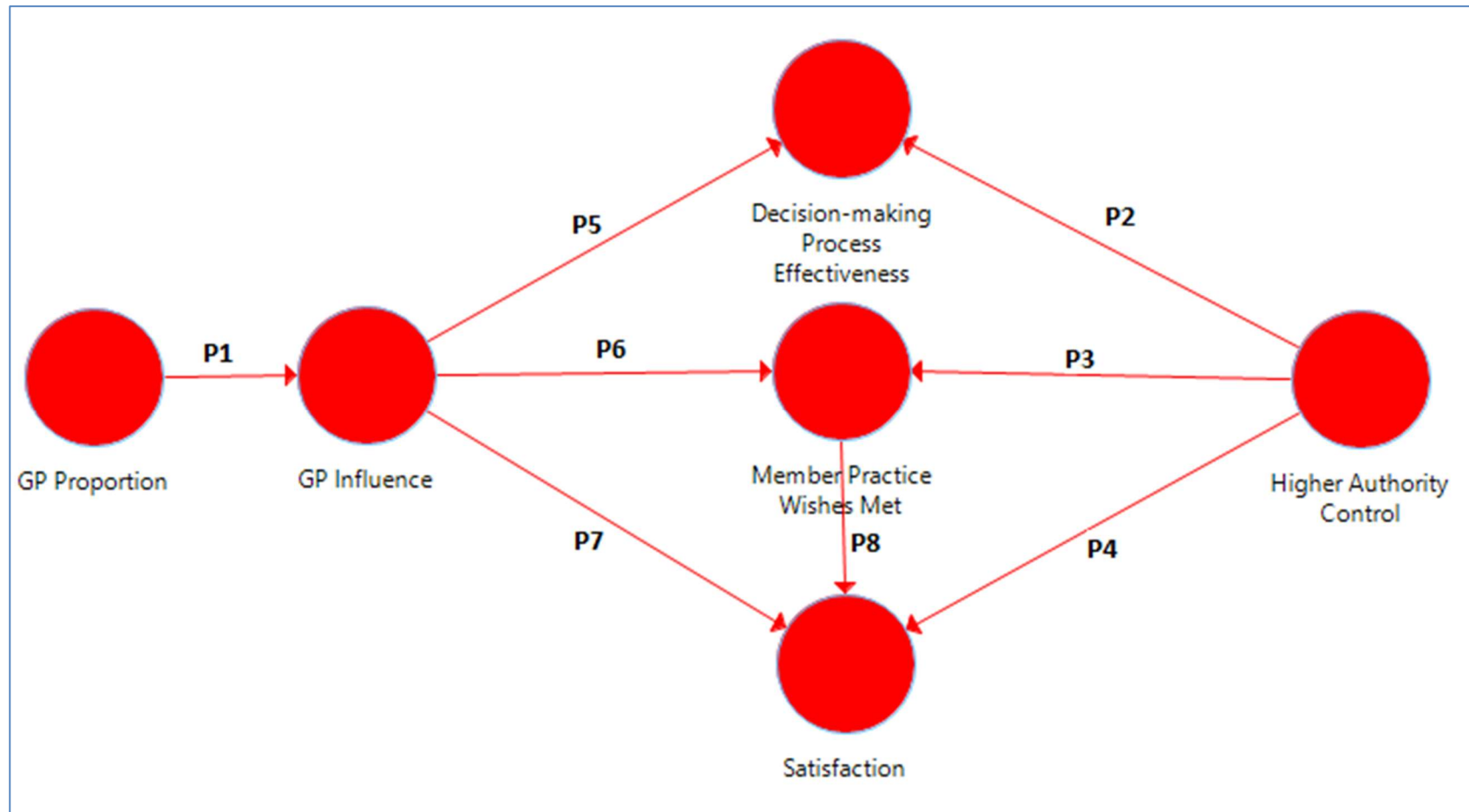


Figure 2.11 CCGs Decision-making Conceptual Model (Source: Author's own 2019, unpublished)

2.5.3 Conceptual model

The diagram in Figure 2.11 depicts the perceived reality in terms of a network of causal effects across different latent variables, at the time when the research instrument was designed. The model is not designed to prove causation between two latent variables but to only indicate the compatibility of the model with the data being tested, thereby helping to ascertain causal effects strengths (Bozionelos 2003).

The conceptual model was produced at the literature review phase with the view that it was subject to change depending on the data obtained and subsequent model fitness tests at the data analysis phase. The relationships in the model depict that *Decision-making Process Effectiveness* is an effect of *GP Influence* and *Higher Authority Control*. On the other hand, *GP Influence* is causally determined by *GP Proportion*. *Satisfaction* is the effect of *GP Influence*, *Member Practice Wishes Met*, and *Higher Authority Control* while at the same time *Member Practice Wishes Met* depends on *Higher Authority Control* and *GP Influence*. *GP Proportion* and *Higher Authority Control* are exogenous latent variables, meaning that they are the causes of *GP Influence*, *Satisfaction*, and *Decision-making Process Effectiveness*. *Member Practice Wishes Met*, on the other hand, is an intervening variable with its causality role just being on *Satisfaction*, meaning that on its own it cannot exert that causation (Russo 2009).

2.6 Summary

More research is needed to understand perceived effective decision-making within the CCGs. To start with, CCGs were created so that they could commission health care services directly at the local level, thereby enabling them to improve patient care and increase accountability. The PCTs, which were replaced by the CCGs, were, on the contrary, run from the centre, which made it difficult to understand and appreciate the local needs. When viewed with the theoretic lens, CCGs resemble the professional model of Mintzberg's models of the structure of organisations whereas their predecessor PCTs bore the structure of the bureaucratic model in the same Mintzberg's framework (Mintzberg 1979). The latter have operational decisions made centrally in a top-down fashion while the former aims to yields the prerogative of decision-making to the local domains for them to self-manage their operations.

As decentralised organs, the CCGs have been perceived as not adequately fulfilling the wishes of the local services that they support due to the policies that they (CCGs) produce (BMA 2014a). Most of the challenges leading to this predicament are bigger than the CCGs. While on paper the CCGs were intended to be autonomous entities that should be free from the influence of the central blueprint, in practice the macro-level centre imposes stringent bureaucratic controls on these bodies – for example, asking them to operate under restricted budgets yet at the same time setting targets hard to achieve without adequate funding (Checkland et al. 2018; HFMA 2018; HFMA 2017). Also, CCGs have been found to be so complex, with internal systems difficult to understand as well as intricate external relationships (Checkland et al. 2016; McDermott et al. 2015).

With decisions that the CCGs make being critical to the delivery of health care in the English NHS, discovering the factors influencing the perceived effective decision-making process within these organs is important. Also, getting insight into the roles that the GPs occupy in the CCGs will add to the existing knowledge which previous studies have cited as being partial in this regard. For these reasons, the primary goal of this study was to identify the factors influencing the perceived effective decision-making process while the secondary goal was designed to assess the formal roles occupied by the GPs in the CCGs. To achieve this, a mixed methods design was employed.

CHAPTER 3

RESEARCH DESIGN

3.1 Introduction

The purpose of this study, outlined in Chapter 1, was primarily focused on exploring decision-making profiles in the CCGs to identify factors influencing the effective decision-making process as perceived by the GPs, since they were the intended key decision-makers, but apparently unhappy. The secondary aim was to discover the formal roles occupied by the GPs in the CCGs. The background to the study as well as its supporting rationale is provided in Chapter 1. Section 1.5 introduces the methodology, mixed methods, which I used to gather the data for investigation to fulfil the research aims. This chapter, Chapter 3, is designed to build on that introduction, explicating the procedures that I followed in the development of the study under the mixed methods approach. Pivotal to the procedures was the philosophical foundation, pragmatism, which underpinned the design.

Another aspect that will be noticed about this chapter is that it is longer than an average thesis Research Design one. This was because of the methodological approach, mixed methods, that I used, which resulted in twice the amount of written content when contrasted with other approaches like a single quantitative or qualitative study method (Creswell & Plano Clark 2011; Bryman 2007).

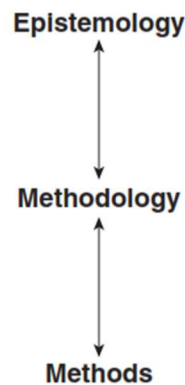
3.2 'Philosophical position' and methodological stance

This study was conducted from the philosophical foundation of pragmatism in line with the recommendation of numerous academics who argue in favour of the suitability of this stance for a mixed methods research (Creswell & Plano Clark 2011; Morgan 2007; Johnson & Onwuegbuzie 2004). A key attribute of pragmatism, which makes it unique, is that it allows the researcher to use schemes and methods that the researcher deems suitable for his or her study (Mertens 2009). While the standard understanding of pragmatism holds that "multiple paradigms can be used to address the research problem" (Rossman & Wilson 1985, cited in Creswell & Plano Clark 2011, p.26), in this study pragmatism is viewed via Morgan (2007, p.68) who advocated that pragmatism

in social science research should not be seen from the conventional sense of philosophy, as “that is the province of philosophers”. Morgan argued for a shift from the traditionally held “metaphysical paradigms” characterised by excesses of philosophical knowledge on related methodologies. Paradigms in this context denote a collection of “beliefs and assumptions about knowledge that informs ... [the] study” (Creswell & Plano Clark 2011, p.39). To this end, Morgan proposed an alternative model – the “pragmatic approach”. The pragmatic approach model is intentionally not referred to as a paradigm as Morgan argued that his naming convention might help avoid confusion “around the concept of paradigm” (Morgan 2007, p.65). Morgan was, nonetheless, quick to mention that his model is a direct challenge to the conventional metaphysical paradigms. The marked difference is that the pragmatic approach is purged of the weight of philosophical knowledge, which is why the phrase ‘philosophical position’ in this section’s heading is placed in quotation marks.

While the pragmatic approach model seeks to avoid the excesses of traditionally held metaphysical paradigms, it however acknowledges and embraces the epistemological implications underpinning the general approach that a researcher assumes. Emphasis is placed on how the epistemological implications of the knowledge generated by the research relate to the methods used to produce that knowledge. That is, this approach argues its case from the standpoint focused “on methodology as an area that connects issues at the abstract level of epistemology and the mechanical level of actual methods” (Morgan 2007, p.68). In this framework, the “strong tendency ... to privilege epistemology over methods” (ibid), as commonly found in standard research approaches, which include typical mixed methods designs where pre-existing philosophical commitments are respectively applied to quantitative and qualitative strands (Creswell & Plano Clark 2011), is negated. Figure 3.1 demonstrates how epistemology and methods are pivoted on methodology in the pragmatic approach model.

Placing Methodology at the Center



SOURCE: Morgan (2007, p.67)

Figure 3.1 Methodology - A connecting link between epistemology and methods

The pragmatic approach advocates a methodological framework that simply draws attention to central issues. For example, the focus is placed on explaining how theory and data are connected, how the researcher should relate to the research subject, and on explicating the question concerning how the empirical findings can be applied. Figure 3.2 illustrates this notion by drawing a comparison between the pragmatic approach and traditional research approaches. The pragmatic approach column in the diagram incorporates both quantitative and qualitative approaches.

A Pragmatic Alternative to the Key Issues in Social Science Research Methodology

	Qualitative Approach	Quantitative Approach	Pragmatic Approach
Connection of theory and data	Induction	Deduction	Abduction
Relationship to research process	Subjectivity	Objectivity	Intersubjectivity
Inference from data	Context	Generality	Transferability

Source: Morgan (2007, p.71)

Figure 3.2 Pragmatic approach methodological framework versus traditional approaches

3.3 Research methodology

A mixed methods research design was used to achieve the aims of this study. Mixed methods encompass both quantitative and qualitative research strands in a single

study. The rationale for opting for a mixed methods design was “to develop a more complete understanding of [the phenomenon of study]” (Creswell & Plano Clark 2011, p.77) by synthesising complementary quantitative and qualitative data. The quantitative research provided a predictive framework (Lowry & Gaskin 2014; Hair et al. 2012; Henseler et al. 2009) while the qualitative strand provided an interpretive framework. The qualitative research afforded this by its virtue of access to rich information through descriptions provided by the participants about the phenomenon of study. The other reason for adopting mixed methods design was the time-factor, which is explained later in this section.

Academics have “little agreement ... about what mixed methods research is” (Morse & Cheek 2014, p.3). For example, some academics are not convinced about mixed methods because of the unconventional practices promoted in the concept, such as combining of different philosophical positions in a single study (Creswell & Plano Clark 2011; Mason 2006). The mixed methods methodology has also been criticised for privileging the quantitative research by relegating the qualitative research strand “to secondary or auxiliary status” (Creswell et al. 2006). Notwithstanding, I planned my research to be driven by the quantitative strand, as would be seen later in the text. Another thing worth mentioning about the mixed methods is that some see this approach as merely being a data collection technique, a view which Creswell and Plano Clark (2011) countered by explaining that, while mixed methods may be a data collection technique, it is also a methodology as it incorporates a scheme for managing research.

There are six types of mixed methods designs, namely – Explanatory, Exploratory, Convergent, Embedded, Transformative, and Multiphase (Creswell & Plano Clark 2011). Most of these have different variants associated with them which are predicated on timing in the implementation of the design. That is, timing may be concurrent, where quantitative and qualitative strands happen at the same time; or sequential, where quantitative and qualitative strands are implemented in two separate phases, one after the other; or multiphase, where quantitative and qualitative data collection along with data analysis are done collectively in various segments over an extended time (Creswell & Plano Clark 2011). The current study adopted a convergent parallel design with concurrent timing. The convergent parallel

mixed methods was considered appropriate in the interest of time, as mixed methods designs are known to typically take a longer time in data collection and analysis than other research methodologies (Creswell & Plano Clark 2011).

In the convergent parallel mixed methods, both strands are given equal priority, and both run concurrently in a single phase to collect data (Creswell 2013a; Creswell & Plano Clark 2011). Once the data have been collected, they are analysed, compared, and contrasted in line with the research strategy. Mixing, a central tenet in mixed methods where quantitative and qualitative data are integrated into one, must occur at some stage. Green (2007, p.120, cited in Creswell & Plano Clark 2011, p.64) designates this activity as the “most salient and critical” in the design. In this study, mixing happened at two points; each referred to as a “point of interface” (Creswell & Plano Clark 2011, p.66). These were at data analysis level, and at interpretation level, as depicted in Figure 3.3.

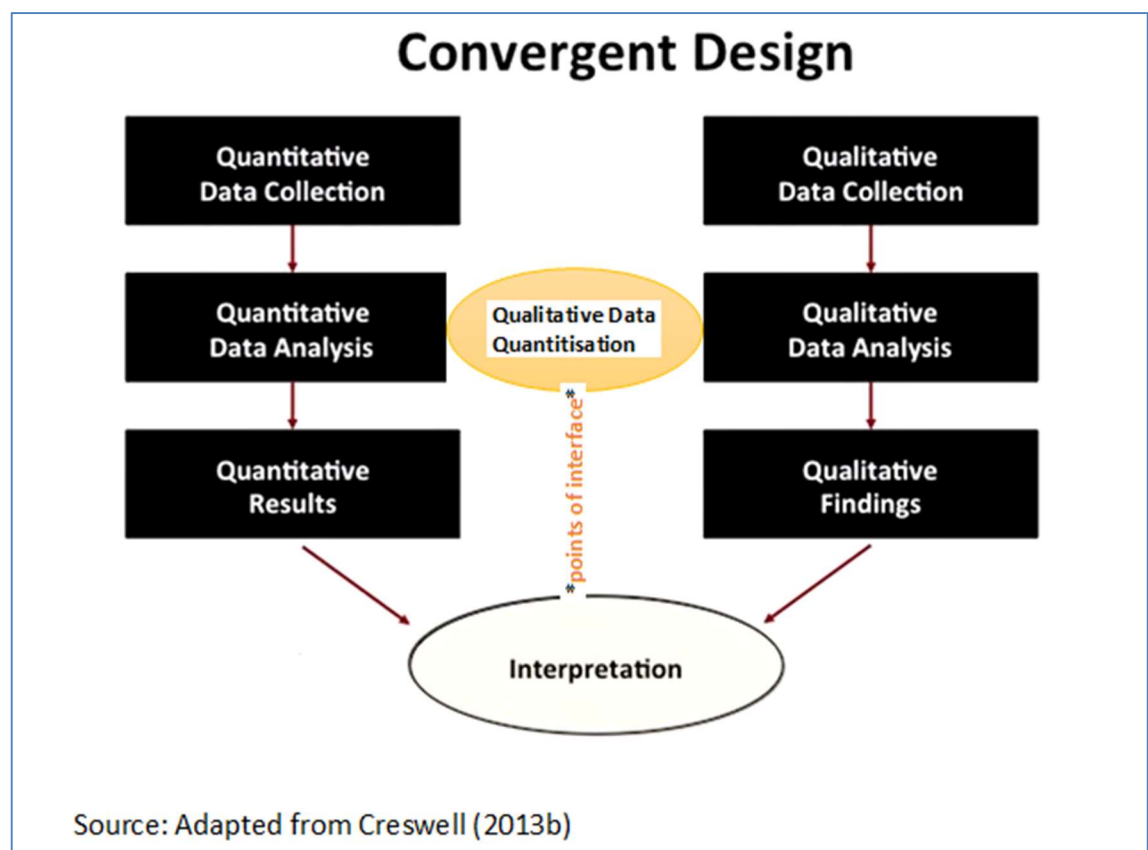


Figure 3.3 Convergent parallel mixed-methods approach

The mixing strategy employed at each point was merging. At the data analysis level, this was achieved by quantising qualitative data for statistical analysis. The term

quantitising denotes transformation of qualitative data by converting it into codes or binary values which are then analysed statistically (Doyle et al. 2016). Quantitisation of qualitative data in a mixed methods design study is a recognised mixing technique ‘in its own right’, as advanced by Creamer (2011). At interpretation level, merging occurred when conclusions and inferences were drawn through synthesis and comparison of the combined results of quantitative and qualitative studies. Apart from the two points of interface, all other processes were done separately, tied to their respective strand as portrayed in Figure 3.3.

Other than having mixing activity at analysis and interpretation points, mixing can also be done at other different points of the study (Creswell & Plano Clark 2011). For example, at the design stage, mixing can be achieved through embedding in which one study strand is embedded into the other. There is also “connecting”, a strategy normally applied at the analysis phase where analysis of one data type triggers a need for the other. Say, the analysis results of quantitative data triggering need for qualitative data to get a comprehensive picture of the phenomenon being investigated. Lastly, the mixing strategy can be at programme level where “multiple projects or studies” are joined “in a multiphase project” (Creswell & Plano Clark 2011, p.68).

The mode that I utilised in connecting theory and data is abduction; an integral part of the pragmatic approach model, shown in Figure 3.2.

Abduction

Abduction, also known as abductive reasoning, is a term that implies “explanatory reasoning” in which a simple explanation is made to define evidence of the observed phenomenon (Magnani & Bertolotti 2017; Douven 2011b). While that may be the general understanding of the concept, Gabbay and Woods (2005) argue extensively that reasoning does not necessarily have to be explanatory, citing examples like the legal industry where non-explanatory abduction can be used in law. As can be seen, already, the concept of abduction is mired in controversy in academic circles as there is no agreed standard position on it (Magnani & Bertolotti 2017; Douven 2011b) so much that researchers have come to an agreement that they “have failed to secure the core meaning of abduction” (Magnani & Bertolotti 2017, p.134). As such, there are different

forms of abduction advanced by numerous philosophers who include Peirce, Harman, Thagard, Magnani, Gabbay and Woods, Schurz, and Hoffmann (Park 2015). This thesis is not intended to discuss the entire collection of the abduction variants. Instead, the thesis only focuses on Peirce's abduction, which, along with additional insights from Mirza et al. (2014), informed the abduction that I adopted for this study.

Peirce's abduction was advocated by Charles Sanders Peirce, who is not only known for inventing the term "abduction" (Douven 2011a) but is also referred to as the "father of pragmatism" (Mirza et al. 2014). Peirce's abduction entails the generation of hypotheses to explain the observed phenomenon, an occurrence which Peirce initially considered as "nothing but guessing" (CP [Charles Peirce] 7.219 1901, cited in Magnani & Bertolotti 2017, p.183). However, displeased with the notion of guesswork, Peirce is reported as having endeavoured "to uncover the logic through which new ideas come into existence" (Fann 1970, cited in Mirza et al. 2014, p.1982). His journey to this end caused him to be criticised for being vague and paradoxical. For example, on the one hand, Peirce stated that "hypotheses are the products of imagination" while on the other hand, he said hypotheses "are products of a certain sort of logical inference" (Frankfurt 1958, p.594). His position on this and several other components on his form of abduction changed with time, resulting in something that he called "qualitative induction" as opposed to a hypothesis (Park 2015), although both were essentially designed to serve the same purpose, but differently (Tuzet 2007).

The other thought of interest that Peirce advanced alongside his work on abduction is the argument that reasoning encompasses three forms – abduction, deduction, and induction, which he took as "different modes of inferences" (Park 2015, p.228). Peirce, however, was faced with the challenge of conflating induction with abduction, something which led him to change his mind later in his career where he assumed the view that the three kinds of reasoning were in fact "different stages in inquiry" (Park 2015, p.228). Mirza et al. (2014, p.1981) enhance this view by stating that, while abduction is "the process of generating hypotheses, theories or explanations", deduction and induction "allow for the consequent processing of those ideas". Deduction explains logically, "the consequences" of abduction while induction explains the same empirically. Based on this understanding, I developed my approach

of abduction which is described below. This approach basically encapsulates what Peirce identified as “different stages in inquiry” (Park 2015, p.228).

Abduction: As the first stage of inquiry, the process of abduction in my study started from the footing of existing knowledge in the professional and academic domains, which I used as a basis for the development of the hypotheses. This process was enabled by retroduction; a form of reasoning which considers existing facts to extrapolate insight, which Peirce (1907) portrayed as a “process whereby from a surprising array of facts we are led to a conjectural theory to account for them” (MS 318:21-3, cited in Bergman & Paavola 2018b). In this contextual background, I developed a conceptual model, described in Chapter 2, Section 2.5, designed “to explain meaningful underlying patterns” (Mirza et al. 2014, p.1982) of the perceived reality in the CCGs’ network of causal effects in decision-making. I then produced hypotheses, referred to as propositions at this stage, which explained the causal relationships across the different latent variables. The propositions were subsequently turned into causal (or explanatory) hypotheses for statistical analyses performed in Chapter 4, leading the process to the second stage of inquiry, deduction.

Deduction: Deduction occurred at the testing stage of the explanatory (causal) hypotheses, which were tested based on the premise described on each hypothesis. The Partial Least Squares Structural Equation Modelling (PLS-SEM) technique was used on the path model adopted and enhanced from the conceptual model initially created in Chapter 2. As explained earlier, as per Mirza et al. (2014), the purpose of deduction in the three stages of inquiry is to provide a logical explanation of the conclusions reached in the abduction stage. A unique characteristic of deduction is that it provides certainty of the conclusions about the premise being tested (Schurz 2008; Svennevig 2001). However, deduction is not context sensitive (Svennevig 2001) – that is, it does not take into consideration the contextual background of the inferred premise. In contrast, induction, which is the next in the stages of inquiry, does consider the context of the inferred premise.

Induction: Induction, a form of reasoning that I employed to produce the conclusions of the current study, is enumerated by Peirce as being “a much stronger kind of inference than hypothesis” (CP [Charles Peirce] 2.642; W 3, p.336, cited in Park

2015, p.224). Additionally, Schurz (2008, p.202) characterises induction as serving “the goal of inferring something about the future course of events – which is important for planning”, something which, when viewed from Mirza et al. (2014) standpoint, is realised by explaining “the consequences” of abduction empirically. To achieve this in the current study, I did not only consult the guaranteed conclusions proffered by the process of deduction applied to the quantitative data but, together with those, I used the data from the qualitative study strand which was so rich that ultimately the study conclusions were contextualised on it. The conclusions that I produced fulfilled the primary and secondary aims outlined in Section 1.1.

The focus will now shift to the description of the data collection methods that I used.

3.3.1 Data collection: Survey

The study used a survey in a cross-sectional design setup adapted to handle both quantitative and qualitative study strands running in parallel on a single phase. The term survey, in this case, denotes a systematic collection of data “about a sample drawn from a specified larger population” (Sternberg et al. 2007, p.54), whereas cross-sectional design signifies a one-off study on the sample (Callegaro et al. 2015). While surveys are traditionally associated with quantitative studies (Groves et al. 2004), incorporating qualitative data collection alongside quantitative data collection in the survey proved worthwhile. The reasons supporting this assertion, along with other factors addressing the question of using a survey in the current study, are discussed in the next section, Section 3.3.2.

The qualitative survey is not widely adopted in research, and hence not extensively discussed in the literature (Jansen 2010). Qualitative survey essentially aims at determining “meaningful variation” (Jansen 2010, no page) in responses on the phenomenon of study as opposed to quantitative survey where a count of the number of respondents is done to establish characteristics like “frequencies, means or other parameters” (Jansen 2010, no page). To obtain “meaningful variation” in the current study, participants were drawn from different CCGs across the whole of England. The survey was administered using a questionnaire through the web. There is, however, a limitation worth mentioning about the web-based qualitative research. This approach

restricts flexibility and in-depth access of insights that unstructured face-to-face interviews can offer as, in that setting, it is possible to adapt and change in line with the respondent's answers (Rowley 2012; Rose 1994). Besides, unlike web-based questionnaires, in face-to-face interviews clarification can be provided instantly in the event of ambiguity on one or more questions (Williams 2003). The downside with face-to-face interviews is interviewer bias that can be introduced. For example, visual or verbal cues can influence the participant to respond in a certain way. Besides, face-to-face interviews may also "provoke anxiety and distress in participants" (Richards & Schwartz 2000, p.136).

3.3.2 Why survey?

Using a survey for my study presented several advantages, even though there were disadvantages and weak points too. The overarching advantage pertained to the coverage of a wide range of the CCGs across England. Cost was also a big advantage, in the sense of time and money (De Leeuw 2005; Williams 2003). It was relatively quicker and cheaper to deploy web survey (interchangeably referred to as online survey in the text) using free survey software, Google Forms, as opposed to face-to-face interviews. This was particularly useful considering that my research was based on a mixed methods design, meaning that with this kind of methodological approach I managed to address both strands of the design expeditiously. Another key advantage is related to the degree of freedom of expression on the part of the respondents. Previous research has suggested that respondents are relatively comfortable to disclose better quality information to sensitive questions on self-administered surveys than on face-to-face interviews (De Leeuw 2005).

The main drawback that I faced was nonresponse, which studies have shown is "higher in self-administered questionnaires than in interviews" (De Leeuw 2005, p.245). Since I was already aware that I was likely to face this challenge due to the kind of population that I was dealing with, the effort that I ultimately put into boosting the response rate was considerable and financially costly because of the unexpected events which occurred around the time of data collection. The events in question pertained to a global cyber-attack which was discussed all over the news at the time, an event that risked severely impacting the willingness of the potential respondents from participating in the survey seeing that it was web-based. The cyber-attack in

question, along with the details of the actions that were taken to offset the likely associated consequences on response rate, is in Section 3.5.5.

Overall, I believe that opting for a survey under the circumstances that constrained my research was the best choice that I could make. What is reassuring is that several studies examining the quality of different modes of data collection have shown that no data collection mode can be held more highly than the others. The point in case in those studies was a comparison between face-to-face interviews and web surveys. The results demonstrated no difference between the two (Revilla 2015). I view quality in this instance from the perspective of Revilla (2015, p.1219), which is, “the strength of the relationship between the latent concept of interest and the observed answers”.

The discussion will now look at the associated epistemological implications on quantitative and qualitative strands.

3.3.3 Epistemological Implications

First, in keeping with pragmatic approach model adopted for this study from Morgan (2007), the excesses of traditionally held metaphysical paradigms are avoided while at the same time the epistemological implications underpinning the general approach that a researcher assumes are acknowledged. Since my study was deployed under the convergent parallel mixed methods design, an “umbrella” paradigm was assumed for that context in line with the recommended guiding principles (Creswell & Plano Clark 2011). Pragmatism, already described at the beginning of this chapter, underpinned the study. What this means is that ““what works” to address research question [was embraced]” (Creswell & Plano Clark 2011, p.42).

From the position of the pragmatic approach by Morgan (2007), I adopted a pluralistic attitude, which was characterised by epistemological dualism, where I worked back and forth between objectivity and subjectivity. I applied objectivity on the quantitative strand while subjectivity was on the qualitative strand, a scenario which Morgan (2007) labels as an intersubjective approach. Intersubjectivity is an important component in the pragmatic approach relating to the relationship of the researcher to the research process.

Concerning objectivity, I endeavoured to avoid the purist stance represented in positivism, which holds the notion that there is a single version of truth (Hatch and Cunliffe 2006). Instead, I leaned towards post-positivism, which recognises a limitation that a researcher has in influencing the observation that he or she makes (Reichardt & Rallis 1994). On the other hand, subjectivity, a derivative of subjectivism which contends that knowledge is developed from ways or experiences unique to the individual depending on their background (Lincoln and Guba 1989), was manifested in two areas in my study; the researcher and the researched. The best philosophical commitment that subjectivity could be practicably described from in this context, is interpretive phenomenology, because of the intention that I had to capture “the essence of the lived experience” (Williams & Paterson 2009, p.694) of the participants. Before making any further explanations about this, it is useful to set a brief contextual background of phenomenology to develop a better understanding of how subjectivity underpinned my study.

Van Manen (1997) describes phenomenology as a “study of lived experience or the life world” (cited in Lavery 2003, p.22). Epistemologically, phenomenology has different typologies which are collectively grouped into two broad categories, descriptive and interpretive. Descriptive phenomenology, coined by Edmund Husserl, is characterised by descriptive disposition in which a researcher must put aside his or her personal assumptions about the phenomenon of study in order to gain an uncontaminated understanding of the case (Gill 2014; Lavery 2003). In this premise, the focus “is to examine the essence or structure of experiences in the way it occurs to our conscious ... without the influence of any external theory” (Tuffour 2017, p.2). On the other hand, interpretive phenomenology, first developed by Martin Heidegger from Husserl’s conception and subsequently modified into several variants by other proponents, argues that a researcher, or observer, cannot be detached from the phenomenon of study but should be part of it (Cal & Tehmarn 2016; Gill 2014). Interpretative phenomenological analysis (IPA), which the current study assumed, is one of the variants of Heidegger’s interpretive phenomenology, which was proposed by Jonathan Smith (Tuffour 2017).

A question may be asked, what exactly did the current study intend to capture on the lived experience of the GPs respecting the decision-making process? Likewise,

another bigger question may be asked; why an emphasis on ‘the lived experience’ in a web survey, where there is no direct contact with the respondents? To appreciate the essence of these questions, the response below paralleled with an example of what lived experience could be, as described by van Manen (1990, p.5, cited in Arslan & Yildirim 2015), may be useful. In this example, lived experience is portrayed as being different from person to person even if the circumstances of the phenomenon being faced may be similar.

“Based on van Manen’s analogy, teacher A who has no experience in teaching as this is her first day on the job has different experiences compared to teacher B who has ten years of experience. The expert teacher forgets the presence of the students during the lecture while the novice teacher feels the glance of the students. According to van Manen, the novice teacher is constantly aware of her own experience on the first day of school. However, the expert teacher is unaware of her acts during the lecture because she is used to lecturing and behaves more spontaneously”.

As explained in Chapters 1 and 2, when the CCGs were introduced in England, they were given the responsibility of “planning and commissioning of health care services for their local area” (NHSCC [No Date]), with the GPs intended to lead the system (Checkland et al. 2016). In the previous scheme under the Primary Care Trust (PCT) structure, the responsibility of making such decisions was centralised in the individual PCTs and was performed by non-clinical staff (managers) with no direct input from the GPs (see Figure 2.5). Given the GPs were relatively new to commissioning decision-making activities, it is possible that most found the responsibility tricky. Like a novice teacher used in van Manen’s example of lived experience who is conscious of students’ eyes being on her, it is possible that the GPs also felt the pressure of their responsibility. Actually, regarding leadership role of a management nature in the CCGs, one of the GPs was quoted in the most recent research saying, “I think the clinicians in those roles find it quite tough sometimes because it is not something that clinicians are trained for” (Storey et al. 2018, p.50). In light of this, it was an exciting thought to seek what the GPs had to say about their experiences in their various role capacities within the CCGs, which is why phenomenology was considered suited for epistemological alignment.

Regarding the import of subjectivity in the premise of the researcher and the researched; as a researcher, I was placed in a position in which I was “attempting to make sense of the participant, who ... [in turn, was] making sense of his or her experience” (Aisbett 2006, cited in Charlick et al. 2016, p.211). That is, as the participants try to make sense of their experience, describing it based on their subjective individual perceptions, the researcher, in the meantime, tries “to make sense of the participants’ sense making” (Tuffour 2017, p.4), similarly using his or her own subjective individual perceptions. This set of circumstances is known as double hermeneutics. Hermeneutics is described as “the art and science of interpretation or meaning” (Tuffour 2017, p.3).

As a researcher, I was aware that I had preconceived ideas and biases that I held about the research topic, a paradox that risked obscuring the sense making process that I was supposed to deliver from the participants’ sense making. To accurately capture the experiences of the participants, the preconceptions that I held needed to be contained, and that was to be achieved through bracketing. Tufford and Newman (2012, p.81) describe bracketing as “a method used by some researchers to mitigate the potential deleterious effects of unacknowledged preconceptions related to the research and thereby to increase the rigor of the project”. The foreknowledge, or preconceptions, which may potentially predispose the researcher to bias, about the phenomenon of study are recognised and embraced in interpretation under IPA, but reflexively (Tuffour 2017). Accordingly, below is a description of two related preconceptions that I held:

1. Leading up to my research, I had pre-existing passionate regard for decentralised configurations in decision-making owing to the professional contexts that I always worked in where such a system was fostered. This position is explained in Chapter 1, Section 1.2, where my experience in Scrum environments is outlined. While my enthusiasm for decentralised organisational structures was an asset that had the potential to contribute to the description of the concept positively, I, however, risked introducing unintentionally biased opinions in the study. Additionally, I also risked harbouring prejudicial feelings about what might have appeared

incongruent with what I viewed as logical in regard to decentralised organisational settings.

2. When I engaged in my research, I had a strong affinity for the CCGs' model, particularly moved by the idea that the clinicians held power to run their own affairs as specified in the Health and Social Care Act 2012 (United Kingdom Government 2012). While the CCGs had always been at 'arms' length' from my core professional business, I held the notion that CCGs could perform brilliantly if the system did not nag them with bureaucracy. Because of these strong feelings, I realised that I needed to guard against premature and pre-drawn conclusions. What is more, I had to be careful about the quality and tone of my questions on the questionnaire so that they were neither leading nor had any "implicit assumptions" (Rowley 2012). By contrast, having strong feelings about a given phenomenon may not necessarily be a bad thing as noted by Boden et al. (2016, p.1078) who argue that, "without the resonance of feelings [in the researcher] ... words appear empty or disingenuous". Similarly, Gemignani (2011, p.701) claims that it is almost impossible to dissociate one's feelings as a researcher from the researched phenomenon, especially if the phenomenon involves the "core dimensions of the researcher's identities and subjectivities".

3.3.4 Study authentication and generalisation

The assessment criteria for authenticating the quantitative study strand in this research were validity and reliability. I believe that the same results from this study can be achieved "when the assumption is being made that the object being measured has not changed" (Scott & Morrison 2006, p.208), which is what reliability is about. In like manner, I believe that this survey measured and described decision-making profiles in CCGs to identify factors influencing the effective decision-making process as perceived by the GPs, which is what validity is about (Bell 1999).

Authentication of a qualitative study is customarily based on confirmability of the collected data (Lincoln & Guba 1989). The collected data, along with their analyses and interpretation, should all be linkable to the researched subjects and their background circumstances. However, it gets complex when considered from

interpretive phenomenology position. The challenge concerns semantics and a lack of standardised process. In this regard, Lavery (2003, p.31) argues that “issues of rigor in interpretive inquiry are confusing to discuss, at times, as there is not an agreed upon language used to describe it or one universal set of criteria used to assess its presence”. Along the same line, but with a suggested approach in addressing the issue, Ajjawi and Higgs (2007, p.631) note that “the criteria used to ensure quality in interpretive research should be consistent with the philosophical and methodological assumptions”. Respecting the current study, as already explained earlier, interpretive phenomenology was embraced as the lens through which epistemological positioning was considered, but at an abstract level, in line with Morgan (2007) pragmatic approach. Having embraced IPA to guide the qualitative study, I was faced with the predicament that there is no specific way that can be used to evaluate the credibility of IPA (Cassidy et al. 2011). IPA is not intended “to produce a definitive analysis” (Cassidy et al. 2011, p.269) because of the assumed interpretative position. Therefore, to ensure credibility of the qualitative strand, my focus remained on the participants’ “attempt to make sense of their experience” (ibid). I allowed the text to “assert its own truth” (Smith et al. 2009, cited in McManus Holroyd 2007, p.208). Credibility, in this case, is regarded as denoting “vividness and faithfulness of the description to the phenomena” (Ajjawi & Higgs 2007, p.631).

Arguments about generalisability and the context-bound nature of quantitative and qualitative studies’ findings do not apply when a pragmatic focus is assumed (Morgan 2007). Instead, studies conducted under the pragmatic approach model are transferrable. Transference is achieved through effusive descriptions where the context of the study is painted. The context should be adequately described “such that readers can judge for themselves the applicability of the research findings to their own contexts” (Ajjawi & Higgs 2007, p.207). If the described picture is comparable to the reader’s situation, the reader can “be informed by the findings” (Symon & Cassell 2012, p.207). Lessons “learned in one context” can be transferred to other contexts irrespective of the methods used to generate that knowledge as long as the underlying factors warrant transference (Morgan 2007). Ajjawi and Higgs (2007, p.632) state that “transferability of the research findings to other settings has been proposed as an important indicator of quality in qualitative research”.

3.3.5 Research population and sampling

To understand the factors influencing the perceived effective decision-making process in the CCGs, the research population was drawn from the GPs in England who had roles to perform in their local CCGs. A point of note that I should stress based on design approach is that, I chose to ask GPs involved with CCGs in the hope of getting their particular insights whereas the BMA (2014) study, which inspired this study, surveyed all the GPs. As well as increasing the validity and credibility of the survey results, I believe these persons were better informed about the decision-making process in the CCGs and thus, had the most useful contribution for improvement on the issues that the CCGs were blamed for by the GPs working in surgeries. The GPs working in surgeries expressed negative sentiments about the policies that the CCGs made, stating that they “adversely affected their ability to care for patients” (BMA 2014a). These policies were also identified as restricting GPs’ “freedom to make clinical decisions for their patients ... [with GPs being] told what to do by the CCG rather than being asked to contribute their views” (Ibid). This brings the thesis to the question of how the “appropriate number and type of people to take part” (Hicks 2004, p.24) in the study was determined – that is, sampling.

Sampling

Because my study embodied both quantitative and qualitative research methods which ran concurrently in a single phase using the same sample, one sample was obtained. The original plan was to involve all the GPs who had roles in the CCGs. That was not possible due to certain practicalities which fell outside the confines that delimited this study. The confines in question can be seen in Chapter 1, Section 1.4.1. This meant that I had to come up with a suitable sample from the wider research population. The only practical method for that purpose under the prevailing circumstances in my study was the non-probability convenience sampling technique, which means that a “sample is built from cases which are accessible” (Rowley 2014, p.319). I take accessibility in this case as denoting ease in contacting the participants, as opposed to participants’ response, which is an entirely different matter discussed elsewhere in this chapter. The non-probability convenience sampling technique harmonised with the delimitations that were defined for the study, particularly the criterion that the participants were to be contacted by email only, meaning that only

those participants whose email contact details I had were contacted. This kind of approach introduced sampling bias, which is a situation “when a sample is selected in such a way that it is not representative of the entire population” (Price et al. 2015, p.308). While this, and other biases such as coverage bias, could likely lead to a misrepresentation in the results of the study, the American Association for Public Opinion Research (2013) states that practitioners involved with non-probability convenience samples usually avoid correcting such biases, a stance that I assumed for this study.

In contrast to non-probability sampling that I opted for; probability sampling technique would have been recommendable for the quantitative study strand as studies conducted under this sampling approach can be generalised (Rowley 2014; Sternberg et al. 2007). However, as explained in the previous section, the philosophical position assumed for this study, pragmatic approach, does not recognise generalisation of the findings (Morgan 2007). Besides, the prevailing conditions that I was faced with did not justify that avenue. For example, one of the prerequisites for probability sampling is that “a complete list of all members of the population from which the sample can be drawn” (Sternberg et al. 2007, p.56) should be obtained; after which a random selection of the participants is made. This was not possible and would have posed a huge logistical challenge concerning the time it would have taken and accessibility to the target candidates (Gill & Johnson 2010) owing to the disparate structures and protocols that individual CCGs operated under. By contrast, using non-probability technique opens the option for the researcher to use his or her subjective judgement to best suit the situation, affording easy access to the candidates and involving relatively lower execution costs (Hyman & Sierra 2010; Sternberg et al. 2007).

Sample size

Determining the sample size for my study was tricky. Whereas the traditional mixed methods studies normally fall back to the conventional sample size estimation techniques for the data collection methods that they employ, my data collection method was not consistent with that since both quantitative and qualitative studies were contained in a questionnaire. In a typical quantitative methods study that uses a questionnaire as a data collection method, Rowley (2014, p.310) approximates a sample size of “between 100 and 1,000” to be adequate. Compared with this, Ghauri

and Gronhaug (2005, cited in Rowley 2014) claim that a sample size of 400 will be optimal. On the other hand, Gill and Johnson (2010) do not give a specific recommended sample size, and neither do Creswell and Plano Clark (2011). A common argument that academics give is that an adequate sample size depends on factors like the complexity of the population, the research aims, and the forms of analyses that the researcher intends to conduct (Rowley 2014; Gill & Johnson 2010). Special formulae with “rather detailed and overly complicated process” (Gill & Johnson 2010, p.129) are used to calculate the individual sample sizes. Regarding a typical qualitative study sample size, Creswell and Plano Clark (2011) state that numerous researchers do not like the idea of constraining themselves with predetermined sample sizes. Instead, the matter of what the sample size should be is connected to the type of “the question and the type of the qualitative approach used” (Creswell 2007 cited in Creswell & Plano Clark 2011, p.174). Usually, qualitative studies have relatively lower sample sizes to avoid being inundated by a “sea of data” (Rowley 2012, p.263).

In my methodological setup, I decided to determine my sample size from the premise of quantitative research. While I was cautiously optimistic of getting a modest response rate that would fall in line with the generally recommended range of 100 to 1000 sample size (Rowley 2014), my consideration of sample size was also influenced by the statistical analysis technique that I had planned to use. The planned statistical technique was Partial Least Squares Structural Equation Modelling (PLS-SEM). Even though various reasons made me go with PLS-SEM, one of the leading was that this method supports small sample size, as I did not expect a sizeable amount of response rate, something that I identified beforehand as a limitation (see Chapter 1, Section 1.4.3). The limitations of small sample sizes are particularly evident on the first generation (1G) statistical analysis techniques, such as multiple regression. Some of the limitations in this regard include, (1) a small sample size does not provide satisfactory analyses to establish patterns of variance (Karimimalayer & Anuar 2012), (2) it is not possible to establish sampling distribution on a small sample (Ronkko & Evermann 2013). Consequently, (3) it is not possible to test for statistical significance using a small sample (Ronkko & Evermann 2013; Henseler et al. 2009). In contrast, the abovementioned limitations are not an issue when using PLS-SEM (Lowry & Gaskin 2014; Hair et al. 2012; Henseler et al. 2009). Instead, PLS-SEM can provide satisfactory

statistical analysis results on samples as low as 18, as studies have shown (Hair et al. 2012). More about PLS-SEM is discussed in detail under Section 3.6.1.

Compilation of GPs' email addresses

The strategy for the study was that the sample population was to be contacted by email. As such, I had to compile the GPs' email addresses first after which I sent out invitations to take part in the survey.

To compile the GPs' email addresses, I first contacted the British Medical Association (BMA), a professional association and a trade union for doctors in the United Kingdom (BMA 2017). The reason for this was the belief that the BMA had the information that I was looking for. The first email to the BMA was sent on 18 February 2016 at the time when I was working on the research proposal. At that time, I was planning to use a population of at least 500 GPs. In my email, I provided a brief background of my study along with the request of at least 500 GPs' contact email addresses. The email, which can be seen in Appendix 1.1, also included information relating to ethical clearance subject matter. BMA declined my request citing the reason that they did not have enough resources to assist students in their work. Besides, BMA claimed that due to confidentiality laws in the UK, they were unable to release any of their members' email addresses to me. The full response from BMA which I received on 18 February 2016 can be seen in Appendix 1.2. Following BMA's refusal, I temporarily put aside the idea of gathering the GPs' email addresses as my time was diverted onto other aspects of the research process, and thus temporarily left this issue to be addressed later.

On 20 December 2016, I decided to contact all the CCGs directly requesting for the GPs' names and business email addresses under the Freedom of Information Act 2000 (FOI). I got the list of CCGs in England from the NHS website (NHS England 2012). FOI is an Act of Parliament of the United Kingdom which "provides public access to information held by public authorities" (Information Commissioner's Office [Open Government Licence v3.0]a). The Act stipulated that once a request was made, the public authority was required by law to respond within 20 days from the day they received the request. Out of a list of 212 CCGs, I contacted 178. The remaining 34 did not have email contact details on their websites. One hundred and twenty-five responded to my request with the GPs' names and business email addresses. Some

CCGs refused to supply their GPs' contact details citing internal policies and Data Protection Act 1998 (Information Commissioner's Office [Open Government Licence v3.0]b). The outline of the email that I sent to the CCGs can be seen in Appendix 2.1. Also, the details of the CCGs that were contacted along with the information of the ones that responded and the ones that did not can be seen in Appendix 2.2.

The number of GP Names that were received along with their corresponding email addresses was 1112. Some CCGs supplied individual specific email addresses, while others gave just one corporate email address to be used for all the names that were given for the CCG in question. Other CCGs gave the GPs' Personal Assistants' email contacts, while one CCG supplied a media-related email address for their GPs.

Table 3.1 gives an outline of the types of email addresses that were received.

Table 3.1 Email Address Count by Type

Email Address Type	Count
Business – Corporate	594
Business – Personal	476
Business – Personal Assistant	32
Business – Unconventional	10

3.4 Measurement of variables

Five latent variables were identified in Chapter 2 (Section 2.5), of which measurement of those four; *GP Proportion*, *GP Influence*, *Member Practice Wishes Met*, and *Satisfaction*, was based on literature. In this background, *GP Influence*, *Satisfaction* and *Member Practice Wishes Met* were assessed using a 5-point Likert scale while *GP Proportion* was measured using multiple-choice. The scale for variable *GP Influence* was adapted from Holder et al. (2016) and Naylor et al. (2013) where 1 represented "Minimum Influence" and 5 represented "Maximum Influence". *Satisfaction* was developed from BMA (2014a) in which in the Likert scale 1 represented "Deeply Dissatisfied" while 5 represented "Very Satisfied". Similarly, *Member Practice Wishes Met* was adapted from BMA (2014a) in which in the Likert scale 1 represented "Strongly Disagree" and 5 represented "Strongly Agree". Adopting a 5-point Likert scale was supported by the rationale that 5 points are thought to be adequate to

reflect “all possible feelings of a person towards a particular stimulus” (Stavroulakis 2013, p.380). What is more, a 5-point Likert scale has been widely used and supported in investigating feelings and emotions (Hejase et al. 2017; Stavroulakis 2013; Bodena & Berenbaum 2011; Prieto 2010). A further discussion on the Likert scale is done in Section 3.5.1. Use of multiple-choice on variable *GP Proportion* was adopted from BMA (2014a). On the other hand, variable *Decision-making Process Effectiveness* is a new concept which has not been measured in previous studies.

3.5 Data collection

My study employed an online self-complete questionnaire for data collection, which is one method amongst several that can be used in a survey. Other methods include face-to-face interviews, telephone interviews, and paper questionnaire (Moy & Murphy 2016; De Leeuw 2005). The reason for using a questionnaire was driven by the desire to “gather responses from a relatively large number of people in scattered and possibly remote locations” (Rowley 2014, p.309). Other advantages which supported the use of questionnaire mirror those discussed earlier on Section 3.3.2, where the justification for using a survey is outlined. To recapitulate, with a questionnaire, respondents can freely express their thoughts better than on a face-to-face interview, especially when responding to sensitive questions. Also, a questionnaire is relatively cheaper to deploy than other data collection methods, such as telephone or face-to-face modes. Besides, a questionnaire can be completed at the respondents’ convenience (Williams 2003). It should, however, be noted that questionnaires require well-constructed questions to elicit insightful responses from participants (Rowley 2012).

3.5.1 Structure and design of the questionnaire

To begin with, the questionnaire was developed based on the conceptual model described in Chapter 2, Section 2.5. While the quantitative questions were designed to fit as close as possible the latent variables and the hypotheses, the qualitative questions, directly informed by the conceptual model, were developed to generate “a more complete understanding of [the phenomenon of study]” (Creswell & Plano Clark 2011, p.77).

The questionnaire was entitled “Decision-making Effectiveness Survey”. It was divided into three sections which were; “About you”, “Your CCG’s Governing Body”, and “General questions on decision-making”. The landing page first thanked the participants for agreeing to take part in the survey. The purpose of the survey was then explained as being part of the research for a Doctor of Administration Degree designed to seek the thoughts of the participants about decision-making in their CCGs. The estimated time to complete the survey was stated, which was 10mins. The participants were then reassured about the anonymity of their responses. On the question of anonymity, at the end of the questionnaire, the participants were explicitly asked to indicate by ticking a box if they wanted complete anonymity. Those who did not mind waiving their anonymity were asked to leave their email contact details so that they could be contacted for a follow-up study, should there be a need.

Turning back to the landing page, information about the ethicality of the study was provided to the participants. That is, that the study was ethically reviewed and approved by the Sheffield Hallam University Research Ethics Committee, and that it complied with the university’s research ethics policy. A link for the website with the details of the university’s ethics policy was provided. The contact details of the student, the Director of Studies, and the Supervisor were then listed for those who preferred to contact any of the mentioned. A short message of appreciation for taking part in the study was given as the last item on the landing page. Figure 3.4 illustrates how the landing page looked like.

Decision-making effectiveness

Thank you for agreeing to take part in this survey which is research for a Doctor of Business Administration degree. The purpose of the survey is to seek your thoughts and views about decision-making in your local CCG. This survey should take about 10mins to complete. Be assured that all the answers you provide are completely anonymous unless you choose otherwise at the end of the questionnaire.

ETHICS CONSIDERATIONS:

This study has been ethically reviewed and approved by the Sheffield Hallam University Research Ethics Committee and complies with the university's research ethics policy which can be found on this link <https://www.shu.ac.uk/research/ethics-integrity-and-practice>. Please feel free to contact any of the following contacts should you see a need:

Mpumelelo Sibanda (Researcher): Mpumelelo.Sibanda@student.shu.ac.uk

Dr Richard Breese (Director of Studies): R.Breese@shu.ac.uk

Professor Ilfryn Price (Supervisor): I.Price@shu.ac.uk

Your participation is highly valued and much appreciated.

Figure 3.4 Questionnaire landing page (Source: Survey questionnaire)

Immediately after the landing page was a consent statement where the participants were given the opportunity to indicate if they were happy to take part in the study by responding to a simple Yes/No question illustrated on Figure 3.5. The statement was set in such a way that if the participant selected the "No" option, the survey would end instantly by taking the participant to the closing page that had a thank you message for taking part in the study.

By completing this survey, you consent that your answers can be used for academic research purposes.

Yes

No

Figure 3.5 Consent statement (Source: Survey questionnaire)

The questionnaire had 24 questions which fell into two categories, open-ended and closed-ended questions. There were a few exceptions where a single question comprised of both open-ended and closed-ended variants. Table 3.2 displays a breakdown of the questions' categories.

Table 3.2 Type of questions in the questionnaire (Source: Survey questionnaire)

Closed-ended Questions	Open-ended Questions	Open and Closed-ended
2	3	1
5	4b	4a
6	13	7
8	14	23
9	15	
10	16	
11	17	
12	20	
18	22	
19		
21		

Open-ended questions were set to allow the respondents to use their own words to express their opinions and feelings. There was no limit to the number of words on the comments that the respondents had, as illustrated in Figure 3.6 which shows the question in design mode where the designer is being informed that the provided answer space is of “Long answer text” type. This is contrary to the insinuation by Rowley (2014, p.314) that “open questions simply invite respondents to ... offer short comments (typically between one and three sentences)”.

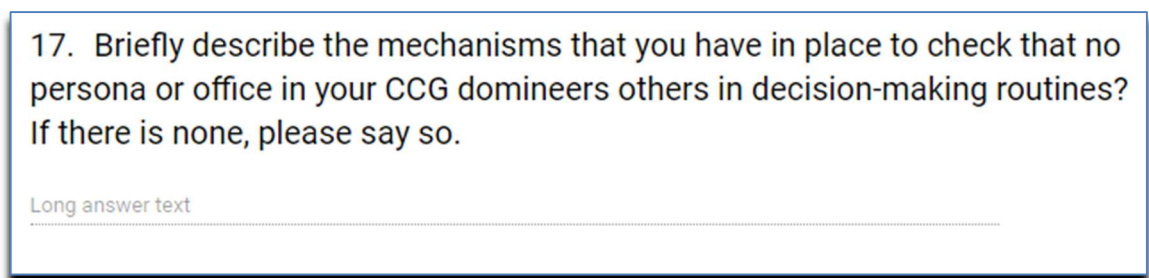


Figure 3.6 Example of long answer text (Source: Survey questionnaire)

There were some questions which were set for short answers, a sentence or two in length. Figure 3.7 illustrates this in the design mode of the question where the designer is being informed that the provided answer space is of “Short answer text” type.

23. What is the professional background of the Accountable Officer in your CCG?

a. GP

b. Clinician other than a GP

c. Manager

d. Other (Please describe in the space below)

Short answer text

Figure 3.7 Example of short answer text (Source: Survey questionnaire)

While there was no interviewer to guide the respondent, the process was interactive in different ways. For example, certain questions were displayed depending on the answer given on the previous question. Some questions were set to be mandatory while others were optional. On the mandatory questions, the respondent was required to complete the question before he or she could proceed to the next question. If the respondent did not answer a mandatory question, the system would prompt him or her to do so and will not allow him or her to proceed to the next stage until the mandatory question was completed.

Closed-ended questions were of dichotomous, scaled, and multiple-choice varieties. Out of 15, two were dichotomous providing Yes/No options, eight were multiple-choice with all having radio-buttons from which to select a single option, while the remaining five were of Likert scale type. A Likert scale in this thesis is considered to be a psychometric scale where the level of agreement to an opinion, in “both the direction and strength” (Garland 1991, p.66) of the rating, is specified by the respondent. The key reason for adopting Likert scale was that Likert scales have not only been widely used in surveys, but they have also “been extensively tested in both the marketing and social science literature” (Garland 1991, p.67).

A 5-point scale was used on all the questions that had a Likert scale. A 5-point scale was chosen cautiously given how crucial the number of points on the scale is in determining the level of peculiarity within the rated items (Matell & Jacoby 1971). Most surveys normally adopt 5 or 7-point scales (Allen & Seaman 2007). Although the number of points can vary from 2 to 100 (Cummins & Gullone 2000), too many points may result in unwieldy faded lines of distinction between the rated items while too few may give rise to a coarse rating which risks loss of “discriminative powers of which the raters are capable” (Matell & Jacoby 1971, p.657). Notwithstanding, Cummins and Gullone (2000) support scale with the higher number of points than the customarily used 5 or 7 points varieties, as they argue that the higher number of points increase sensitivity. Reliability is another important element in the number of points on a scale (Matell & Jacoby 1972; Matell & Jacoby 1971). Reliability in this instance denotes internal consistency (Matell & Jacoby 1972), which research has indicated that it is inconsequential across different Likert scale variants. So, what is the optimal number of points on a Likert scale then and why was a 5-point scale selected for this study?

The literature discusses that the decisive factors for the number of points on the scale are context bound (Matell & Jacoby 1972). For example, the type of aspects being rated must be taken into consideration. If it is time that is being rated, the number of points on the scale is likely to be considerably higher when contrasted with the number of points that could be used to rate emotions or feelings, for instance. The other question of interest concerns the subject of whether the central “uncertain” category or mid-point of the scale should be incorporated into the provided alternatives. Some schools of thought like Garland (1991) argue that it is not necessary for it to be on the scale, especially in research where the researchers will be looking for definite responses. In this respect, a 5-point scale would be 4 points or a 7-point scale would be 6 points.

One more aspect worth considering about Likert scales is the controversy about whether the data from a Likert scale is interval or merely ordinal. Ordinal data in this thesis has been taken as “data in which an ordering or ranking of responses is possible but no measure of distance is possible” (Allen & Seaman 2007, p.64). On the other hand, interval data has been taken as “integer data in which ordering and distance measurement are possible” (Allen & Seaman 2007, p.64). Given that feelings may

never be accurately rated since the “feeling thermometers, like the Likert scale ... collapse the subject’s emotional self-report to some summary state” (Redlawsk 2006, p.43) that flattens “subject’s self-report into a single valence response”, data from Likert scales are therefore, as a rule, regarded as ordinal (Stavroulakis 2013). The quandary respecting irregular classification of feelings is only apparent to the researcher while “from the standpoint of the subject, an equal interval modelling is adopted in order to classify a personal intensity of feeling” (Stavroulakis 2013, p.382). The assumption, therefore, is that, if the subject expressing his or her feelings assumes the cognition that the scale has equal intervals, it can be inferred that statistically, the data can be treated as interval data. Besides, Cummins and Gullone (2000) argue about the assumption made concerning the psychometric distance between the Likert scale categories, that the distance is equal as the scale is portrayed with equally-spaced points. As such, instead of naming the categories on the scale, Cummins and Gullone (2000) recommend the use of linear incrementally represented numbers to reinforce the assumed outlook of interval data, for example from 1 to 5. As such, all data collected from questions that used Likert scale in this study has been considered as being intervally scaled, consistent with the arguments discussed in the literature (Stavroulakis 2013; Cummins & Gullone 2010).

Questions order

Rowley (2014, p.315) advises about the order of the questions, recommending that questions should be “clustered under theme or section headings”, a phenomenon demonstrated in my questionnaire in which the questions were divided into three main sections, described next.

About you: Questions under this theme sought to gather background information of the participants. The questions in this section ranged from focusing on the individual respondents’ professional background outside the CCG to the roles that the respondents held in their local CCGs. This theme aimed to build a profile of the respondents to demonstrate that they were qualified “to offer useful insights and comments on the research topic” (Rowley 2012, p.264). There were five questions under this theme.

Your CCG's Governing Body: This theme had 12 questions which were designed to gather key data about CCGs' decision-making approach at Governing Body level. The questionnaire was set in such a way that only those respondents who indicated that they sat on the Governing Body on the previous question could access this theme. Those who indicated that they did not sit on the Governing Body were automatically taken to the next theme, which was incrementally numbered from the previous theme.

General questions on decision-making: All respondents had access to this theme which comprised of 7 questions. The purpose of this theme was to enhance understanding of decision-making approach in CCGs at a general level, as opposed to the preceding theme which was specific to the Governing Body.

3.5.2 Survey questions

Table 3.3 outlines all the questions that were asked along with the reasons for choosing those questions. The questionnaire was administered through an online tool, Google Forms. However, before data collection commenced, certain conditions had to be met. These included ethical clearance, piloting, and then questionnaire distribution, which all are described in the subsequent sections following this.

Questions were either mandatory or optional, as indicated against each question outlined in Table 3.3. Additional to that, there is a delineation against each question specifying if the question was the product of my own work or was identified from the previous literature. The words, "own work" are used for the former and "identified from literature" are used for the latter.

Table 3.3 Outline of questions

	Question	Reason for the question
About you	<p>1. <i>(Mandatory question – own work)</i> Which of the following statement best describes your professional background outside CCG? Please select one.</p> <ul style="list-style-type: none"> a. I am a GP b. I am a Specialist Secondary Care Consultant c. I am neither a GP nor a Specialist Consultant. (Please specify your professional background in the space provided below). 	<p>This question sought to establish the kind of people who took part in the survey as this study was primarily targeted at clinicians, with particular interest directed on the GPs with roles in the CCGs. The question consisted of closed and open-ended responses. The open-ended part was to be attempted only by those who had no option to select from the close-ended answers.</p>
	<p>2. <i>(Mandatory question – own work)</i> How long have you been involved with your local CCG?</p> <ul style="list-style-type: none"> a. Less than 1 year b. Between 1 and 3 years c. More than 3 years 	<p>A close-ended question which sought to establish the participants' level of experience and exposure to CCG routines in their capacity as CCG representatives. The working assumption was that the longer one was involved with their CCG, the more 'mature' in substance their response was going to be, thereby boosting the quality of the data received.</p>
	<p>3. <i>(Mandatory question – identified from literature)</i> In the space provided below, please briefly describe exactly what you do in your local CCG.</p>	<p>An open-ended question which sought to understand the roles that the GPs do in their CCGs. Understanding the roles that the GPs are engaged in was intended to address the secondary aim of this study which was informed by previous research (Checkland et al. 2016) in which a lack of full awareness in understanding what GPs do at their local CCGs was discovered.</p>

	Question	Reason for the question
About you	<p>4. 4a. <i>(Mandatory question – identified from literature)</i> Which of the following statements best describes your involvement at various committees level?</p> <ul style="list-style-type: none"> a. I sit on the Governing Body b. I sit on other committee(s) but not on the Governing Body c. I sit on both Governing Body and other committee(s) d. I have a different nature of involvement which is neither Governing Body nor any other committee. (If you have selected this option, please briefly describe what your involvement is in your CCG on the provided space below) 	<p>This question, identified from the literature (Checkland et al. 2016; McDermott et al. 2015), was comprised of close-ended and open-ended parts designed to simply establish the number of GPs who served in the Governing Body relative to the number of GPs with formal roles in the CCGs. The question was complemented by a proposition developed in the review of literature which stated that “A high proportion of GPs in the Governing Body committee will cause a difference in the level of GP influence.”.</p>
	<p>4b. <i>(Optional question – identified from literature)</i> If you have selected option “b” or “c” on the previous question, please list in the provided space below the “other committee(s)” that you sit on.</p>	<p>This open-ended question was designed to capture other committees that exist in the CCGs, thereby illustrating the diversity of GP roles as intimated by previous research. McDermott et al. (2015, p.30) suggested that “asking what the role of GPs is or should be in CCGs is a complex question with as many answers as there are CCGs”.</p>
	<p>5. <i>(Mandatory question – identified from literature)</i> Which statement below best describes your status in the Governing Body? Please select one.</p> <ul style="list-style-type: none"> a. I am a voting member b. I am a non-voting member 	<p>This was a close-ended question, identified from the literature (Checkland et al. 2016; McDermott et al. 2015), which was designed to determine the level of contribution to final decisions that the respondents had in their local CCG from the standpoint of being able to</p>

	Question	Reason for the question
		vote proposed decisions into policy. Collection of this type of data was purely numerically based with no other factors considered that might limit candidates from voting.
	<p>6. <i>(Mandatory question – identified from literature)</i> How big is the membership of your CCG’s Governing Body?</p> <ul style="list-style-type: none"> a. Less than 10 members b. Between 11 and 20 members c. More than 20 members 	Identified from Checkland et al. (2016), this was a close-ended question designed to capture information about the sizes of different CCGs’ Governing Bodies simply to get a picture to that extent.
	<p>7. <i>(Mandatory question – identified from literature)</i> Which of the following statements best describes the way your Governing Body functions.</p> <ul style="list-style-type: none"> a. Our Governing Body is structured to receive reports and suggested decisions for endorsement from other committees. That is, the operational function of primary decision-making lies with other committees outside the Governing Body. b. Our Governing Body actively participates in primary decision-making routines in which operational discussions are made. c. Our Governing Body functions differently from the two above mentioned methods. (If your Governing Body functions differently, please describe briefly how it operates in the space provided below). 	A combination of close-ended and open-ended question type designed to get a picture of how different CCGs’ Governing Bodies operated in decision-making approach. This question was inspired by findings from McDermott et al. (2015) study in which different styles of operation at the committee level were discovered.

	Question	Reason for the question
Your CCG's Governing Body	<p>8. <i>(Mandatory question – identified from literature)</i> What would you say the proportion of GPs is compared to the whole Governing Body membership in your local CCG?</p> <ul style="list-style-type: none"> a. Below 25% b. Between 25% and 50% c. Between 51% and 75% d. More than 75% 	<p>While previous research has reported variation in Governing Body sizes (Checkland et al. 2016), this question did not only seek to substantiate that finding but also linked with latent variable <i>GP Proportion</i>. A working assumption made prior to empirical evidence was that the GPs were possibly being outvoted in decision-making routines in cases where they constituted a smaller proportion in the Governing Body.</p>
	<p>9. <i>(Mandatory question – own work)</i> Using a scale of 1 to 5, where 1 represents “Minimum Influence” and 5 represents “Maximum Influence”, how would you rate the level of influence that you think the GPs in your Governing Body have in decision-making routines.</p>	<p>This question was designed to ascertain power-balance – that is, whether the GPs thought they were exerting adequate influence in decision-making. The question linked to the latent variable <i>GP Influence</i>. It also linked to the proposition, “The level of GP influence in the Governing Body will cause a difference in the effectiveness of the decision-making process”.</p>
	<p>10. <i>(Mandatory question – own work and identified from literature)</i> Using a scale of 1 to 5, where 1 represents “Strongly Disagree” and 5 represents “Strongly Agree”, please indicate your views on the following statements.</p> <ul style="list-style-type: none"> i. I feel that our local Governing Body is dysfunctional in the way that it operates. ii. Often, decisions in my CCG’s Governing Body are influenced by a few strong personalities. 	<p>This was a close-ended question broken down into three parts. All constituent parts bore connotations of factors that hindered a perceived effective decision-making approach. For this reason, this question was designed to gather a measure of the level that these perceived barriers to the effective decision-making process contributed to the primary aim.</p> <p>Part (i) and (ii) were my own devising while Part (iii) was</p>

	Question	Reason for the question
	<p>iii. To avoid being perceived as violating trust, I feel that some members in the Governing Body yield their views to their colleagues' choices even if they may not agree with them.</p>	<p>identified from the literature based on theory of groupthink discussed in Section 2.3.6.1.</p>
Your CCG's Governing Body	<p>11. <i>(Mandatory question – identified from literature)</i> Has there been any time in your knowledge where a senior member or a government official used his or her authority to veto decisions that your Governing Body made? a. Yes b. No</p>	<p>Considering the power that senior authorities have, as discussed in Section 2.5.1, this close-ended question sought to establish if it is possible for a higher authority to overrule decisions made by the Governing Body. This would help in determining the influence of bureaucratic control, if any. The question linked to the latent variable <i>Higher Authority Control</i>.</p>
	<p>12. <i>(Mandatory question – identified from literature)</i> From your standpoint as a GP, are there any decisions that your Governing Body has made in the past which you feel are (or were) unfriendly to the profession? a. Yes b. No</p>	<p>These two questions (Questions 12 and 13) intended to get the views of the GPs as to whether there were any decisions that their respective CCGs have made that were potentially damaging to their profession. These questions were inspired by the BMA (2014a) study whose findings underpinned the primary aim of the current study. As such, these questions sought to ascertain if the characteristics described in the BMA (2014a) findings still existed in the CCGs about three years later from the time when the BMA study was done.</p>
	<p>13. <i>(Optional question – identified from literature)</i> If you have responded "Yes" to the previous question, please briefly describe the unfriendly decision in question and the impact that you think it had (or will have) on patient care or any other aspect in the primary health care delivery.</p>	

	Question	Reason for the question
	<p>14. <i>(Optional question – own work)</i> What would you attribute the reason for unfriendly decisions to? That is, what possibly fuelled or facilitated such unfriendly decisions to be passed?</p>	<p>An open-ended question which sought to get insight into the reasons that the GPs thought were the cause for unfriendly decisions. In that way, it was hoped that barriers to the perceived effective decision-making process would be flagged in the respondents' answers.</p>
	<p>15. <i>(Mandatory question – own work)</i> Give up to three aspects that you feel your Governing Body is good at in decision-making.</p>	<p>An open-ended question intended to extrapolate factors that are the enablers of perceived effective decision-making from the respondents' answers.</p>
	<p>16. <i>(Mandatory question – own work)</i> Give up to three aspects that you feel your Governing Body is bad at in decision-making.</p>	<p>An open-ended question intended to extrapolate factors that are the barriers to perceived effective decision-making from the respondents' answers.</p>
General questions on decision-making	<p>17. <i>(Mandatory question – own work)</i> Briefly describe the mechanisms that you have in place to check that no persona or office in your CCG domineers others in decision-making routines? If there is none, please say so.</p>	<p>An open-ended question intended to extrapolate factors of both the enablers of and barriers to perceived effective decision-making from the respondents' answers.</p>
	<p>18. <i>(Mandatory question – identified from literature)</i> Using a scale of 1 to 5, where 1 represents "Strongly Disagree" and 5 represents "Strongly Agree", please indicate your views on the following statement: Decisions made by</p>	<p>This question acted as a follow-up probe to the BMA (2014a) study findings where it was discovered that the GP Practices perceived the CCGs as formulating policies that curbed effective patient care. Since GPs with formal</p>

	Question	Reason for the question
	<p>my CCG reflect the wishes of the members (GP practices) that my CCG serves.</p>	<p>roles in the CCGs represent that interest of the GP Practices, gauging the degree of their responses to this question would indicate the fitness of the CCGs from the standpoint of the primary aim of the current study. This question linked with the latent variable <i>Member Practice Wishes Met</i> in the conceptual model.</p>
	<p>19. <i>(Mandatory question – identified from literature)</i> Using a scale of 1 to 5, where 1 represents “Deeply Dissatisfied” and 5 represents “Very Satisfied”, how satisfied are you with the way decisions are made in your local CCG? This does not apply to the Governing Body decisions only, but any other decision making processes.</p>	<p>This question simply aimed to gather the general feeling from the respondents about the fitness of the decision-making environments in the CCGs. It linked to the latent variable <i>Satisfaction</i>.</p>
	<p>20. <i>(Optional question)</i> If you have any comments to make about the preceding question, please do so in the space provided below.</p>	<p>Any comments made here were designed to help inform the researcher with further insights about of the factors influencing the perceived effective decision-making process.</p>
	<p>21. <i>(Mandatory question – identified from literature)</i> Using a scale of 1 to 5, where 1 represents “Strongly Disagree” and 5 represents “Strongly Agree”, please indicate your views on the following statement: I feel that my local CCG is GP led as defined in the Health and Social Care Act 2012.</p>	<p>Like Question 19, this question aimed at gathering the general feeling from the respondents about the fitness of the decision-making environments in the CCGs.</p>

	Question	Reason for the question
	<p>22. <i>(Mandatory question – identified from literature)</i> How is GP Practice member engagement achieved in your CCG? In other words, how does your CCG engage different GP Practices falling under its remit?</p>	<p>This question was suggested by one of the respondents in the pilot study and then linked up with the literature, as discussed in Section 2.4.3. The purpose of this question was to establish if the CCGs engaged with their member practices as that is key to learning their wishes, which subsequently inform decisions made.</p>
General questions on decision-making	<p>23. <i>(Mandatory question – identified from literature)</i> What is the professional background of the Accountable Officer in your CCG?</p> <ol style="list-style-type: none"> GP Clinician other than a GP Manager Other (Please describe in the box below) 	<p>The Accountable Officer is one of the two top leadership positions in the CCGs (NHS Commissioning Board 2012a). As such, at the time when I launched this study, I worked under the assumption that leadership normally influences decision-making, as the case is portrayed in the literature elsewhere (Tyssen et al. 2014; Rolfe 2011; Avolio et al. 2004). Establishing the background of this office would help infer if this office could be implicated on the decisions perceived as unfriendly by the GPs.</p>

3.5.3 Ethical considerations

Regarding the subject of ethical considerations, when the proposed research profiles of doctoral research students in my cohort were vetted, mine was identified as requiring formal clearance since my research was to be performed in the NHS. This decision parallels the research procedures outlined by one of the NHS Trusts, Norfolk and Suffolk NHS Foundation Trust (NSFT), which states that “all student research involving the NHS requires approval before you can start to conduct your study” (NSFT 2014, V1 Jul14). The ethical considerations at issue denote norms and standards of conduct that need to be adhered to for research to be considered acceptable (Resnik 2015; Fouka & Mantzourou 2011). To this end, there were several steps that I had to fulfil before the commencement of fieldwork. First, I had to complete Sheffield Hallam University’s research ethics approval form, which was to be reviewed by the University Research Ethics Committee (REC). This form is standardised across all the research institutions in the UK to overcome “the problem of inconsistencies in the paperwork required by different committees” (Jamrozik 2004, p.286). Alongside this, I had to submit a proposal of my planned research to REC to satisfy REC that my research satisfied the ethical guidelines of the university. Next, there was a second approval that I was advised I needed to obtain, also because my research was going to be performed in the NHS. This was to be achieved through a standardised system called Integrated Research Application System (IRAS), which acted as a single point for applications to gain permissions to conduct health and social care research in the UK (United Kingdom Clinical Research Collaboration 2005). IRAS application was online.

Meanwhile, I received a conditional approval from REC indicating certain areas in my application that I had to address before getting full clearance. A copy of that approval email dated 15 September 2016 can be seen in Appendix 3.1. The identified areas for revision were addressed accordingly, and the full clearance was finally granted on 09 December 2016.

Regarding the question of clearance from IRAS, there are significant logistical challenges both to me as a student and to the applicable immediate staff that handled ethical clearance matters at the Sheffield Business School that this presented. I was affected in a sense best described in Jamrozik’s words when he commented about the then just introduced nationally standardised research ethics form for local research

institutions. Jamrozik (2004, p.286) remarked that the form was “incredibly long ... [and threatened] to overwhelm both committees and investigators with paperwork”. While the nationally standardised research ethics form did not overwhelm me, demanding as it was, it is the IRAS form that did overwhelm me. IRAS form did not only ask for information about my proposed study but also included in its requirements things like the curriculum vitae (CV) of both of my supervisors as well as a list of the contact names and contact addresses of all the CCGs that I intended to contact, which were more than 100. From the Sheffield Business School position, the challenge about the IRAS form was that no one in the immediate staff had a definite knowledge of how it operated. It was not until this case was escalated to the university’s Head of Research Ethics that the problems about IRAS were resolved, revealing that after all, I did not have to complete the IRAS form. To this end, the Head of Research Ethics sent me an email on 14 December 2016, which can be seen in Appendix 3.2.

Once ethical clearance was fully granted, the study took to the fieldwork. The sample was drawn (see Section 3.3.5), the questionnaire had been developed (see Section 3.5.1), and the next step was to conduct a pilot study which precluded the full data collection exercise.

3.5.4 Pilot study

Prior to distributing the questionnaire to the sample, I ran a pilot study to ascertain how the respondents were going to “interpret and react to the questions” (Gill & Johnson 2010, p.144). This action was intended to expose any weaknesses in the research design. Piloting was done in two stages, in line with the recommendation by Rowley (2012). The first stage was conducted with my friends and my supervisors to determine whether the questions made sense. The second stage was done with a selected group of 45 candidates from the sample, randomly selected from all the CCGs across England. An email inviting these candidates to participate in the pilot study was dispatched in two batches, the first 15 were done on 10 April 2017 and the next 30 on 14 April 2017. The reason for the additional 30 candidates on the second batch was prompted by fear of low response rate to the request. The subject of the email was “Decision-making Practices in CCGs: Pilot Study”. This email gave a brief background about the research topic, where the original purpose of introducing the CCGs by the government of the day was explained. A previous study which was run by the BMA in

June 2014, just a year after the CCGs were introduced, was also mentioned along with a summary of the findings of that study – that is, the findings which partly contributed to the rationale of the current study. An attempt to incentivise the candidates was made by including a sentence which highlighted the potential that the findings of the study had in streamlining the decision-making approach in the CCGs. What is more, the candidates were promised that the findings of the study would be communicated to all the CCGs when the study concludes. A link to the webpage that had the questionnaire was included. The full email which was sent to the 45 GPs inviting them to take part in the pilot study can be seen in Appendix 2.3.

The pilot study questionnaire was a finished product, as it were, ready for the final deployment to the full sample pending appraisal by the pilot candidates. The pilot candidates were asked to provide feedback on the following points.

1. How long did it take you to go through the questions?
2. Were all the instructions and questions clear?
3. Are there any inappropriate questions?
4. Are there any critical issues about the subject under investigation that you feel should have been asked?
5. What do you think about the layout of the questionnaire?

The feedback that the pilot candidates were to provide was incorporated into the questionnaire. This was not only designed for convenience to the respondents but also ensured anonymity in the responses; something that I felt would give the respondents freedom of expression, including criticism, if there was any.

Pilot study reminder emails

Ten days after the last batch of 30 emails was sent out, there were no responses from the pilot study candidates. At that point, 24 April 2017, I decided to send out a reminder email, which De Leeuw (2005, p.243) cites as “an efficient tool to increase response rates”. The email, which had the subject “Reminder: Invitation to participate in a pilot study”, was sent to all the 45 pilot study candidates. It referenced the original invitation email which I had sent just over a week before that date. In that email, I

repeated in brief all the points that were in the original mail. The closing statements read “I look forward to your goodwill in participating in this pilot study. Please send your response by the end of April”. A link to the webpage with the questionnaire was also included. The full reminder email can be seen in Appendix 2.4.

April ended without a single response from the pilot study candidates. This was 20 days after the first batch of invitation emails to participate in the pilot study was dispatched. At this stage, the plan to run my study on a survey appeared dim. I nearly gave up on the idea of using a survey as I thought of just resorting to face-to-face interviews. That, however, threatened all the preparations that I had hitherto made based on mixed methods design. As a last resort, I thought of seeking confirmation from the candidates to find out if they received the original invitation, plus reminder, to take part in the pilot study. Alongside this, I decided to also ask for the possible reasons that held the candidates from responding to my request. To that end, on 03 May 2017, I sent out an email with the subject, “Your advice in three minutes”, to all the 45 pilot study candidates. This email had the tone of entreaty, somehow pleading for support from the GPs. The full script of that email is shown below:

Dear Dr First Name Surname,

This email is a humble request seeking two to three minutes of your time. I just wanted to confirm if you received my invitation to take part in a pilot study based on Decision-making Practices in the Clinical Commissioning Groups (CCGs). Please note that this email is not asking that you complete the pilot study. All that I am looking for this time is a confirmation that you received the invitation. If so, can I please ask in a sentence or two for reason(s) why you didn't respond to the invitation. Please rest assured that this is not a 'witch hunt' exercise. Instead, it is purely for academic purposes so that I can academically justify the reasons for non-response from the invitees. You are not the only one who did not respond to my invitation, but all the doctors that I invited did not respond. I need to justify this predicament. Hope you understand my dilemma.

You can either reply directly to this email or respond anonymously by using the electronic form on Google forms which can be found on this secure link

https://docs.google.com/a/my.shu.ac.uk/forms/d/e/1FAIpQLSfJMPeS4VrryRFSr1txmVTR1cv9svtp8BuASHIvpOITprchA/viewform?usp=sf_link

As mentioned above, its only two questions that I need you to address.

- 1. Did you receive the invitation to take part in the pilot study mentioned above?*
- 2. What do you think held you from responding to the invitation?*

Thank you in advance for supporting me in this matter.

Kind regards,

Mpumelelo Sibanda

(Doctoral student – Sheffield Hallam University)

Soon after the 'entreaty' email, there was a change. I started receiving responses from the very day that I sent out that email, notwithstanding that ultimately the response rate was low. What mattered most under the circumstances was the value that I got from those responses, which contributed to the improvement of my questionnaire. In total, three candidates completed the pilot study questionnaire where they attempted all the questions while on the other hand, seven decided to email me directly. Respecting the completion of the questionnaire, the feedback indicated that it took the respondents approximately 10mins to go through the questionnaire contrary to my original estimate of 20 to 30mins. All respondents indicated satisfaction in the format of the questionnaire and the tone of the questions. One respondent suggested an additional question to be included, which he or she felt was crucial to the investigation. The question was, "how is GP member practice engagement achieved". As such, suggested amendments were implemented accordingly.

Turning to the seven replies sent directly to me, the candidates acknowledged that they received my invitations to take part in the pilot study. Some wrote to simply inform me that they had completed the pilot study. One of the candidates said the link to the questionnaire was not working. All that I could think of for being the cause of that was a security setting on the network that the candidate tried to open the link from since the link worked for others. The general overarching message in most of the replies was about workload and scarcity of time to attend to matters like my questionnaire because of being busy. Below are three of the examples from the seven emails. All the seven emails can be seen in Appendix 2.5.

EXAMPLE 1:

On 3 May 2017 at 23:07, XXXX, xxxx (NHS SUNDERLAND CCG) <xxxx@nhs.net> wrote:

Hi so sorry for the late reply-

I did receive the invite for the questionnaire but due to a huge workload I didn't get around to responding - I work a day a week for the CCG only and am a practising GP for 3 days a week as a GP partner. I hold some strategic responsibility for urgent and ambulatory care for Sunderland so a large remit and limited time. If you wanted to resend the questionnaire I could try to find some time to look at it. Sorry again for the late reply to your request.

Best wishes xxxx

Dr xxxx xxxx

*Deerness Park Medical Group
Sunderland CCG.*

EXAMPLE 2:

On 3 May 2017 at 22:43, XXXX, xxxx (TUDOR PRACTICE) <xxxx@nhs.net> wrote:

Dear Mpumelelo,

To confirm I did receive your email. I do receive many unsolicited emails in my CCG role. I am terribly sorry but I just do not have the time to answer all. Time constraints and prioritising work are the main issues.

Best wishes

xxxx

Dr xxxx xxxx

Tudor Practice

EXAMPLE 3:

On 6 May 2017 at 12:48, XXXX, xxxx (NHS GLOUCESTERSHIRE CCG) <xxxx.xxxx@nhs.net> wrote:

Hi - I have now responded! I would not have done due to pressure of work - over 100 emails every day to manage!

Dr xxxx xxxx

Clinical Chair

Gloucestershire CCG

Once all the necessary final amendments were made to the draft questionnaire which was used for the pilot study, the questionnaire was ready for distribution to the rest of the sample population.

3.5.5 Questionnaire distribution

Questionnaire distribution was planned to take place on Sunday, 14 May 2017. This was going to be accomplished through emails in which all GPs who were on the email list, except the ones already contacted for the pilot study, were going to be sent emails inviting them to take part in the study. However, two days before the planned date a huge event which threatened to nullify my efforts occurred across the globe. On Friday 12 May 2017 there was an international cyber-attack called WannaCrypt Ransomware which hit many organisations across the globe (The Register 2017a), with the NHS worst affected in the UK (*The Guardian* 2017; *The Register* 2017b). In the wake of this, chances of getting a reasonable response to my survey were significantly reduced, so it seemed, especially considering the kind of population that I was dealing with. With this cyber-attack, it was likely to be even harder to get the GPs to participate in the study, in the sense that the GPs were possibly going to avoid opening an email from an unknown and unexpected source. What is more, that email had a weblink which the participants were instructed to click to access the questionnaire. To me as a researcher, all this painted a foreboding picture on my study. To circumvent these challenges, a pragmatic course of action had to be taken.

Sending the invitations to take part in the study by email on Sunday 14 May 2017 was halted, with a new course of action taken instead. The new course of action was to send a hard copy letter by post to all the GPs, 1067 in total, that were targeted for the invitation to participate in the study. The purpose of the hard copy letter was to go ahead as a forerunner to introduce beforehand the pertinent aspects of the study. First, I introduced myself and the study that I was planning to perform in the CCG from the beginning of June 2017. I then highlighted that the issuance of that letter was prompted by the recent developments in the cyberspace in which WannaCrypt Ransomware attacked several IT systems around the world. At that point, I informed the prospective participants that my planned study was web-based and as such, I was shortly going to be sending them invitation emails to take part in that study. I then advanced the fact that, for that reason, the purpose of the hard copy letter was to

create awareness, as a precautionary measure, about the legitimacy of the emails inviting them to take part in the study. I mentioned that my emails would be identifiable by my name, “Mpumelelo Sibanda”, as a sender, coming from a Sheffield Hallam University (SHU) email domain. Last in the hard copy letter were the email contact details of the Director of Studies (DoS) and the researcher (myself), along with the SHU postal address directed to the researcher with the care of (c/o) DoS. A copy of this letter can be seen in Appendix 2.6. All the letters were posted on 22 May 2017 using first-class postage (Royal Mail 2018).

There were mixed responses to the hard copy letters. First, on 23 May 2017, I received a complaint from one of the CCGs’ front desk staff raising concerns about the volume of letters which suddenly arrived at the same time in their letterbox. The best that I could do about this was to send an apology for the inconvenience caused, which was well received. The complaint letter can be seen in Appendix 2.7. Another interesting response was from one of the GP leaders, sent directly to the DoS on 24 May 2017. The email sought to confirm if my research was legitimate. Further, the email applauded my efforts of advising the targeted recipients about the emails that I was planning to send them in the face of the recent cyber-attack. One of the statements in the email read, “I have to say it is full credit to Mpumelelo that he has recognised the recent cyber-attack and is warning the directors to expect an email from him”. The full email can be seen in Appendix 2.8. There is another email which was sent directly to me at a later stage, 27 June 2017, expressing the same sentiment as above about what the respondent called “a good idea to introduce yourself prior to sending the survey request”. That full email can be seen in Appendix 2.9. One of the GPs emailed on 25 May 2017 in response to the letter expressing interest to participate in the study. That email can be seen in Appendix 2.10. One of the striking responses was an absolute refusal by the whole CCG to take part in the study. Part of the email read, “I have however been asked to advise that we as a CCG do not wish to take part on this occasion. We would, therefore, request that you do not email your survey to those you addressed the letter to”. The full email can be seen in Appendix 2.11. Finally, one of the responses advised about a doctor who had retired.

A period of two weeks was given from sending out of the hard copy letters to sending out of the emails inviting the GPs to take part in the study. On 04 June 2017,

the survey went live, with a total of 1058 emails sent out to the GPs inviting them to participate in the study. The candidates who had been excused from further communications about this study due to retirement or non-interest were excluded from this list. The email was presented in such a way that it would be obvious to those who had received and read the hard copy letter. The subject of the email depended on the email address category that each recipient fell under. These categories are shown in

Table 3.1, Section 3.3.5. For the GPs with personal email addresses, the email subject was “A Survey of Decision-Making in CCGs: Sheffield Hallam University”, while for those with personal assistants plus those grouped under their respective corporate or unconventional email accounts, the email subject was “For the attention of Dr First Name Surname – A Survey of Decision-Making in CCGs: Sheffield Hallam University”.

The salutation on all emails was specific and personalised, for example, “Dear Dr John Smith”, if the GP’s name was John Smith. The email message opened with a reference to the hard copy letter, as a way of establishing continuity to communication. The invitation to participate in the study was then extended with the indication that it would take about 10minutes to complete the survey. A brief background of the CCGs along with the studies that had been previously done on the CCGs, where CCGs’ decision-making routines were implicated, was explained. At that point, the purpose of the current research was given using the statement, “I am using a doctoral research project to try to better understand the CCGs’ current structure and decision making”. The recipients were then provided with a link to the webpage of the questionnaire. A reassurance about the anonymity of responses to the questionnaire was provided. Just to make sure that my email was received, a statement to this end which read, “Would you please be so kind as to acknowledge receipt of this mail”, was included in the invitation followed by a “thank you for your support” note. The full content of the invitation email can be seen in Appendix 2.12.

After the invitation emails were dispatched, 17 had failed delivery notifications, 20 recipients confirmed receipt, and seven recipients/centres requested to be excluded from further communication due to various reasons. The reasons included, “Sorry no time to complete surveys due to excessive work load”, GP not at the CCG

anymore, and GP retired. One of the recipients who confirmed receipt of the invitation email indicated that, in light of recent cyber-attack, their IT department instructed them not to open any weblinks of any kind. The email in question can be seen in Appendix 2.13. One response from the administration staff of the CCG that supplied an email contact which I categorised as unconventional indicated that none of the invitation emails sent to that CCG was forwarded to the intended participants, as the CCG was comprised of “enormous amounts of units in the 3 Boroughs and some staff not listed on the system”. The response in question can be seen in Appendix 2.14. Ten of the target recipients could not be contacted as a result.

Main survey reminder emails

After 11 days from the survey go-live date, 48 participants had responded. Sixteen days after the go-live date, there were no further responses, and so I decided to send reminder emails to the target sample. This was on 20 June 2017. Like the original invitation email, the subject on the reminder email depended on the category that the recipients' email addresses fell under. For those with personal email addresses, the subject was “REMINDER: A Survey of Decision-Making in CCGs – Sheffield Hallam University”, while for the rest of the other categories the subject was “For the attention of Dr First Name Surname – REMINDER: A Survey of Decision-Making in CCGs – Sheffield Hallam University”. 1032 emails were dispatched from which there was one failed delivery notification. Those who indicated that they were busy, or retired, or no longer at the CCG, or with an unconventional email address were excluded from the mailing list. The emails' salutation was personalised, just like the first email. The reminder email first referenced the original email where GPs were invited to participate in the survey. As such, assumption was overtly made that the recipients had previously received the original email. Since the survey was anonymous, a word of appreciation was given to those who had already completed the questionnaire. Those who had not completed the survey were encouraged to do so. A weblink to the questionnaire was likewise provided. Two crucial points were made about possible weblink failures to access the questionnaire further to the indication that one of the respondents made on the original invitation email. The respondent in question mentioned that the link was not working. However, immediately after, she emailed stating that she eventually managed to access the survey after using a different web

browser. It was for this reason that something had to be said on the reminder email to that end with the two points in question being:

If the link appears as if it does not work, please try one of the following as the link has been tested and proved to work.

- 1. Use a different web browser. One of the respondents has advised that they could not access the questionnaire on Internet Explorer but when they tried it on Google Chrome it worked.*
- 2. Try accessing the questionnaire from a different network environment. It could be that security settings on your work network are blocking the link from launching; especially in the wake of the recent WannaCry ransomware cyber-attack, some organizations have intensified their security settings.*

The full reminder email can be seen in Appendix 2.15.

After the reminder email, there were additional 26 responses, which brought the final response rate to 74. Data collection closed on 02 July 2017 with no further reminders sent to the sample. The next section describes the effort schemes that were employed to elicit a high response.

3.5.6 Effort on eliciting high response rate

When I embarked on this research project, I knew beforehand that the population that I was going to deal with was difficult to access telling from the trending news of the day about the way doctors were pressed for time due to excessive workload (BBC News 2015; The Financial Times 2015; The Telegraph 2015). For that reason, there are ways and means that I tried to employ to elicit a high response. To begin with, I tried to engage BMA by exploring the possibility of getting my research mentioned in one of their Newsletters as I imagined that action would add credibility to my study. To this end, on 16 May 2017, I emailed BMA explaining my research and the rationale behind it along with the reason for why it would be useful to get it publicised on their Newsletter. Following on from my email, BMA replied on 17 May 2017 advising me that they were not able to carry out my request. Instead, they referred me to the British Medical Journal (BMJ) citing that BMJ was better placed to advertise my research. As such, they gave me BMJ's postal address and contact telephone number.

The following day I phoned BMJ about my request upon which they told me that they do not deal with issues of that type, and they referred me back to BMA. After a few communication exchanges, BMA informed me that my request was forwarded to their web team. I never heard anything from that despite the attempt of sending them a follow-up email on the 08 June 2017 when my survey was already live. The full email trail of my communications with BMA can be seen in Appendix 1.3.

3.6 Data analysis methods

Data collected from each study strand of the convergent parallel mixed methods design was analysed “separately and independently, using the techniques traditionally associated with each data type” (Creswell & Plano Clark 2011, p.78). While the literature argues about no right or wrong answer concerning the “adequacy of a dataset” from the fieldwork, I was acutely aware right from inception that my study was likely to receive a relatively low response rate for the reasons outlined in Chapter 1 under Section 1.4.3. As such, the strategy that I set for data analysis was formulated from a pragmatic stance. For example, I determined to consider if the received responses were “likely to provide some reasonable and interesting insights (despite potential reservations regarding representativeness and statistical significance)” (Rowley 2014, p.317). My interest was also focused on getting a variety of respondents; respondents “with different roles, experience, backgrounds, and any other source of variability that might influence” (Rowley 2014, p.317) the diversity of responses on approach to decision-making in CCGs (Jansen 2010). Diversity of responses was particularly pertinent to the qualitative study strand as that is central to the qualitative survey (Jansen 2010), while the former strategy was noteworthy for quantitative data analysis.

3.6.1 Quantitative data analysis

The analysis of quantitative data was split into two stages. The first stage focused on basic descriptive analysis. Basic descriptive analysis was taken to denote a production of summaries of the applicable data which were displayed in simple graphs and charts. In this approach, statistical measurements like central tendency and dispersion, which normally are associated with descriptive statistics, were not considered. The reason for this was largely attributed to the question of sampling distribution, which was not

observed in this study owing to the adoption of Partial Least Squares Structural Equation Modelling (PLS-SEM) statistical technique, described and detailed shortly in the next sections. The rationale behind the concept of sampling distribution with respect to PLS-SEM is also explained in the process along with the reasons why PLS-SEM was preferred than other alternatives.

The second stage of data analysis, inferential analysis, was completed using PLS-SEM on SmartPLS 3 statistical software. Partial Least Squares (PLS) belongs to a group of variance-based techniques in Structural Equation Modelling (SEM) method. SEM is a series of statistical methods often used in social sciences to estimate causal relationships across multiple and interrelated variables at the theoretical level (latent variables) and observational level (observed variables) (Hair et al. 2012; Hox & Bechger 1998). In this context, several traditional multivariate processes such as “factor analysis, regression analysis, discriminant analysis, and canonical correlation” (Hox & Bechger 1998, p.354) are performed in a single run.

Additional to PLS-SEM, SEM method also contains a group of covariance-based techniques, abbreviated as CB-SEM. Often, PLS-SEM and CB-SEM have been mistaken as rivals by some researchers, a misconception which Hair et al. (2012, p.415) clarify by stating that, it is “Not “CB-SEM versus PLS-SEM” but “CB-SEM and PLS-SEM””. It is because each of these two approaches has its place in data analysis, hence should not be taken as competitors. While both methods are used to analyse structural path models, there are different in several ways, with some listed in Figure 3.8. Whether the data analysis should use CB-SEM or PLS-SEM is determined by different factors that should be carefully considered. Two main factors were of interest to the current study. The first pertained to theory, with CB-SEM widely used for theory testing while “PLS-SEM ... often serve as a basis for theory development” (Hair et al. 2012, p.424). This respect facilitated in achieving the primary aim, which is described in Chapter 1, Section 1.1. The second is about sample size, where CB-SEM proffers more reliability with a high sample, whereas PLS-SEM can “yield acceptable parameter estimates when the sample size is restricted” (Hair et al. p.423). More about how PLS-SEM suited this study is discussed in Section 3.6.1.1.

While there is an array of statistical techniques that can be used in SEM, Linear Structural Relations (LISREL) and path modelling are leading, with the former widely used in CB-SEM and the latter prominently used in PLS-SEM (Henseler et al. 2009).

Model Requirement	PLS	CB-SEM
Includes interaction effects	Preferable, as it is designed for easy interactions	Difficult with small models, nearly impossible with large ones
Includes formative factors	Easier	Difficult
Includes multigroup moderators	Can use, but difficult	Preferable
Testing alternative models	Can use	Preferable, as it provides model fit statistics for comparison
Includes more than 40-50 variables	Preferable	Sometimes unreliable if it does converge; sometimes will not converge
Nonnormal distributions	Preferable (although it will still affect results, just to a lesser extent)	Should not be used; results in unreliable findings.
Nonhomogeneity of variance	Preferable (although it will still affect results, just to a lesser extent)	Should not be used; results in unreliable findings.
Small sample size	It will run (although it will still affect results negatively)	Unreliable if it does converge; often will not converge

Source: Lowry & Gaskin (2014)

Figure 3.8 Recommendations on when to use PLS-SEM or CB-SEM

3.6.1.1 PLS-SEM: why and how it fitted the current study

This subsection explores how PLS-SEM fitted into my data analysis. I adapted six key subjects from Hair et al. (2012, p.419) over which this discussion is outlined, the subjects being “(1) reasons for using PLSSEM; (2) data characteristics; (3) model characteristics; (4) outer model evaluation; (5) inner model evaluation; and (6) reporting”. Outer model evaluation and inner model evaluation were considered under the subject “Evaluation of PLS-SEM path model”, Section 3.6.1.3.

Occasionally, arguments are advanced where SEM, a second generation (2G) statistical method, is compared to the widely used statistical techniques like multiple regression, which are first generation (1G) techniques (Karimimalayer & Anuar 2012). It is, therefore, useful to note the naming convention of these statistical methods, 1G and 2G, as they are cited in the text.

(1) Reasons for using PLS-SEM

There are four primary reasons which were drivers for selecting PLS-SEM. These are explanation of variance of the endogenous latent variables, theory development, sample size, and non-normal data.

Explanation of variance: Variance here is viewed as denoting a measure of data distribution from the mean or expected value (Bird 2004). Patterns of variance are commonly established using 1G statistical methods like multiple regression, a technique which Karimimalayer and Anuar (2012, p.326) claim to be “one of the best variance predictor in an interval dependent variable”. However, 1G techniques do not support latent variables, which underpinned this study, as described in the conceptual framework (Chapter 2, Section 2.5). Conversely, PLS-SEM supports latent variables and is acclaimed for being originally purposed for explaining the variance of the endogenous type of latent variables (Hair et al. 2012).

Theory development: The primary aim of my research was to identify factors influencing perceived effective decision-making in the CCGs based on GPs’ views. Achieving this correctly using conventional statistical techniques such as found in 1G approaches would not be possible owing to the small sample, which was predicted at the inception of the study (Chapter 1, Section 1.4.3). PLS-SEM would, however, be useful in this context given that PLS-SEM emphasises prediction in situations that may not be amenable to other statistical methods like CB-SEM or 1G techniques (Lowry & Gaskin 2014; Hair et al. 2012; Henseler et al. 2009). Herman Wold, the originator of PLS, accentuated the role that PLS plays in theory development in these words:

PLS is primarily intended for research contexts that are simultaneously data-rich and theory-skeletal. The model building is then an evolutionary process, a dialog between the investigator and the computer. In the process, the model extracts fresh knowledge from the data, thereby putting flesh on the theoretical bones. At each step PLS rests content with consistency of the unknowns. (Lohmoller & Wold 1980, p.1 cited in Henseler et al. 2014, p.200)

Sample size: The question of sample size threatened to stifle this research, as was forecasted at the inception of the study (Chapter 1, Section 1.4.3). This was due to the

kind of the population that I was dealing with, the GPs. It was likely that the sample size was not going to be large enough for satisfactory analyses using techniques like multiple regression to establish patterns of variance, which do not work accurately with small samples (Karimimalayer & Anuar 2012). In contrast, PLS-SEM can accept small sample size, and therefore can be applied in situations less ideal for other techniques (Lowry & Gaskin 2014; Henseler et al. 2009). More about sample size is discussed in the next section which looks at data characteristics.

Non-normal data: I did not have to be concerned about this as PLS models do not have distributional requirements; which means “path modeling can be used when distributions are highly skewed” (Henseler et al. 2009, p.278).

There are a plethora of additional reasons that researchers who have previously adopted PLS-SEM for their studies have given to justify their choices. Several, which are not considered in this thesis as they were not relevant to my situation, are reviewed by Hair et al. (2012).

(2) Data characteristics

Two aspects were considered about data characteristics, which are, sample size and data type. While the general understanding is that PLS-SEM supports small sample size (Lowry & Gaskin 2014; Hair et al. 2012; Henseler et al. 2009), there is however no one agreed standard method for determining the acceptable “small” sample size, thus leaving the researcher with the question, “how small is small sample size”? Research has indicated that there are more than 300 models that have been used in the past, all for actually calculating sample size for PLS-SEM, with the smallest sample size being 18 and one of the largest being 16 096 (Hair et al. 2012). There is, nonetheless, a widely promoted “rule of thumb” instigated by Barclay et al. (1995, cited in Henseler et al. 2009) that I adopted. The rule of thumb is designed to guide the researchers in getting around the sample size question for PLS-SEM. It states that the minimum sample size should be either ten times the maximum number of outer model paths on a latent variable affiliated with the maximum count of indicators, or ten times the number of the maximum inner model relationships directed at single latent variable, depending on whichever is larger (Hair et al. 2012; Henseler et al. 2009). The way that this approach worked in this study is discussed in Chapter 4, Section 4.2.2.1. Regarding the

data type, the current study data was of interval (continuous) type, which is suitable for PLS algorithms (Garson 2016; Hair et al. 2012). While PLS-SEM can also accommodate categorical data, Hair et al. (2012) discourage its use on standard PLS-SEM algorithm's application as it is not adequately supported.

Turning again to sample size, despite the widespread acceptance of PLS-SEM's ability to support a small sample size, Goodhue et al. (2006, cited in Henseler et al. 2009) challenge that notion, denouncing it as misleading. The argument supporting this refutation is that, while PLS has statistical power in small sample sizes (Hair et al. 2012; Henseler et al. 2009), it lacks accuracy. Instead of statistical power, statistical significance should take precedence, as statistical power without statistical significance does not contribute to scientific knowledge (Henseler et al. 2009). On the contrary, Klein (2005, p.644) rejects "the overwhelming emphasis on p-value" which mandates the analyses results to be described in terms of statistical significance. Instead, Klein contends that researchers should look beyond statistical significance, to factors like "confidence limits, effect sizes, and meta-analyses" (Klein 2005, p.644). In this respect, PLS-SEM does consider the effect size criterion. However, it goes beyond that, utilising p-value in null hypothesis significance testing, but not without sharp criticism by some scholars (Ronkko & Evermann 2013) of the process used to that end, which is bootstrapping. Further discussion about PLS-SEM and p-value is done in Section 3.6.1.5. Another test provided by PLS-SEM is confidence limits (confidence intervals). Overall, when considered from the grand scheme of statistical factors such as complex research models, handling of endogenous latent variables to explain variance, along with the question of small sample size, PLS-SEM is more favourable (Hair et al. 2012; Henseler et al. 2009). Commenting on the same line of argument, Wold (1985, p.589-590, cited in Henseler et al. 2009, p.294) states that "in large, complex models with latent variables PLS is virtually without competition".

(3) Model characteristics

Research has revealed different metrics about the average number of latent variables and the average number of inner model relationships in a typical PLS path model. For example, Hair et al. (2012) mention an average number of 7.94 latent variables whereas Shah and Goldstein (2006, cited in Hair et al. 2012) mention an average of 4.70 of the same. While Hair et al. (2012) research notes that the number of latent

variables in studies published after 2000 has been significantly higher, reading 8.43 on average, the current study only had 5, which may appear relatively low. A count of 5 variables is within the recognised range in academic circles, as demonstrated in Table 3.4, which is adapted from Hair et al. (2012). Details of the number of inner model path relationships, number of indicators per reflective latent variable, number of indicators per formative latent variable, and the total number of indicators in models are also listed in Table 3.4. All the results shown in Table 3.4 about Mean, Median, and Range have been directly taken from Hair et al. (2012) research findings. Results under the row “Current study”, relate to this current research.

Table 3.4 Descriptive statistics for model characteristics (Adapted from Hair et al. 2012)

Criterion		Results
Number of latent variables	Current study	5
	Mean (Previous studies)	7.94
	Median (Previous studies)	7.00
	Range (Previous studies)	(2; 29)
Number of inner model path relations	Current study	6
	Mean (Previous studies)	10.56
	Median (Previous studies)	8.00
	Range (Previous studies)	(1; 38)
Number of indicators per reflective latent variable	Current study	4
	Mean (Previous studies)	3.99
	Median (Previous studies)	3.50
	Range (Previous studies)	(1; 27)
Number of indicators per formative latent variable	Current study range	(1; 3)
	Mean (Previous studies)	4.62
	Median (Previous studies)	4.00
	Range (Previous studies)	(1; 20)
Total number of indicators in models	Current study	11
	Mean (Previous studies)	29.55
	Median (Previous studies)	24.00
	Range (Previous studies)	(4; 131)

The path model developed for the current study is balanced, which is one of the two varieties that are said to be a good fit for utilising the predictive power of PLS-SEM

(Hair et al. 2012). A model is said to be balanced if it neither has a high proportion of exogenous latent variables nor a high proportion of “endogenous latent variables and mediating effects” (Hair et al. 2012, p.421). The other type is a focused model, in which there would be a high proportion of the exogenous latent variables, “at least twice as high as the number of endogenous latent variables” (ibid).

3.6.1.2 CCGs' PLS-SEM Path model

This section provides a brief theoretical overview of PLS-SEM path models along with a review of the path model that I developed for the CCGs based on the conceptual model discussed in Chapter 2, Section 2.5. In Chapter 2, only latent variables were described along with postulated influences between the variables in question. To recapitulate, latent variables represent concepts that cannot be measured directly but are estimated using proxies (Lowry & Gaskin 2014; Henseler et al. 2009; Bozionelos 2003). Further explanation about this can be seen in Chapter 2, Section 2.5. In SEM, the latent variables are complemented with observed variables, commonly referred to as indicators or manifest variables (Lowry & Gaskin 2014; Henseler et al. 2009). The resulting relationship between the indicators and the latent variables is called a measurement model or outer model. This and other aspects of the SEM model environment are illustrated in Figure 3.9.

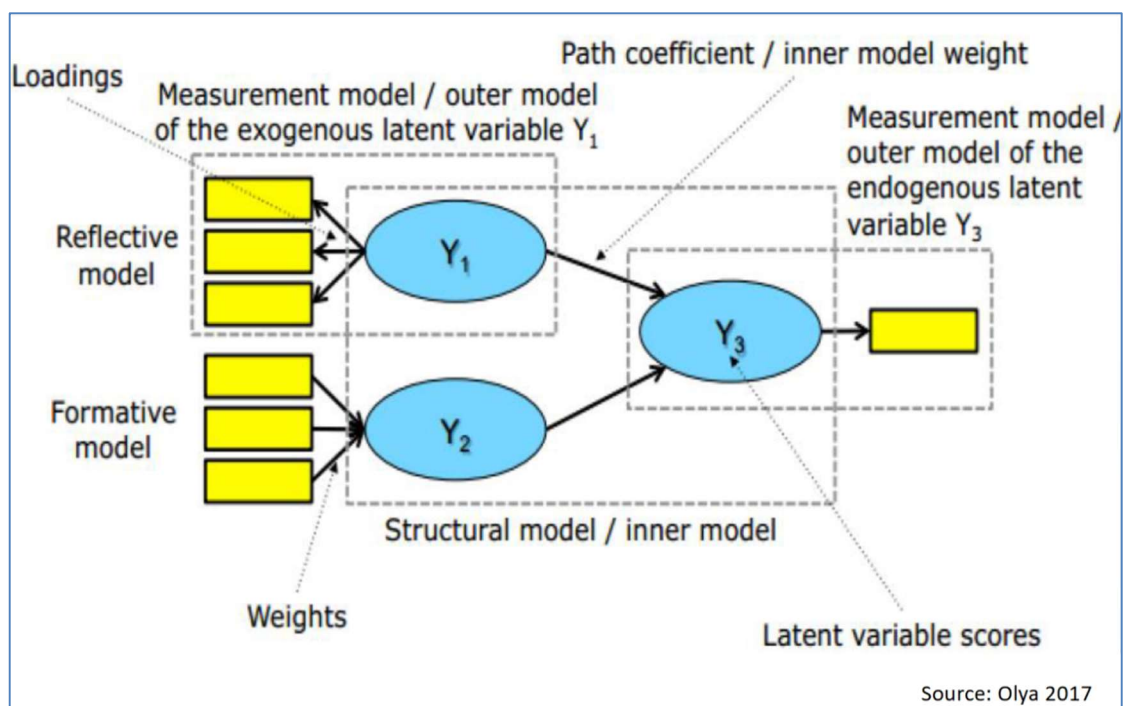


Figure 3.9 SEM Model Ecosystem Illustration

If the outer model is in reflective mode, the latent variable is treated as being the cause of the indicators, with the direction of the relationship pointing to the indicators. In this arrangement, the indicators are meant to reflect variation in the latent variable, thereby suggesting that “changes in the construct are expected to be manifested in changes in all of its indicators” (Henseler et al. 2009, p.289). In other words, indicators denote the mode of the latent variable, as illustrated in Figure 3.9. In contrast, if the outer model is in formative mode, the direction of causality flows from the indicators to the latent variable (Henseler et al. 2009), with the indicators collectively determining the import of the latent variable (Temme et al. 2014). In this arrangement, the latent variable material will be made up of the indicators (Garson 2016). Figure 3.9 illustrates this situation.

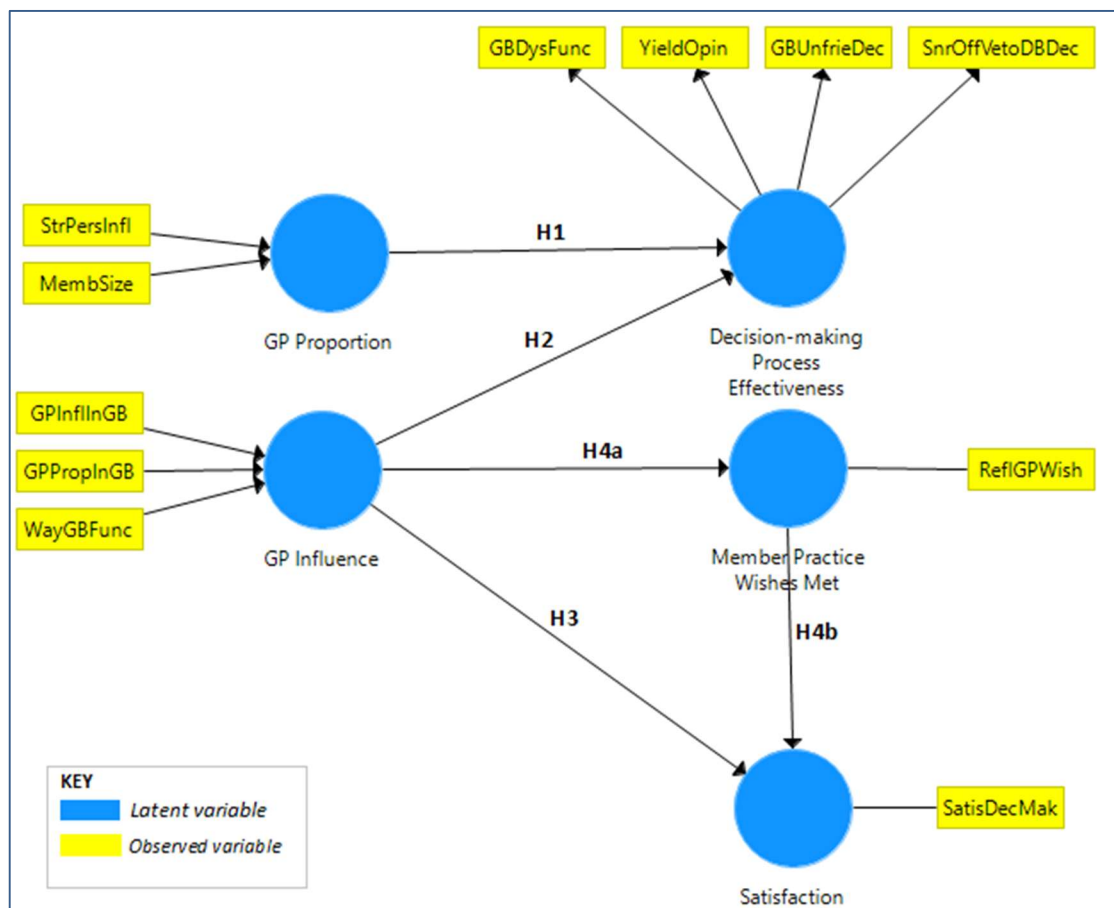


Figure 3.10 CCGs Final Phase PLS-SEM Path Model (Source: Author’s own 2019, unpublished)

The PLS-SEM path model for the current study, shown above in Figure 3.10, had all its latent variables modelled in the first-order. This means that all the latent variables, regardless of their mode, had direct relationships with the associated indicators (Lowry

& Gaskin 2014). In contrast, latent variables that have relationships with other latent variables are known as higher order latent variables. As shown in Figure 3.10, the current study path model was comprised of both formative and reflective indicators. This path model is complemented by Table 3.5, which outlines the items that were measured along with the associated indicators and latent variables, presented in a format derived from Bharati and Chaudhury (2004). The names of the shortened indicators outlined in Table 3.5, as well as those outlined in Table 3.6, were derived from the items that were measured, which are described in the same tables.

Table 3.5 CCGs Final Phase Path Model Sources and Instruments List

INDEPENDENT/ DEPENDENT LATENT VARIABLE	LATENT VARIABLE NAME	INDICATOR	ITEM MEASURED	RELATED SURVEY QUESTION
Independent	GP Proportion	MembSize	CCG Governing Body Membership Size	Question 6
		StrPersInfl	Governing Body Influenced by Few Strong Personalities	Question 10 Part 2
Independent	GP Influence	GPInflInGB	Level of GP Influence in Your Governing Body	Question 9
		GPPropInGB	The proportion of GPs In CCG Governing Body Membership	Question 8
		WayGBFunc	The Way Your CCG Governing Body Functions	Question 7
Dependent	Decision-making Process Effectiveness	GBDysFunc	Governing Body Is Dysfunctional	Question 10 Part 1
		YieldOpin	Governing Body Members Yield Opinions to Others to Avoid Contention	Question 10 Part 3
		GBUnfrieDec	Unfriendly Decisions	Questions 12
		SnrVetoDec	Senior Member or Government Official	Question 11

INDEPENDENT/ DEPENDENT LATENT VARIABLE	LATENT VARIABLE NAME	INDICATOR	ITEM MEASURED	RELATED SURVEY QUESTION
			Vetoed Decisions Made by Governing Body	
Dependent	Member Practice Wishes Met	RefIGPWish	Decisions Made by My CCG Reflect the Wishes of GP Practices That My CCG Serves	Question 18
Dependent	Satisfaction	SatisDecMak	Level of Satisfaction About the Way Decisions Are Made at Your CCG	Question 19

The path model structure which was initially developed, here referred to as early phase path model, is demonstrated in Figure 3.11. This model had to be modified in accordance with the tests for what at this point I will loosely call goodness-of-fit. The tests in question facilitated in increasing the model fitness. Goodness-of-fit ensured that the ensuing tests of the statistical hypotheses were credible. More about goodness-of-fit tests is discussed at length under Section 3.6.1.3. What is useful to note at this point is that some indicators and/or latent variables which returned unsatisfactory results from goodness-of-fit tests were removed from the early phase model in line with the recommended actions to that end (Lowry & Gaskin 2014). For this reason, this thesis only discusses the relevant aspects of the early phase model which will inform the reader about the reasons which led to its alteration. The rest of the individual components in the early phase model are not described as that model was rendered obsolete, and therefore had no bearing on the final results and findings. It is worth mentioning at this point that getting a model wrong in some subparts of the research is a recognised occurrence in the research process. This phenomenon is featured by Henseler et al. (2014, p.201) who state that, “in early phases of research, it is difficult to assure that all subparts of a model are entirely correct”.

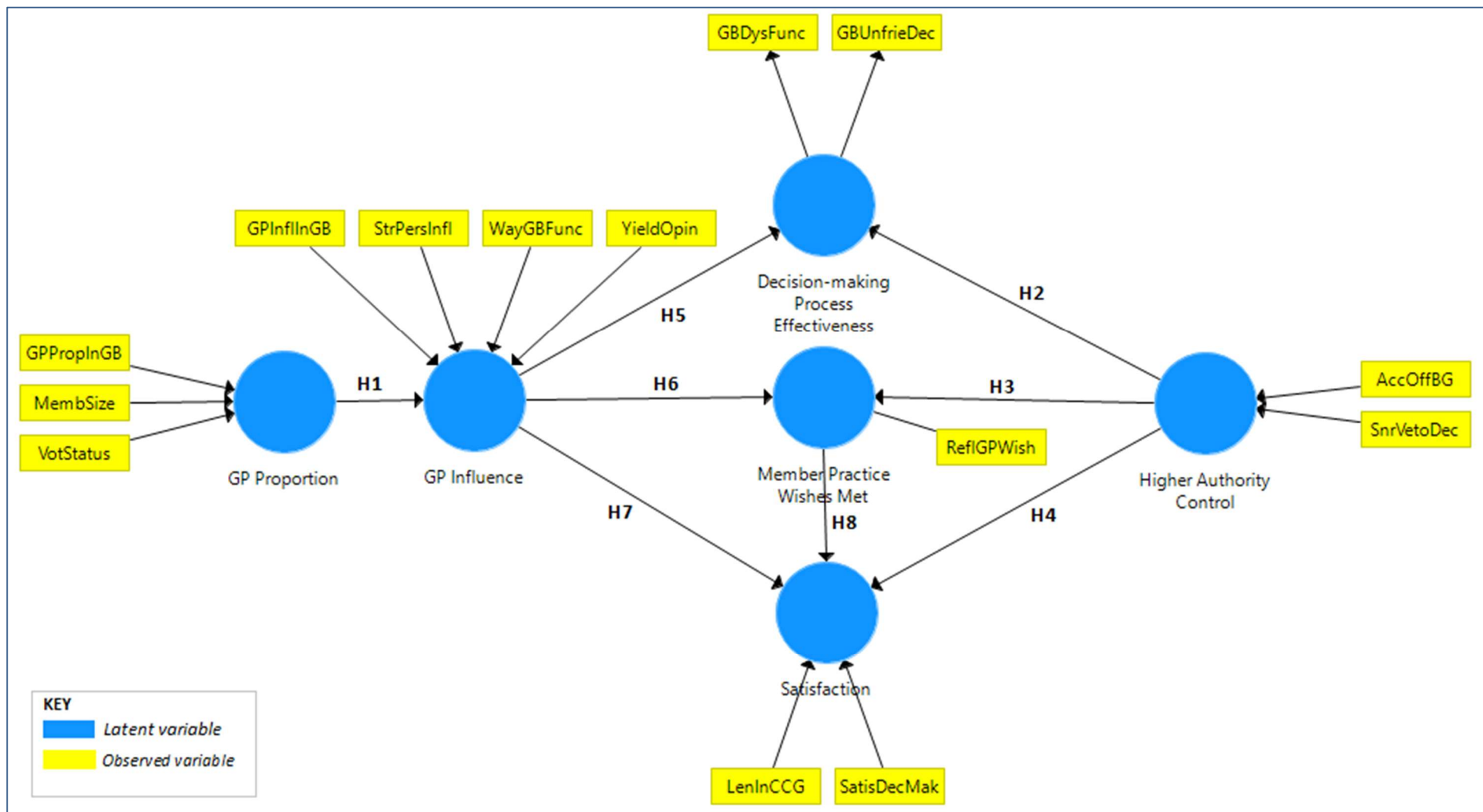


Figure 3.11 CCGs Early Phase PLS-SEM Path Model (Source: Author's own 2019, unpublished)

Figure 3.11 gives a list of indicators that were used in the early phase path model along with their related latent variables and items that they measured. The format of this table was adapted from Bharati and Chaudhury (2004).

Table 3.6 CCGs Early Phase Path Model Sources and Instruments List

INDEPENDENT/ DEPENDENT LATENT VARIABLE	LATENT VARIABLE NAME	INDICATOR	ITEM MEASURED	RELATED SURVEY QUESTION
Independent	GP Proportion	MembSize	CCG Governing Body Membership Size	Question 6
		GPPropInGB	The proportion of GPs In CCG Governing Body Membership	Question 8
		VotStatus	Governing Body Voting Status	Question 5
Dependent	GP Influence	StrPersInfl	Governing Body Influenced by Few Strong Personalities	Question 10 Part 2
		YieldOpin	Governing Body Members Yield Opinions to Others to Avoid Contention	Question 10 Part 3
		GPInflInGB	Level of GP Influence in Your Governing Body	Question 9
		WayGBFunc	The Way Your CCG Governing Body Functions	Question 7
Dependent	Decision-making Process Effectiveness	GBUnfrieDec	Unfriendly Decisions	Questions 12
		GBDysFunc	Governing Body Is Dysfunctional	Question 10 Part 1
Dependent	Member Practice Wishes Met	ReflGPWish	Decisions Made by My CCG Reflect the Wishes of GP Practices That My CCG Serves	Question 18
Dependent	Satisfaction	SatisDecMak	Level of Satisfaction About the Way Decisions Are Made at	Question 19

INDEPENDENT/ DEPENDENT LATENT VARIABLE	LATENT VARIABLE NAME	INDICATOR	ITEM MEASURED	RELATED SURVEY QUESTION
			Your CCG	
		LenInCCG	Length of Service In CCG	Question 2
Independent	Higher Authority Control	AccOffBG	Accountable Officer Professional Background	
		SnrVetoDec	Senior Member or Government Official Vetoed Decisions Made by Governing Body	Question 11

3.6.1.3 Evaluation of PLS-SEM path model

In PLS-SEM path models, there is no provision of a global measure for goodness-of-fit (Henseler et al. 2009). Goodness-of-fit is an assessment used to measure the fitness of a path model in which a comparison between the observed values is made against the values expected from the model at issue (Garson 2016). As PLS-SEM does not support global measurement for goodness-of-fit, model fitness in PLS-SEM is measured through two steps. The first step evaluates the fitness of the outer (measurement) model while the second step evaluates the inner (structural) model (Lowry & Gaskin 2014; Henseler et al. 2009). This two-step process is summarised in Figure 3.12.

Assessment of the outer model is performed on both reflective and formative constructions. The reflective outer models are assessed for reliability and validity whereas the formative outer models are assessed for indicator collinearity and indicator relevance (Henseler et al. 2009). Satisfactory assessment of the inner model can only be achieved if the outer models yield acceptable assessment tests (Hair et al. 2012; Henseler et al. 2009). The next sections describe the strategy that I set to achieve acceptable statistical assessments. This is a continuation of the arguments justifying how PLS-SEM fitted into my data analysis started in Section 3.6.1.1.

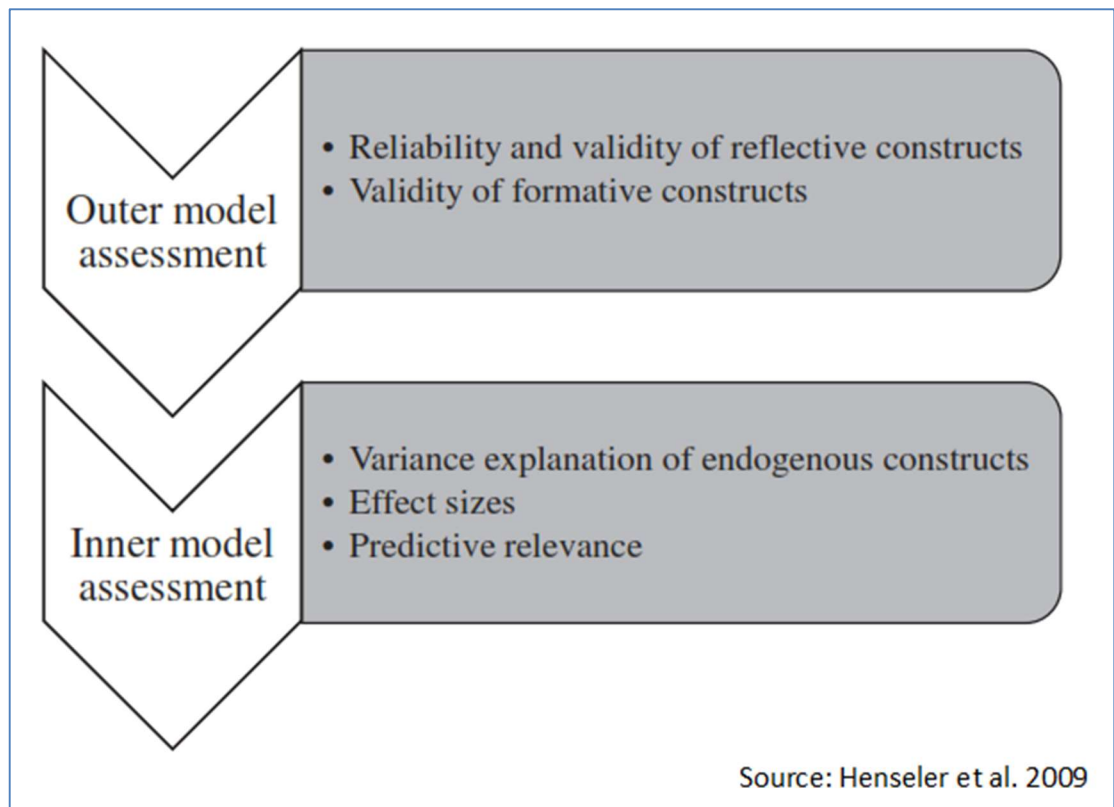


Figure 3.12 A Two-step PLS-SEM Path Model Assessment

(4) Outer model evaluation

The focal function of the outer model evaluation is to ensure the fitness of the model in the sense of reliability and validity by removing or rearranging all the redundant items in each latent variable (Nazim & Ahmad 2013; Hair et al. 2012; Henseler et al. 2009). The phrase “redundant items” refers to the items that fail related tests based on the matching benchmark indices described and detailed in Appendix 4.1. A baseline of acceptable indices per measured feature, along with a list of criteria used in this study to evaluate outer path models, is outlined below in Table 3.7.

Table 3.7 A list of criteria used in this study to evaluate outer path models

Outer Model Type	Category Name	Feature Measured	Name of index/criterion	Level of Acceptance
Reflective measurement model	Internal reliability	Indicator interrelationship on same latent variable. Should correlate positively	Composite reliability score	≥ 0.6
Reflective measurement model	Convergent validity	Degree of indicator correlation on same latent variable	Average Variance Extracted	≥ 0.5
Reflective measurement model	Discriminant validity	Latent variable distinctiveness to prevent multicollinearity	Heterotrait-monotrait correlation coefficient	≤ 0.85
Formative measurement model	Indicator's contribution to the latent variable	Indicator relevance to the latent variable. Weights should be significant	Indicator weights	
Formative measurement model	Multicollinearity	To exclude indicator multicollinearity	Variance inflation factor (VIF)	4 – 5

Inner model evaluation

Inner model estimates can only be safely and appropriately analysed when there is evidence of the validity and reliability of the outer model (Hair et al. 2012; Henseler et al. 2009). Assessment of the inner model's quality is assumed from the premise of "variance-based, non-parametric evaluation criteria" (Hair et al. 2012, p.426). Five tests were considered for this purpose – namely, R^2 of endogenous latent variables, Significance of path coefficients, Effect size f^2 , Prediction relevance Q^2 . Like the outer model assessment, the technical details of these tests have been moved to the appendices, Appendix 4.2. However, a baseline of acceptable indices per given test, along with a list of criteria used in this study to evaluate the inner path model, is outlined in Table 3.8.

Table 3.8 A list of criteria used in this study to evaluate inner path models

Category Name	Feature Measured	Name of index	Level of Acceptance
Endogenous latent variables' explained variance	Individually explained the amount of variance of all endogenous latent variables	R ²	0.67, 0.33, and 0.19 (substantial, moderate, and weak)
Effect size	Measures the magnitude of effect between two variables	f ²	0.02, 0.15, and 0.35 (small, medium, and large)
Prediction relevance	Assesses the inner model's capability to predict	Q ²	>0 (0.02, 0.15, 0.35) (small, medium, high)
Significance of path coefficients	Indicate the strength of relationships between latent variables	Weighted factors	-1 to +1

(5) Reporting

Reporting of the PLS-SEM results of the outer and inner models was organised in line with the tests criteria outlined in Table 3.7 and Table 3.8, respectively.

3.6.1.4 Final phase conceptual model propositions

As mentioned earlier in this section, the early phase path model structure, displayed in Figure 3.11, had to be modified following the model fitness tests just described in the preceding paragraphs. The process that led to the modification of the early phase model is described in Chapter 4, Section 4.2.2.2. This meant producing a revised conceptual model (Figure 3.13). While the description of the latent variables remained the same as explained in Chapter 2, Section 2.5, the causal relationships changed, meaning that a new set of propositions had to be defined. These are outlined below.

Proposition 1 (P1): A high proportion of GPs in the Governing Body committee will improve the decision-making process effectiveness.

Proposition 2 (P2): The level of GP influence in the Governing Body will cause a difference in the effectiveness of the decision-making process.

Proposition 3 (P3): A high level of GP influence in the Governing Body will increase the degree of GP satisfaction about decision-making.

Proposition 4 (P4): The level of GP Influence in the Governing Body will increase the scale of member practice wishes being met thereby causing a difference in the degree of GP satisfaction about decision-making, such that the positive impact on satisfaction about decision-making is stronger with increasing values of member practice wishes met.

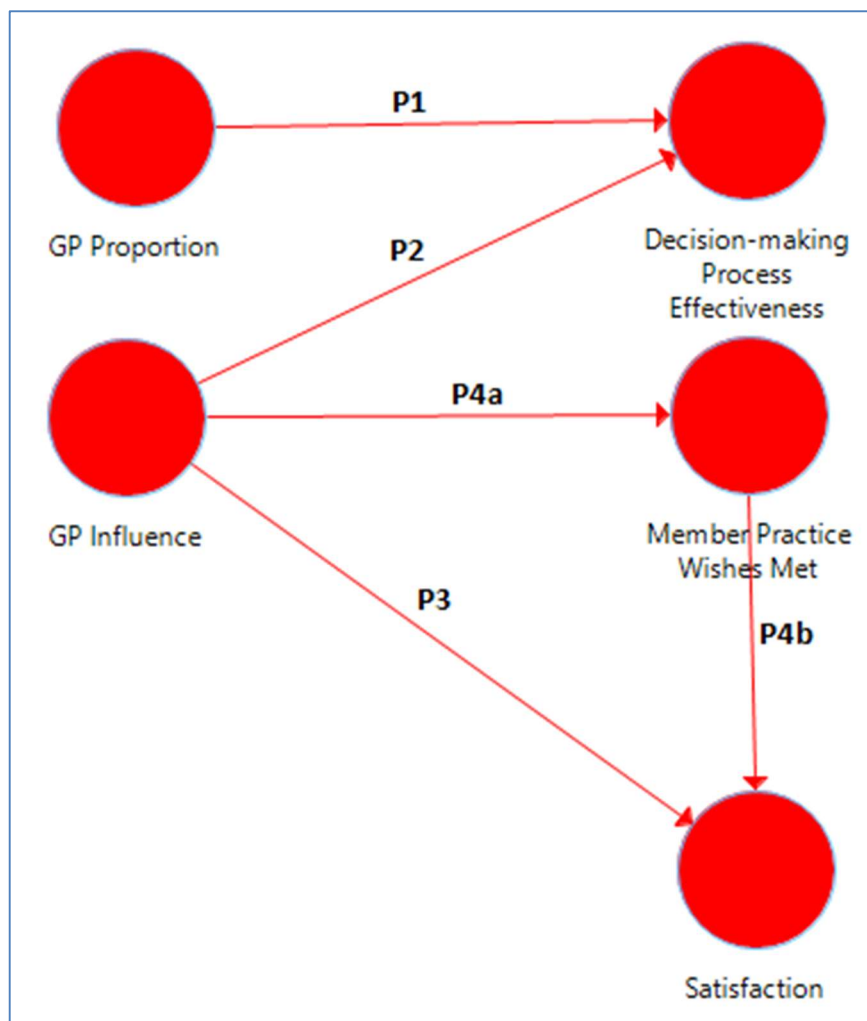


Figure 3.13 Final Phase CCGs Decision-making Conceptual Model

The relationships in the model depicted in Figure 3.13 above denote that *Decision-making Process Effectiveness* is an effect of *GP Proportion* and *GP Influence*. On the other hand, *Satisfaction* is causally determined by *GP Influence*, and *Member Practice Wishes Met*, which, in the relationship matrix, depends on *GP Influence*. *GP Proportion* and *GP Influence* are exogenous latent variables, meaning that they are the causes of

Satisfaction and Decision-making Process Effectiveness. Member Practice Wishes Met, on the other hand, is an intervening variable with its causality role just being on *Satisfaction*, meaning that on its own it cannot exert that causation (Russo 2009).

3.6.1.5 Inner model statistical hypotheses

Statistical hypotheses for this study were derived from the four propositions, which were developed from a revised conceptual model shown in Figure 3.13 above. While typical statistical hypotheses are generally stated in two formats, Null Hypothesis (H₀) and Alternative Hypothesis (H_A), where H₀ suggests the absence of statistical significance in a set of given observations and H_A suggests the opposite (Scheff 2016), some scholars argue that null hypothesis cannot be used in PLS (Ronkko & Evermann 2013). The reason for this lies in the fact that null hypothesis significance testing (NHST) relies on “statistical inferences [that] are ... based on the *p* value ... [with] a known sampling distribution” (Ronkko & Evermann 2013, p.438). In PLS, the precise distribution of the path coefficients is unknown since it is dependent on the indicator weights. Therefore, Ronkko and Evermann (2013, p.439) contend that bootstrapping, an approach which they criticise, must be performed “to obtain the *p* value”. On the contrary, other scholars view bootstrapping favourably, as it is not restricted by statistical assumptions such as normal distribution of the underlying data, thereby offering “a solution to situations where conventional methods may be difficult or impossible to find” (Streukens & Leroi-Werelds 2016, p.2).

Henseler et al. (2014) make a direct counterargument to the criticisms advanced by Ronkko and Evermann (2013) of the use of NHST in PLS-SEM. First, Henseler et al. (2014, p.195) argue that “PLS is routinely used for testing relationships derived from formal hypotheses ... and that prior simulation studies have underlined PLS’s suitability for hypothesis testing across a wide range of model setups”. The second argument pertains to the distribution of parameter estimates, which Ronkko and Evermann (2013) suggested that they are ‘adulterated’ with bootstrapping. Henseler et al. (2014, p.198) state that an array of tests that performed under different conditions did not reveal “any problematic behavior of PLS in combination with bootstrapping”. This argument holds even for relatively low sample sizes. What is more, Henseler et al. (2014) remark that researchers using SmartPLS are unlikely to

face problems with NHST because of the way bootstrapping default settings are set, consistent with the recommended approach.

Testing approach adopted for this study

The current study adopted the widely assumed approach to hypothesis testing, where the Null Hypothesis (H₀) and Alternative Hypothesis (H_A) are both used. Hypotheses were generated based on perceived causality effects between latent variables displayed on the path model in Figure 3.10. All the hypotheses generated for this study are nondirectional, which, accordingly, were created in the rival formation of H₀ and H_A. The reason for nondirectional hypotheses is because this research was cross-sectional, and therefore, it was not possible to assert causality with accuracy on the latent variables as that, under the circumstances, “can be only speculated” (Bozionelos 2003, p.7). In contrast, directional hypotheses predict the direction that one variable will have on the other and only allow a one-tailed test of significance (Brewer & Stockton 2010). More details about this can be seen in Chapter 2, Section 2.5, where theoretical propositions upon which the causal hypotheses are based were developed.

As can be seen in Figure 3.10, all the latent variables are linked to each other by a causal effect path relationship. The *Decision-making Process Effectiveness* is an effect of *GP Proportion* and *GP Influence*. *Satisfaction* is causally determined by *GP Influence* and *Member Practice Wishes Met*, which depends on *GP Influence*. The latent variable *GP Influence* is called a moderating variable. Its influence antecedes variables *Member Practice Wishes Met* and *Satisfaction*. This arrangement presents spurious effects and suppression. “Spurious effect”, is when “two variables share an antecedent cause” that can be incorrectly inferred as being “correlated but this effect may be spurious” (Garson 2016, p.24). Alternatively, suppression denotes a situation whereby “the antecedent variable is positively related to the predictor variable ... and negatively related to the effect variable” (Garson 2016, p.24). As a result, the antecedent variable suppresses the effect variable, making it appear weaker than it really is. Below is a list of the statistical hypotheses that I generated, and subsequently tested in Chapter 4.

Causal Hypothesis 1: A high proportion of GPs in the Governing Body committee will influence the decision-making process effectiveness.

Ho: There will be no change in the decision-making process effectiveness as a result of a high proportion of GPs in the Governing Body committee.

H_A: There will be a change in the decision-making process effectiveness as a result of a high proportion of GPs in the Governing Body committee.

Causal Hypothesis 2: The level of GP influence in the Governing Body will cause a difference in the effectiveness of the decision-making process.

Ho: There will be no change in the effectiveness of the decision-making process as a result of the level of GP influence in the Governing Body.

H_A: There will be a change in the effectiveness of the decision-making process as a result of the level of GP influence in the Governing Body.

Causal Hypothesis 3: A high level of GP influence in the Governing Body will impact the degree of GP satisfaction about decision-making.

Ho: There will be no change in the degree of GP satisfaction about decision-making as a result of a high level of GP influence in the Governing Body.

H_A: There will be a change in the degree of GP satisfaction about decision-making as a result of a high level of GP influence in the Governing Body.

Causal Hypothesis 4: The level of GP influence in the Governing Body will impact the scale of member practice wishes being met, thereby causing a difference in the degree of GP satisfaction about decision-making.

Ho: There will be no change on the degree of GP satisfaction as a result of the level of GP influence in the Governing Body impacting the scale of member practice wishes being met.

H_A: There will be a change on the degree of GP satisfaction as a result of the level of GP influence in the Governing Body impacting the scale of member practice wishes being met.

The study achieved hypotheses testing by use of p-values and confidence intervals. These results were produced using SmartPLS 3 in which a bootstrap of 4,999 samples was performed in a single run. P-values were used to verify if the causality

relationships between the latent variables in the path model were due to chance or not. If not due to chance, then the relationships are considered as significant in research domains. The significance threshold in the current study was set at .05, meaning that if the p-value was below this “pre-defined α -level” (Henseler et al. 2016, p.12) the coefficient path was regarded as significant, while a p-value above .05 indicated an insignificant relationship. The smaller the p-value, the stronger the probability that the results are not due to chance. Since the relevance of the p-value only shows the level of significance on the causal relationships; to understand the strength and direction of causality effect on the relationships, confidence intervals had to be assessed in line with recommendations for statistical testing of this kind (Henseler et al. 2016; Wasserstein & Lazar 2016). Confidence intervals supplement p-value method as they emphasise estimation over testing (Wasserstein & Lazar 2016). Confidence intervals provide a range of values that a researcher is confident contain the actual population mean for the parameter of interest being measured. The confidence interval for the current study was set at 95%. To be regarded as significant, confidence intervals should not cross zero (0), a point known as the line of no effect (Henseler et al. 2016). A narrow confidence interval suggests that “the estimated value is relatively reliable” (Clarke 2012, p.1) while wider confidence intervals may suggest high variability in the sample being measured.

3.6.2 Qualitative data analysis

A dual approach was implemented in the analysis of qualitative data. First, the qualitative data were quantitised, after which a basic descriptive analysis described next, in Section 3.6.2.1, was performed. Secondly, the analysis was done using an interpretive approach within a phenomenological framework, discussed in Section 3.6.2.2. To help me “simplify and focus on specific characteristics of the data” (Nowell 2017 et al. 2017, p.5), I generated codes that I attached accordingly to applicable data cases. These codes served on both descriptive analysis and interpretive analysis. For the latter, the devised codes shaped “the basis of themes across the data set” (Nowell 2017 et al. 2017, p.6). More about themes is discussed later in this section. Focus for now will be turned to the approach that was used in the descriptive analysis of the data that were quantitised.

A Data Dictionary with a full list of codes that were developed along with the associated code descriptions is provided in Appendix 5.

3.6.2.1 Qualitative data analysis: Quantitisation and descriptive analysis approach

On the data that were collected, some of the responses from individual participants spanned across several codes which were formulated in line with the set data analysis framework. For example, Question 3 asked the participants about the roles that they were involved in at their local CCGs. Most of the respondents in that question gave the roles which fell into more than one code. To demonstrate this, Respondent 17 indicated that his or her roles were executive member as well as clinical lead in mental health. From the codes that were formulated out of all the received responses for this question, those two roles fell under Executive and Lead, with codes EXEC and LEAD, respectively. This demonstrates that Respondent 17's answer had two codes. Given this, to extrapolate more descriptive meaning from such qualitative data, a two-pronged approach was adopted in the presentation of the statistical results. The first branch was named *Format 1 Analysis* while the second was *Format 2 Analysis*. In *Format 1 Analysis*, all the codes per given question were pooled together. Proportions based on each code were then computed. The product of this computation was intended to paint a picture of the prevalence of certain characteristics occurring within the contextual background described in the related question regardless of who contributed to it. Figure 3.14, below, gives a pictorial outline of the Format 1 and Format 2 Analysis approaches.

Format 2 Analysis focused on weighting. In this case, codes were collected into groups in line with the contextual background described in the question. For example, Question 3, which sought to identify the kind of roles that the GPs were involved in had five groups allocated to it, with each group based on the number of roles that a participant said they occupied – that is, “1 Role”, “2 Roles”, “3 Roles”, “4 Roles”, and “>=5 Roles”. The assigned naming convention of each group was developed in such a way that it denoted an incremental count, or incremental weight, on associated names, thereby painting a logical picture of the estimated weight that each group represented. A bar column chart was then used to paint a picture of the weight that the GP population contributed to the respective groups.

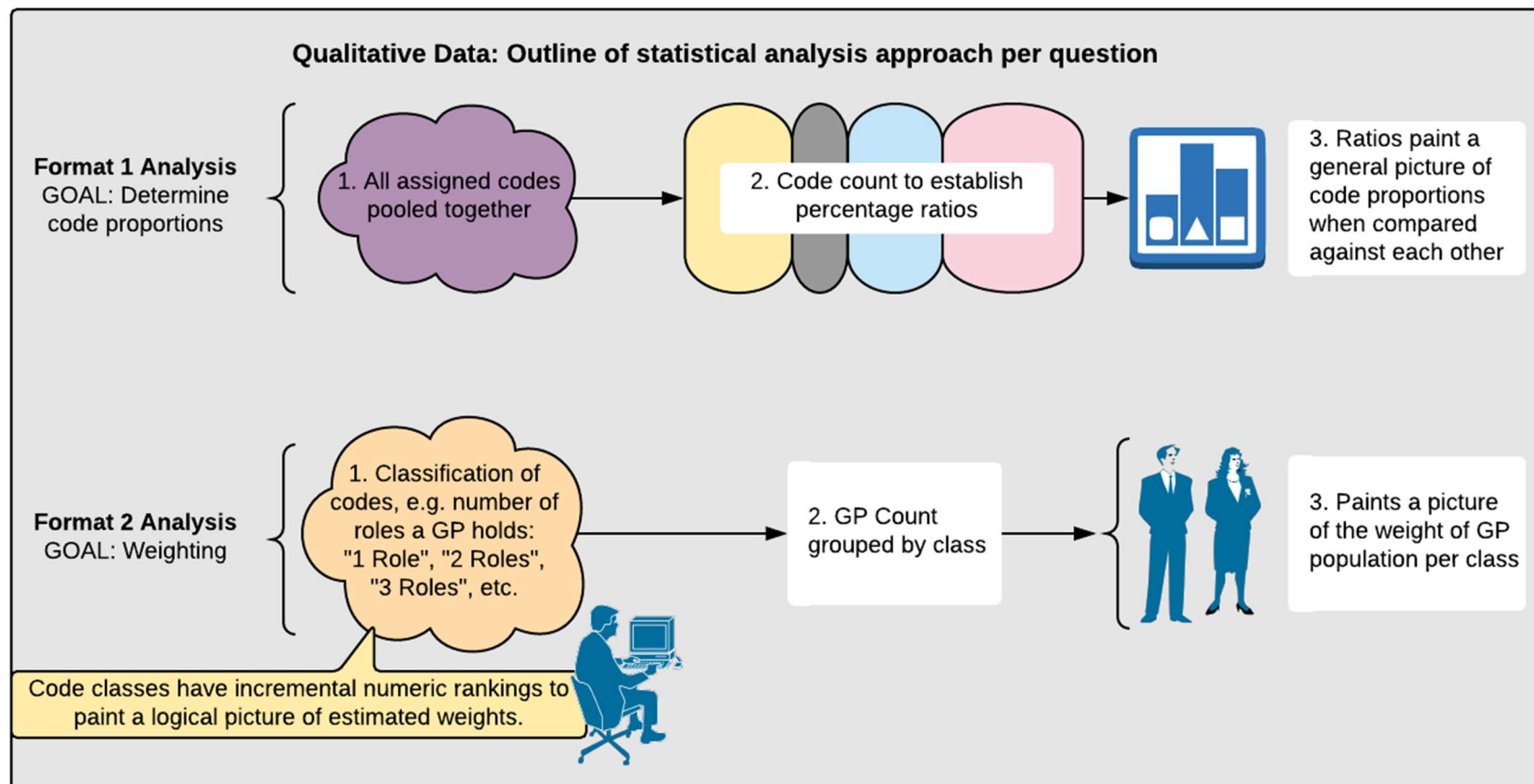


Figure 3.14 Qualitative Data Statistical Analysis Approach (Source: Author's own 2019, unpublished)

This approach, Format 1 and Format 2 in descriptive analysis collectively complemented interpretive analysis, thus generating a rich insight into the roles that the GPs do in the CCGs as well as shedding light about factors influencing the perceived effective decision-making process.

In the interest of clarity and brevity, all accompanying tables to support *Format 2 Analysis* descriptions have been put under the Appendices section, where necessary, as some of those tables are unwieldy long.

3.6.2.2 Qualitative data analysis: Interpretive approach

The second approach performed analysis within the parameters of a phenomenological framework using an interpretive approach. As explained earlier in Section 3.3.3, the qualitative data analysis was guided by the interpretative phenomenological analysis (IPA) approach by Jonathan Smith (Tuffour 2017). Because of the preponderance of hermeneutical underpinnings in IPA, this thesis interchangeably refers to IPA as a hermeneutic phenomenology or interpretive phenomenology in line with the convention used by other scholars such as Tuffour (2017), Charlick et al. (2016), Sloan and Bowe (2014), and Lavery (2003). McManus Holroyd (2007) alternatively identifies the approach as interpretive hermeneutic phenomenology.

The “commitment to explore, describe, interpret, and situate the participants’ sense making of their experiences” (Tuffour 2017, p.3) inspired interest to embrace IPA. What is more, the appeal for IPA was enhanced by its capacity to embrace the fore-knowledge that the researcher may have about the phenomenon of study. The key concepts of hermeneutic phenomenology, consistent with pragmatic approach that I embraced in the generation of knowledge in this study, are fore-structure of understanding, the context of the phenomenon, and bracketing. An apt description of these concepts can be seen in Appendix 5.1. Notwithstanding, it suffices at this point to say that fore-structure of understanding recognises the projected understanding that the researcher may have about the phenomenon of study. As a result, instead of detaching the researcher from the phenomenon of study, the researcher is incorporated to be part of the study (McManus Holroyd 2007; Wojnar & Swanson 2007). Ultimately, the researcher interprets the lived experience of the researched

through the lens of his or her (researcher) fore-structure of understanding. Meanwhile, components like the culture and social context in which the lived experience happens should be considered, which is the context of the phenomenon.

To uphold the rigour of the study, preconceived ideas about the phenomenon of the study should be mitigated, which, in hermeneutic phenomenology is done through bracketing (Tufford & Newman 2012; Lavery 2003). In IPA, bracketing is done beforehand to bring into awareness the researcher's preconceptions. Striking a balance between bracketing of preconceptions while at the same time using them as a source of insight is a challenge that is tackled by approaching interpretative descriptions reflexively (Palaganas et al. 2017; Tuffour 2017; Gill 2014; Brannick & Coghlan 2007; Lavery 2003). A brief description of the concept of reflexivity within the context of hermeneutic phenomenology is provided in Appendix 5.2. For now, it suffices mentioning that reflexivity allows the researcher to take advantage of his or her presuppositions, and thus "articulate tacit knowledge ... and reframe it as theoretical knowledge" (Brannick & Coghlan 2007, p.60).

Data analysis procedure

To begin with, the objective of the qualitative strand is well illustrated in Wojnar and Swanson (2007, p.177) statement, which was "to identify the participants' meanings from the blend of the researcher's understanding of the phenomenon, participant-generated information, and data obtained from other relevant sources". To this end, the setting of the study was as follows: the object of the phenomena was the decision-making process in the CCGs while the subject was the GPs with roles to fulfil in the CCGs. The latter comprised the participants who were chosen to take part in the study. Put together, the phenomenon of the study was the GPs' experiences with decision-making processes in their local CCGs. To produce rich descriptions of lived experience, the research question was formatted in a way that symbolised the desired need, as per recommendation by Giorgi (1997). To that effect, the current study's research question, which is also presented in Chapter 1, was:

Research Question: How do the GPs with roles to perform in the CCGs explain and describe their experience regarding decision-making at their local CCGs;

- i. During the decision-making process, and

- ii. Once the decision-making process has concluded and the decisions have been made?

In keeping with the epistemological alignment assumed for this study's qualitative strand, data analysis was developed from phenomenological and hermeneutic principles recommended for a systematic qualitative data analysis approach. Guiding principles were drawn from the experts in the field such as Smith et al. (2009, cited in Charlick et al. 2016, p.210), Benner (1994), and Colaizzi (1978, cited in Wojnar & Swanson 2007, p.177). Having said that, it is useful to mention that hermeneutic analytic methods, which include IPA, lack a standardised formal approach, with the context of the phenomenon given the prerogative to determine how data analysis can be performed (Langdrige 2007, cited in Sloan & Bowe 2014, p.9). In this respect, Gill (2014, p.126) describes IPA as the approach that "employs flexible guidelines, rendering it more of a craft than a technique". In the same vein, Charlick et al. (2016, p.210) state that "there is no single, definitive method employed to undertake IPA ... data analysis". As a result, Tuffour (2017, p.4) highlights that the lack of standardisation exposes IPA to "being riddled with ambiguities", something which IPA is criticised for. What is more, IPA is perceived by some scholars as being "mostly descriptive and not sufficiently interpretative" (Tuffour 2017, p.4). Owing to the lack of standardisation, a method specific to this study was thus formulated. This method, which comprised of four main steps outlined below in Figure 3.15, was largely derived from Benner's (1994) hermeneutic analysis.

What Figure 3.15 depicts is a process that I followed in my data analysis management. First, I read and reread several times all the textual data that was collected to get a feeling of the participants' experiences. Reading was performed in a question by question basis. My approach to this was of an inductive disposition. This means that I viewed the data in a bottom-up manner, which led me to derive general concepts from the data in question (McAbee et al. 2017). In other words, instead of trying to fit the emergent concepts into a pre-existing conceptual framework, something done in a top-down approach, observations from the collected data were allowed to lead to conclusions. In this process, I isolated paradigm cases with outstanding accounts from which I drew emergent themes, still on a question by question basis. At the same time, I also selected associated EXAMPLE QUOTES to

illustrate the themes. EXAMPLE QUOTES were tagged with unique identifiers of the matching respondents who contributed them. All respondents had unique identifiers which were individually assigned to them.

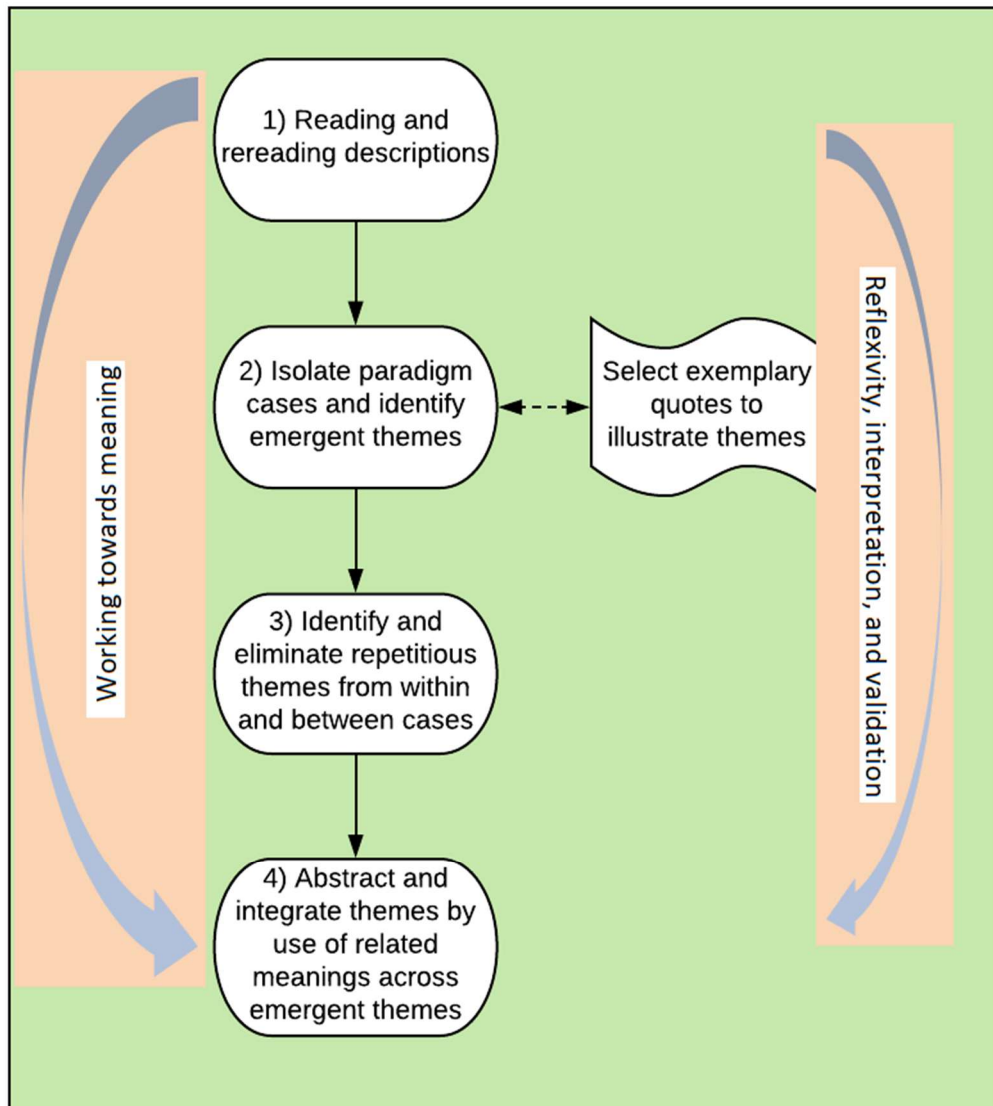


Figure 3.15 Qualitative data analysis steps (Adapted from Benner 1994)

Further analysis through rereading identified repetitious themes in the text from within and between the cases per given question. I also put effort into identifying inconsistencies with the original main themes as well as ensuring that the themes did not overlap. This meant that some themes were merged, some separated, and some even removed. At the end of this phase, I intended to have internal coherence within individual themes and clearly defined distinctions across different themes. Cases which did not fall under any of the themes that were developed from the construed

paradigm cases were grouped into what Braun and Clarke (2006, cited in Nowell et al. 2017, p.8) called “miscellaneous” theme. While the literature characterises “miscellaneous theme” as being a group made up of marginal themes, this study pragmatically considered only those cases that were insightful, and not necessarily marginal, if they did not fall under any of the main themes.

The next phase was abstraction and integration of themes across the questions. In this step, the concepts from the emerging themes were described and combined accordingly. That is, the themes that were similarly named under different questions were analysed, “identifying the story that each theme told while considering how each theme fit into the overall story about the entire data set in relation to the research questions” (Nowell et al. 2017, p.10). This resulted in the construction of a thematic based theoretical model regarding the participants’ experiences with decision-making processes. Throughout the process, there was a continuous interpretation of the participants’ descriptive responses based on the pre-structure of understanding that I had about the phenomenon of study. Alongside this, was a continual process of reflexivity in which I challenged and tested the perspectives and assumptions that I held prior to the research. This exercise helped to allay any biases that I held which were possibly developed from what I had previously “heard, read about, or seen on TV” (McGraw 2012, p.75).

3.6.3 Interpretation

Interpretation involved two sets of data, with one dataset from the quantitative strand and the other from the qualitative strand. The analysis method that was assumed for qualitative data incorporated a scheme that inherently performed some interpretation in the process. With inferential analysis of the quantitative data, interpretation of the results that were generated was made using the criteria defined in Table 3.8. Further interpretation was realised from the descriptive data analysis of both quantitative and qualitative data, with the latter being quantified where applicable. The next level of interpretation was performed in Chapter 5 at which point conclusions were drawn. At that point, results of the quantitative and qualitative strands were mixed using a basic approach that Creamer (2011) identified as linking or juxtaposing of two types of data with no data transformation conducted. In that process, questions such as the following were addressed (adapted from Creswell & Plano Clark 2011):

1. Do the respondents' views expressed in the quantitative and qualitative responses converge or diverge?
2. Are there any contradictions or relationships between the two datasets? If so, to what extent and in what ways?
3. In what ways do the qualitative responses explain the quantitative results?

The conclusions that were drawn demonstrated “what was learned from the combination of results from the two strands of the study” (Creswell & Plano Clark 2011, p.67).

3.7 Conclusion

This chapter has described the research methodology that I adopted for my study. To establish a more complete understanding of the phenomenon of study, a mixed methods design was adopted positioned on pragmatic approach, a variant of pragmatism advocated by Morgan (2007). Pragmatic approach is stripped of the weight of philosophy, only recognising epistemological implications at abstract level on the acquired knowledge. A convergent parallel mixed methods was assumed in which a survey was performed utilising a questionnaire for both quantitative and qualitative studies. The participants were recruited through purposive sampling technique from a population of GPs with formal roles in the CCGs. The quantitative data were analysed using Partial Least Squares Structural Equation Modelling (PLS-SEM) on SmartPLS 3 tool while the analysis of qualitative data was performed manually, guided by interpretative phenomenological analysis (IPA), due to the small sample of participants. Mixing, a core tenet of the mixed methods approach, was performed in data analysis and interpretation of the results. The results of this study are discussed in the next chapter.

CHAPTER 4

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents and analyses the data which were collected from a survey conducted on CCGs across England to address the problems presented in Chapter 1 of this thesis, using the method outlined in Chapter 3. A discussion of the findings is also made alongside the analyses. Data analysis was split into two sections comprising quantitative and qualitative data. There is, however, a point of interface where mixing occurs, a process achieved through quantitisation of qualitative data. Quantitisation of qualitative data is a mixing method recognised and advanced by some academics; for example, Creamer (2011). The discussion starts with a review of the response rate after which quantitative data analyses and qualitative data analyses are presented.

It will be noticed in the text that frequently there is reference to managers which, unless otherwise stated, refers to the non-clinical management staff.

4.1.1 Response rate

1058 invitations to take part in the survey were sent out. 74 participants agreed to be part of the survey. Of this, 73 were considered valid for the study, of which 72 were GPs and one a Specialist Secondary Care Consultant (Figure 4.1). This resulted in a response rate of 6.9%. The one response which was considered unusable out of the 74 was completed by a non-clinician. It is not clear how a non-clinician managed to complete the survey considering that the questionnaire was intended for, and addressed to, the doctors only. In the interest of smooth flow of arguments, all clinicians, including the specialist consultant, who participated in the survey, will henceforth be collectively identified as GPs in the text unless otherwise specified.

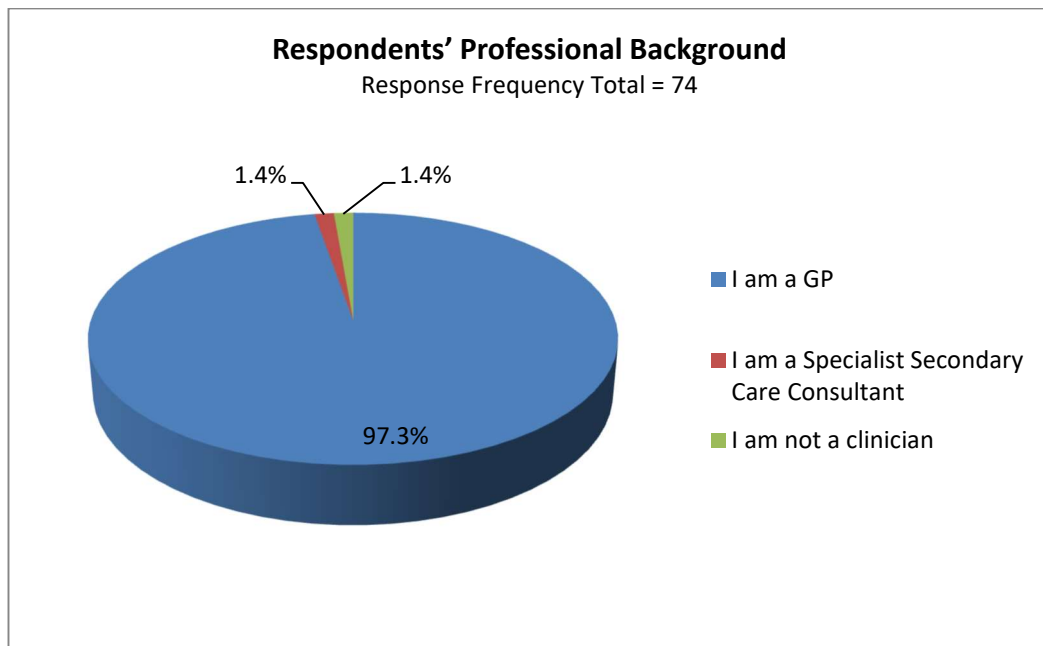


Figure 4.1 Respondent's professional background breakdown (Source: Analysis of survey data)

4.2 Quantitative Results

The quantitative data were taken from close-ended questions and open-ended questions. All questions that were close-ended were analysed quantitatively in which descriptive and inferential results were produced. On the other hand, the relevant open-ended questions constituting qualitative data were quantised and used to produce descriptive results while the responses to other open-ended questions were analysed using Interpretative phenomenological analysis presented in Section 4.3. There was no missing data as all the questions were completed in their entirety.

4.2.1 Quantitative study strand: Descriptive statistics

The descriptive statistics were considered from four levels, with first three in line with the structure of the questionnaire described in Section 3.5.1, and the fourth level based on the correlation matrix of the latent variables in the path model described in Section 3.6.1.2. As mentioned in Section 3.6.1, statistical measurements like central tendency and dispersion were not considered in this study because of non-normal sampling distribution owing to the small sample, which was part of the reason for adopting PLS-SEM (see Section 3.6.1.1).

Apart from the general response rate, attention was given to the personal characteristics of the participants, discussed under the subsection "About you". This

was followed by consideration of factors related to decision-making, discussed under subsections “Your CCG’s Governing Body” and “General questions on decision-making”. It is worth reiterating that, of the various decision-making committees that the CCGs may have, specific focus was put on the Governing Body as mentioned in Chapter 1, Section 1.4.1.

4.2.1.1 About you

First, the participants were asked about their professional background to inform the research about who did or did not meet the planned selection criteria. Table 4.1 outlines the details according to the professional background (PB), length of service in CCG (LOS), involvement at committees (IAC), and Governing Body Voting status (GBVS). Only the 51 participants who sat on the Governing Body answered the GBVS question.

Table 4.1 Participants’ Demographic Information Outline (Source: Analysis of survey data)

Focus		Professional Background Count (PB)	Length of Service in CCG Count (LOS)	Involvement at Committees Count (IAC)	Governing Body Voting Status Count (GBVS)
PB	I am a GP	72			
	I am a Specialist Secondary Care Consultant	1			
	I am not a clinician	1			
LOS	Less than 1 year		1		
	Between 1 and 3 years		24		
	More than 3 years		48		
IAC	I sit on the Governing Body			11	
	I sit on other committee(s) but not on the Governing Body			15	
	I sit on both Governing Body and other committee(s)			40	

Focus		Professional Background Count (PB)	Length of Service in CCG Count (LOS)	Involvement at Committees Count (IAC)	Governing Body Voting Status Count (GBVS)
	I have a different nature of involvement which is neither Governing Body nor any other committee			7	
GBVS	I am a voting member				50
	I am a non-voting member				1
Grand Total		74	73	73	51

Length of time with CCG

The question about the length of time with local CCG was designed to establish how well the GPs knew the development of the CCG that they served. The working assumption was that the longer one was involved with their CCG, the more ‘mature’ in substance their response was going to be, thereby boosting the quality of the data received. This is noteworthy especially considering that CCGs had only been in existence for just over 4 years at the time when the study was done. 65.8% of the respondents indicated that they had more than 3 years while 32.9% said they had between 1 and 3 years, and 1.4% had less than 1-year. A breakdown of these results is displayed in Figure 4.2.

The aspect of GP service in the CCGs has received remarkable attention in the literature (Storey et al. 2018; Moran et al. 2017b; Checkland et al. 2016; Drake 2016; Holder et al. 2016; Robertson et al. 2016; Robertson et al. 2014). For example, Storey et al. (2018) and Robertson et al. (2016) review the situation about leadership responsibility that the service redesign assigned to the GPs. On the other hand, Moran et al. (2017b) and Holder et al. (2016) discuss GPs planning to continue with or quit their service in the CCGs. There is no awareness in the existing knowledge accessed at the time of this study about the length of time that the GPs have served their local

CCG. The current research discovered that most of the GPs (65.8%) had served their CCGs for more than 3 years, which was beneficial for this study as the gathered data about decision-making processes in the CCGs was perceivably going to be 'mature'.

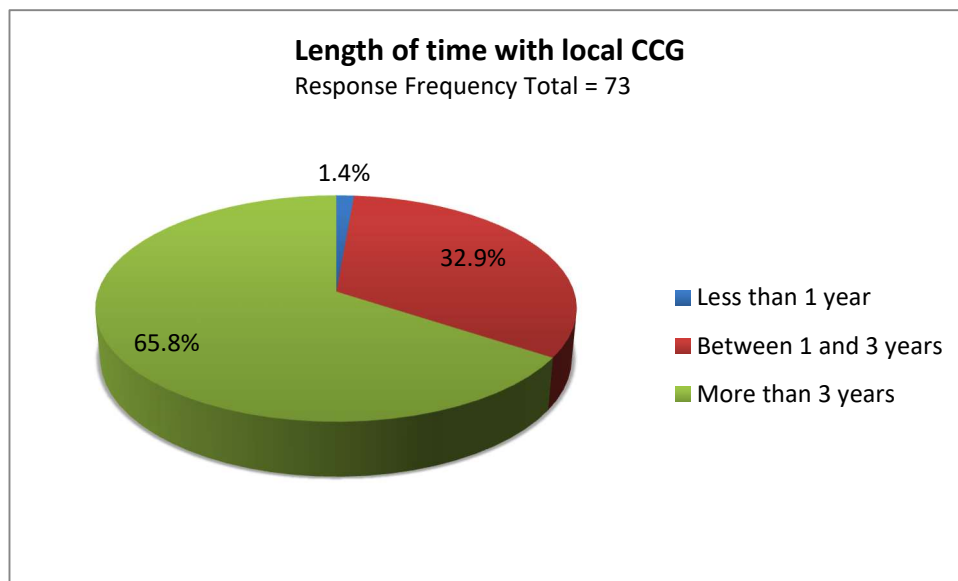


Figure 4.2 Length of time with local CCG (Source: Analysis of survey data)

There is something that the current study also demonstrated, which possibly supports findings from previous research. The question at issue concerns the minuscule proportion (1.4%) of GPs who had served their CCGs for less than a year. The same tendency is reproduced on the proportion of the GPs who had served their CCGs for up to 3 years, whose proportion account for scarcely a third of the whole sample in the current study. As demonstrated in Figure 4.2, the remaining proportion was taken up by those with more than 3 years of service. What could be the reason accounting for that low proportion of new entrants to the system? Could it be solely what Checkland et al. (2014) discovered in their study, which is a lack of enthusiasm in taking up roles in the CCGs? Checkland et al. (2014, p.33) associated this occurrence with a threat to service continuity in the event of existing "GPs retiring or leaving the profession". Another possible reason, as will be seen later under a different context, is a decline of GP representation in the CCGs, owing to factors such as lack of time and the question of money, with the roles that the GPs should play increasingly being occupied by managers (Rosser 2018; Storey et al. 2018; Checkland et al. 2016; Drake 2016). Apart from this, the researcher speculates that the other reason could be that all available

roles are filled up until such a time that new ones are created, or the existing GPs retire or leave the profession.

Description of GP roles in CCGs

The participants were then presented with an open-ended question which asked them to describe what they did in their local CCGs. When the responses were quantified, numerous work streams were identified, with most of the responses indicating that the GPs predominately occupied lead (LEAD) roles. This accounted for 34.6% (Figure 4.3). The groups or teams in which the GPs held lead roles include Cancer, Care Homes, Planned Care, Prescribing, Eyes, Diabetes, Medicines Optimisation, and Mental Health. In some instances, GPs presented as leads of what can be labelled as less-conventional work streams, when viewed from the standpoint of clinical background. These include finance, integration, governance, safety, and equality. One of the roles that appeared unique was “clinical lead for CCG in Rightcare commissioning for value”. Next to the LEAD roles, the widely occupied function was that of the chair (CHR) accounting for 18.8% of the responses, followed by board member (BM) and OTHER, both with responses of 18% each. The roles that were categorised under OTHER had a frequency count of one during data analysis, and in the interest of clarity, they were thus grouped. These include “Member of medicines committee”, “GP advisor to the CCG”, and “Caldecott guardian”. Other codes were roles in which the GPs indicated that they were engaged in being a director (DIR) or an executive (EXEC). For example, “Clinical director mental health”, “Children, young people and maternity”, for the former, while executive portfolio included “Executive GP”, and “Joint Locality Executive Board”. Responses that had unusable data were allocated with code N/A. Such did not have any role name supplied. A detailed list of codes used in this question can be seen in Appendix 7.1.

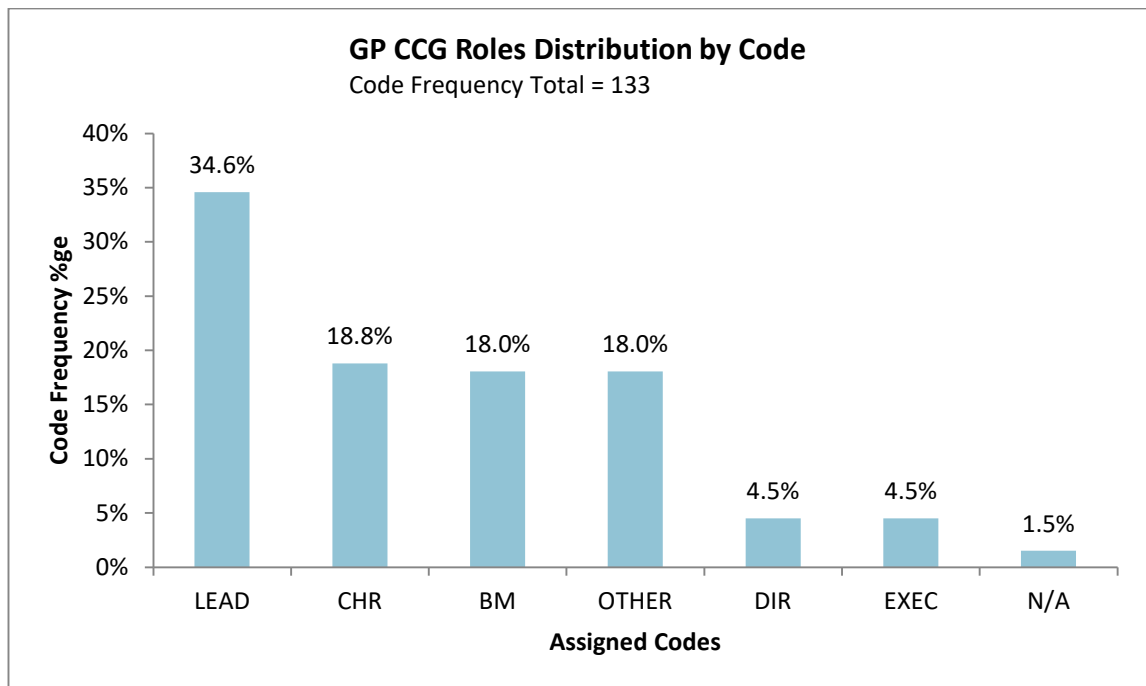


Figure 4.3 GP CCG Roles Distribution by Code (Source: Analysis of survey data)

The data about the roles that the GPs occupied in their local CCGs were also considered and presented in such a way to provide insight into the number of roles that individual respondents held. Based on this, the highest proportion of the respondents (53.4%) fell under the group “1 Role”, denoting that most of the respondents were engaged in only one role in their respective CCGs, as demonstrated in Figure 4.4. Such roles included Lead, Director, and Board Member. 24.7% of the respondents indicated that they held two roles. The associated two-role combinations included ‘Board Member, Chair’; ‘Board Member, Lead’; and ‘Executive, Lead’, while 13.7% of the respondents had “3 Roles”. These included combination examples such as, ‘Board Member, Chair, Lead’; ‘Board Member, Chair, Other’; and ‘Board Member, Lead, Other’. The group, “4 Roles”, was constituted by 1.4% of the respondents with the combination of roles such as one shown in Table 4.2 below, where Respondent 47 is used to illustrate this.

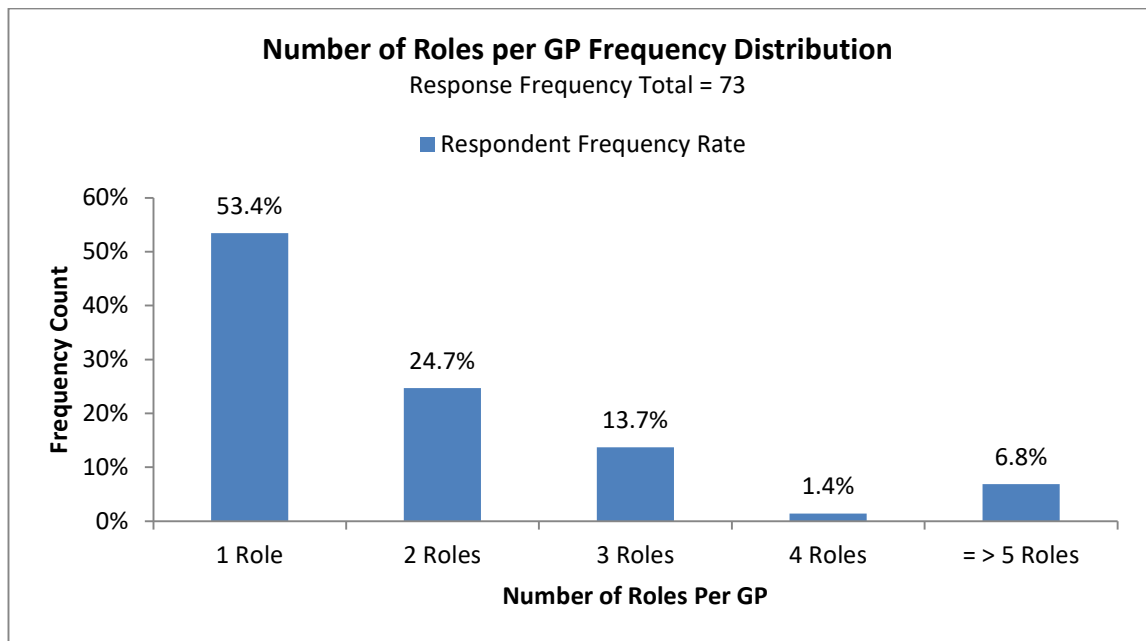


Figure 4.4 Number of Roles Measure per GP (Source: Analysis of survey data)

Table 4.2 Question 3 Format 2 Analysis Example: 4 roles per GP (Source: Analysis of survey data)

Respondent Identity	Code Description	Sub-code Description
47	Board Member	
47	Other	Governor, Children's Hospital
47	Other	Other, Health and Wellbeing Board
47	Other	Partner governor for ... Children's Hospital

The last group in this weighted analysis, group “>=5 Roles”, constituted 6.8% of the respondents. Two examples of such role combinations are displayed in Table 4.3 where Respondent 33 and Respondent 64 are used to illustrate this occurrence.

Table 4.3 Question 3 Format 2 Analysis Examples: 5 or more roles per GP (Source: Analysis of survey data)

Respondent Identity	Code Description	Sub-code Description
33	Chair	Vice chair
33	Lead	Clinical lead on cardiovascular
33	Lead	Clinical lead on governance
33	Lead	Clinical lead on mental health
33	Lead	Clinical lead on primary care

Respondent Identity	Code Description	Sub-code Description
33	Lead	Clinical lead on training & education
64	Board Member	
64	Chair	Vice chair
64	Lead	Clinical lead for primary care
64	Lead	Clinical lead for urgent care
64	Lead	Lead for finance

GP involvement in various committees

On the next question, the respondents were asked about their involvement at various committee levels at their local CCGs. A combined total of 69.9% indicated that they sat on the Governing Body. This total was made up of the two sections specified in the questionnaire – namely, the GPs who exclusively sat on the Governing Body and the GPs who sat on both the Governing Body and another additional committee. On the surface, one would assume that a high proportion of respondent GPs in the Governing Body could be beneficial to the decision-making process seeing that the Governing Body forms part of, or is the final point where decisions are either made or ratified, depending on the setup of individual CCGs. While this may be true, it is not necessarily the case as there may be conditions to that, depending on whether the GPs in question also sit on other committees like commissioning committees that may limit their freedom due to factors like conflicts of interest.

Still on the committee involvement, about a third (30.1%) of the participants indicated that their engagements in their local CCGs had nothing to do with the Governing Body. The implication of this from the position of the current study is that the influence of the GPs in question to decision-making processes was possibly minimal when the consideration that the final decisions are ratified at Governing Body level is made. The good thing about this discovery though is that it adds to existing knowledge regarding the roles occupied by GPs in the CCGs, to the best knowledge of the researcher.

Figure 4.5 displays a breakdown of the various committee involvements that the GPs have in their local CCGs.

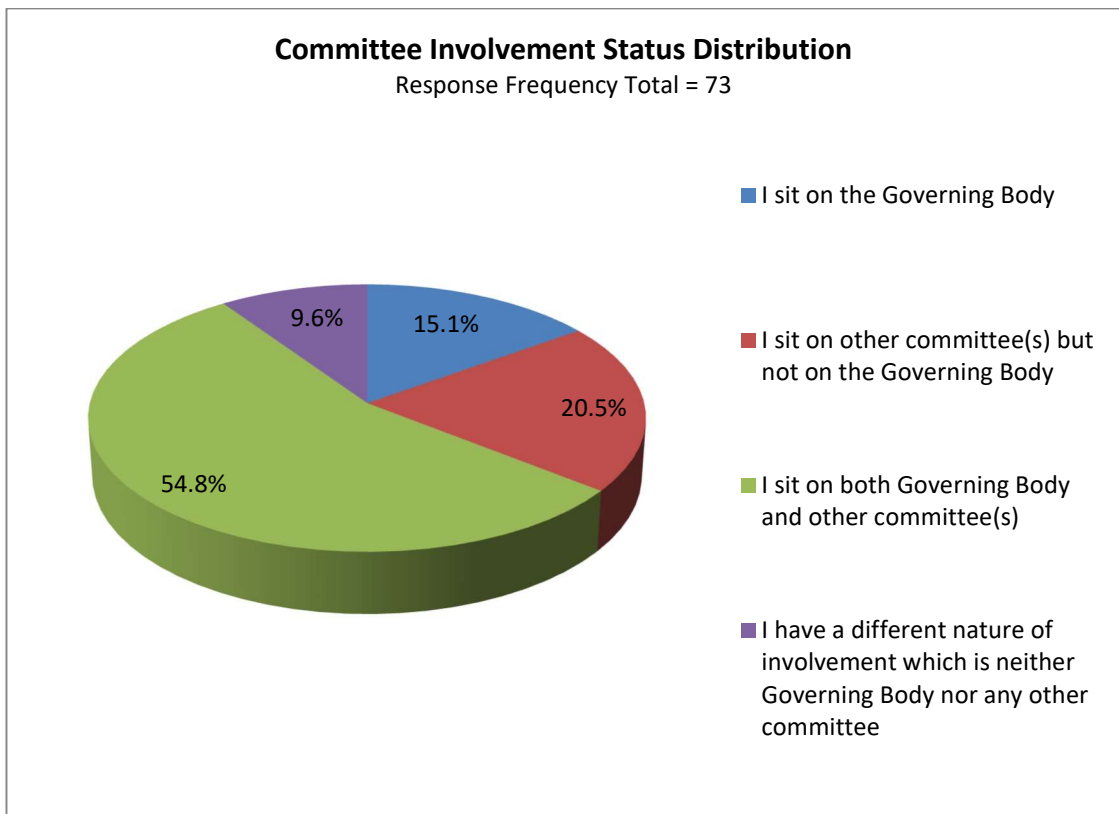


Figure 4.5 Committee Involvement Status (Source: Analysis of survey data)

The next phase on the question of committee involvements sought to understand the other committees outside the Governing Body that the participants sat on. This question was open-ended and optional. It was set to be completed by the respondents who indicated that they sat on both the Governing Body and other committees, or that they sat on other committees but not the Governing Body. A total of 54 participants attempted this question. The various committees that the participants listed were assigned into 23 distinct groups, illustrated in Figure 4.6. The description of the codes used in Figure 4.6 is outlined in Table 4.4.

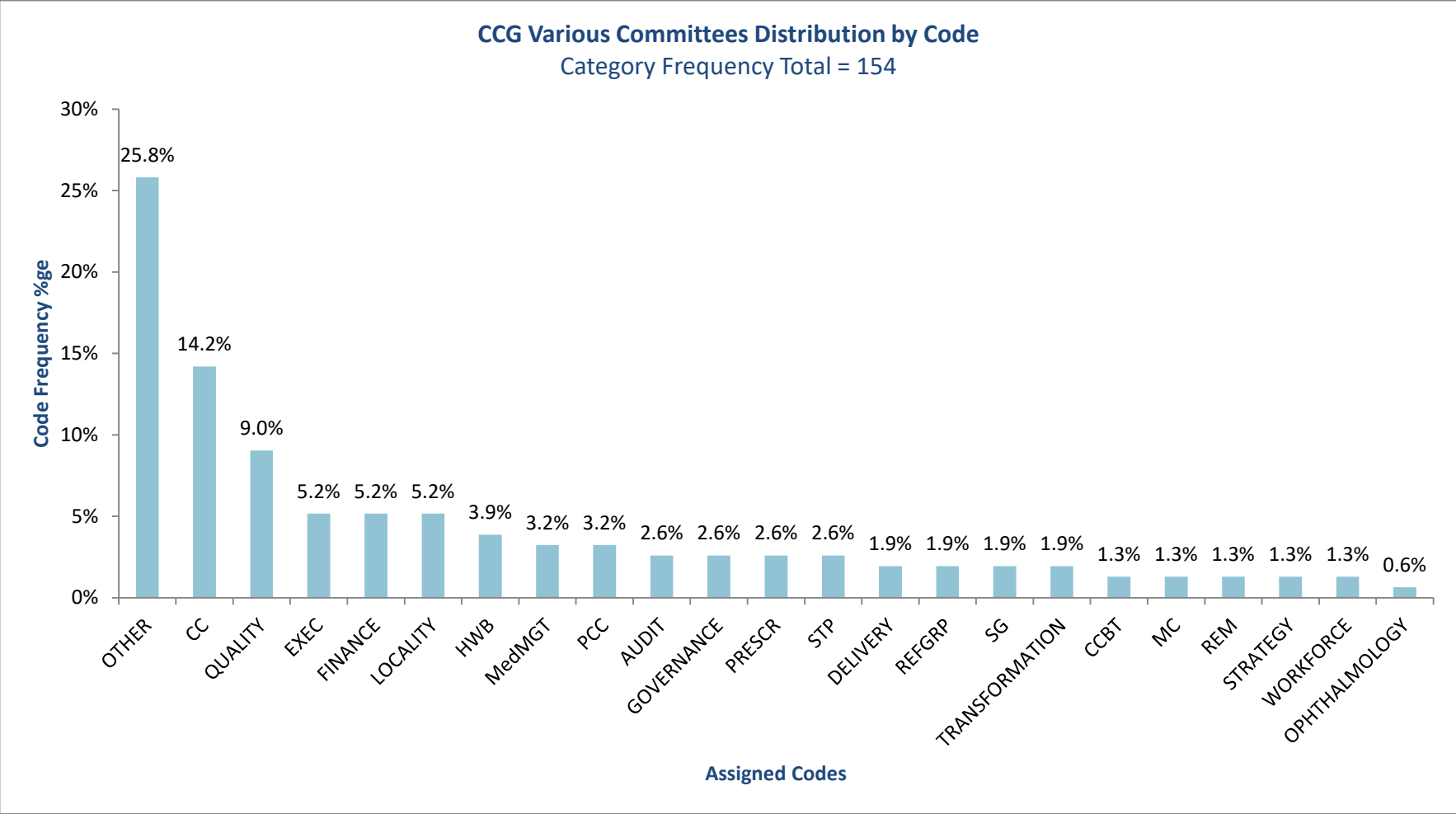


Figure 4.6 CCG Various Committees (Source: Analysis of survey data)

Table 4.4 Question 4b List of CCG committees

Assigned Code	Question 4b Assigned GP Committee Codes
AUDIT	Audit
CCBT	Clinical cabinet
CC	Commissioning Committee
DELIVERY	Delivery
EXEC	Executive
FINANCE	Finance
GOVERNANCE	Governance
HWB	Health and Well Being
LOCALITY	Locality
MedMGT	Medicine Management
MC	Membership Council
OPHTHALMOLOGY	Ophthalmology
OTHER	Other
PRESCR	Prescribing
PCC	Primary Care Committee
QUALITY	Quality
REFGRP	Reference Group
REM	Remuneration committee
SG	Steering Group
STRATEGY	Strategy
STP	Sustainability and transformation partnerships (STPs)
TRANSFORMATION	Transformation
WORKFORCE	Workforce

The code OTHER displayed in Figure 4.6 had the highest frequency ratio of 25.8%. This code represented a group formed up of a collection of committees which had a count of 1 on analysis. A total of 38 discernible committees were represented in this category and these included, Assurance, CCG Clinicians Group, Clinical Guidelines, Charitable Funds, Clinical Effectiveness Group, Clinical Pathway Development, Clinical Policy, and Clinical Senate. It should be noted that these 38 committees were extrapolated at ‘face value’ from the respondents’ answers, hence referring to them as discernible committees. In other words, there is no way of telling if the different names could be denoting the same or very similar functions.

The code Commissioning Committee (CC) had the second highest frequency ratio of 14.2%. Likewise, this group was composed of commissioning committees of different settings such as Joint Commissioning Committee, Mental Health Commissioning, and Children's Joint Commissioning Group, for example. This trend of a descriptive identifying character in each group was displayed in most of the committees that were identified. A full list of all the committees that were identified with associated details that are at respondent level can be seen in Appendix 7.2. Some of the respondents did not name the committees that they sat on but only mentioned that the committees were too many for them to record while, of note, one respondent stated that their CCG "Committees have strange names" (Respondent 61). Unfortunately, the respondent in question did not supply the committee names that he or she considered strange!! When comparing these results to those of older studies, this discovery ties well with Checkland et al. (2016, p.4), who asserted that "GPs roles were many and various". What is more, elsewhere McDermott et al. (2015, p.30) suggested that "asking what the role of GPs is or should be in CCGs is a complex question with as many answers as there are CCGs"; a fact which the current study has strengthened.

Another dimension that the current study sought to achieve was to explain the perceived weight of responsibility that the GPs bore with respect to the committees that they sat on. This was achieved by computing the ratio of committees that individual GPs were involved in at their local CCGs. Five groups were developed for this analysis – namely, "1 Committee", "2 Committees", "3 Committees", "4 Committees", and " ≥ 5 Committees". It was discovered that the highest proportion of the participants, accounting for 43.4%, sat in one committee, as illustrated in Figure 4.7 where the rest of the associated ratio breakdown details are displayed. This is an important finding which may be used as a basis for estimating the time that the GPs are likely to devote to the CCG tasks depending on how demanding their allotted roles are. This line of thought is especially pertinent when considering the recommendations that McDermott et al. (2015) made for policymakers where they argued about how expensive the GPs' time is.

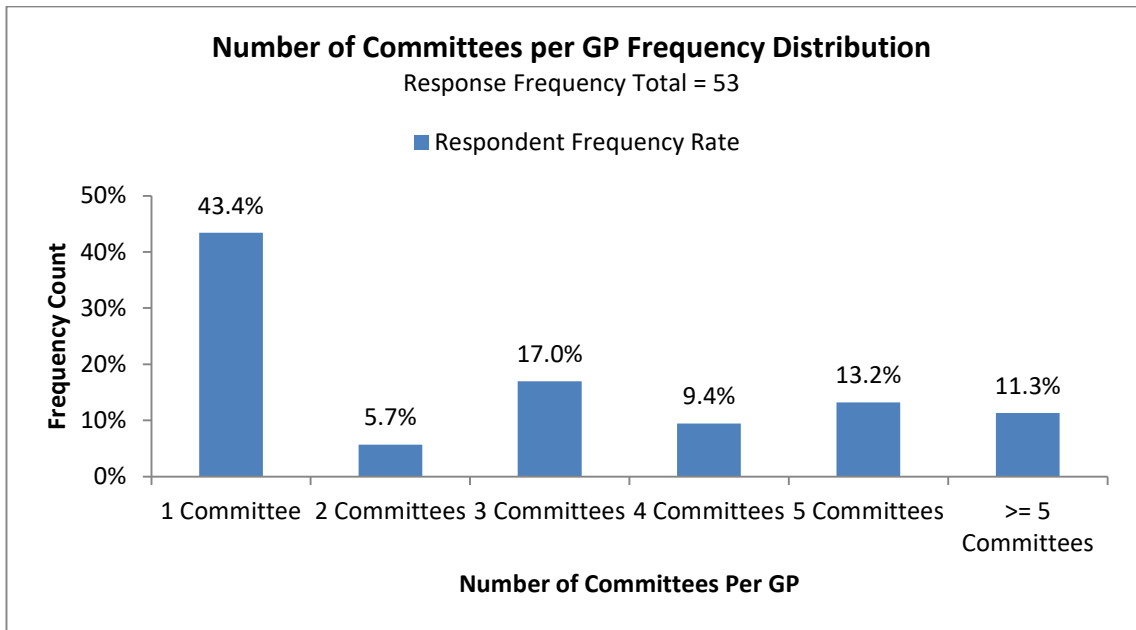


Figure 4.7 Number of Committees Measure per GP (Source: Analysis of survey data)

4.2.1.2 Your CCG's Governing Body

Questions in this section were focused on those participants who sat on the Governing Body. A total of 51 participants said they sat on the Governing Body.

When the participants were asked to indicate what their status was concerning voting in the Governing Body, 98% stated that they were voting members while one respondent said he or she was a non-voting member, as illustrated in Figure 4.8.

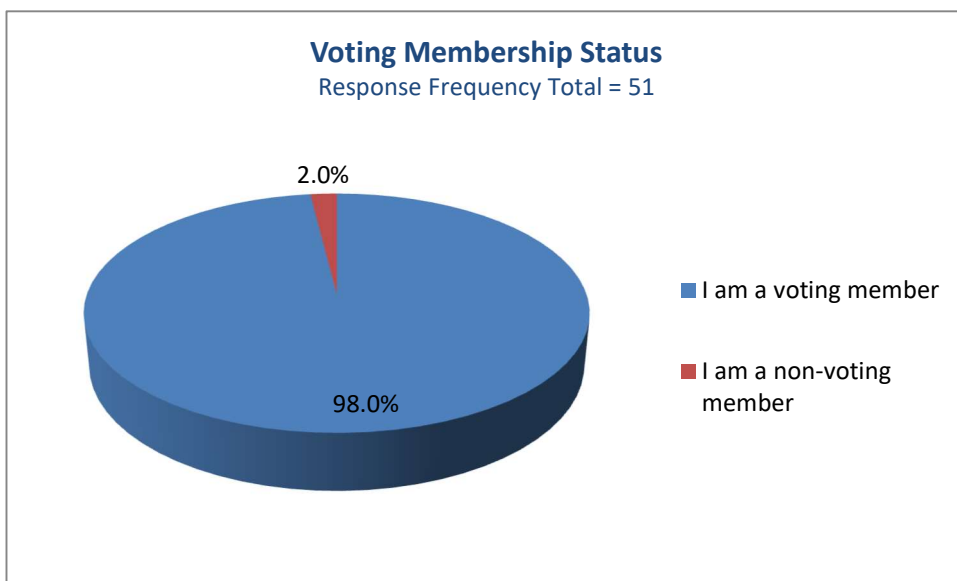


Figure 4.8 Voting membership status (Source: Analysis of survey data)

The interest in the voting status of the GPs was driven by a desire to evaluate the level of representation of clinical interests in the voting platform. While the current study simply sought to understand GP voting status, research by Moran et al. (2017a) gives insight that even if a GP has a status to vote in the Governing Body, it does not necessarily mean that he or she will be able to do so in all motions. This scenario is occasioned by the conflicts of interest which GPs may find themselves faced with. Regarding this issue, Holder et al. (2016) discovered that “One fifth of GPs were concerned about their CCG’s ability to effectively manage conflicts of interest” (Slide 4). On the other hand, Moran et al. (2017a) discovered that, while the conflicts of interest were generally faced in the commissioning committees like Primary Care Commissioning Committee (PCCC), which is different from the Governing Body, membership between the two overlapped in some instances. To manage the conflicts of interest, some CCGs excluded the conflicted GPs from “the discussion and vote for the relevant item” (Moran et al. 2017a, p.10) while other CCGs allowed the conflicted individuals to remain in the room but not vote. Excluding the GPs to vote owing to their conflicted position is an element of note in the factors influencing the perceived effective decision-making process in the CCGs. Whether such impacts the effective decision-making process from the standpoint of this study, requires further research.

Governing Body size

The participants were then asked about the membership sizes of their CCGs’ Governing Bodies. An overwhelming majority of 92.2% indicated that their Governing Bodies had between 11 and 20 members. On the other hand, Governing Bodies with membership less than 10 and those with membership more than 20 each had 3.9% respondents, respectively. Figure 4.9 shows a percentage breakdown of these representations. A study by Checkland et al. (2016) in this respect indicated variation in Governing Body sizes, as demonstrated in the graph below in Figure 4.10. What is more, the same study noted that the sizes of Governing Bodies “appeared to have no clear relationship with CCG size”, a dimension which the current study did not consider.

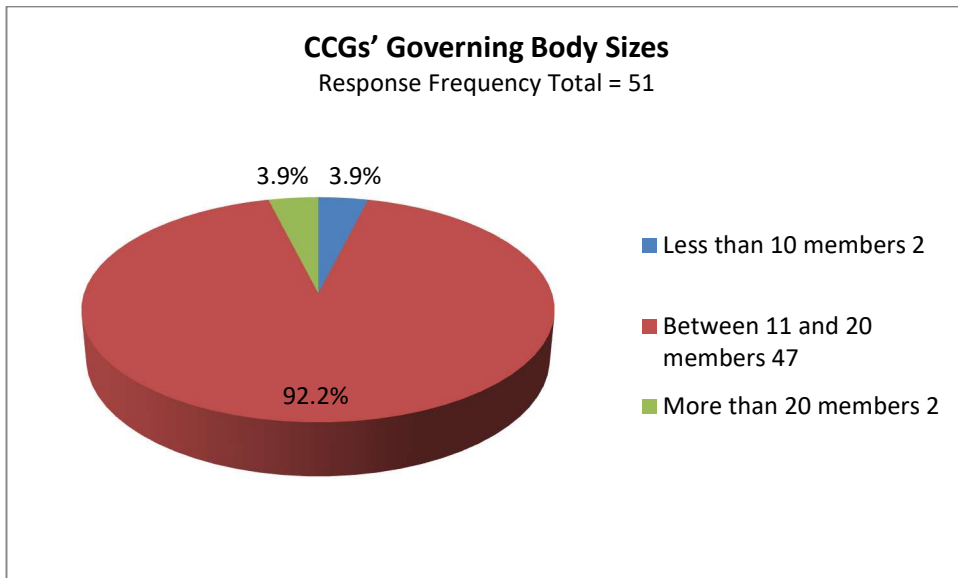


Figure 4.9 CCGs' Governing Body sizes (Source: Analysis of survey data)

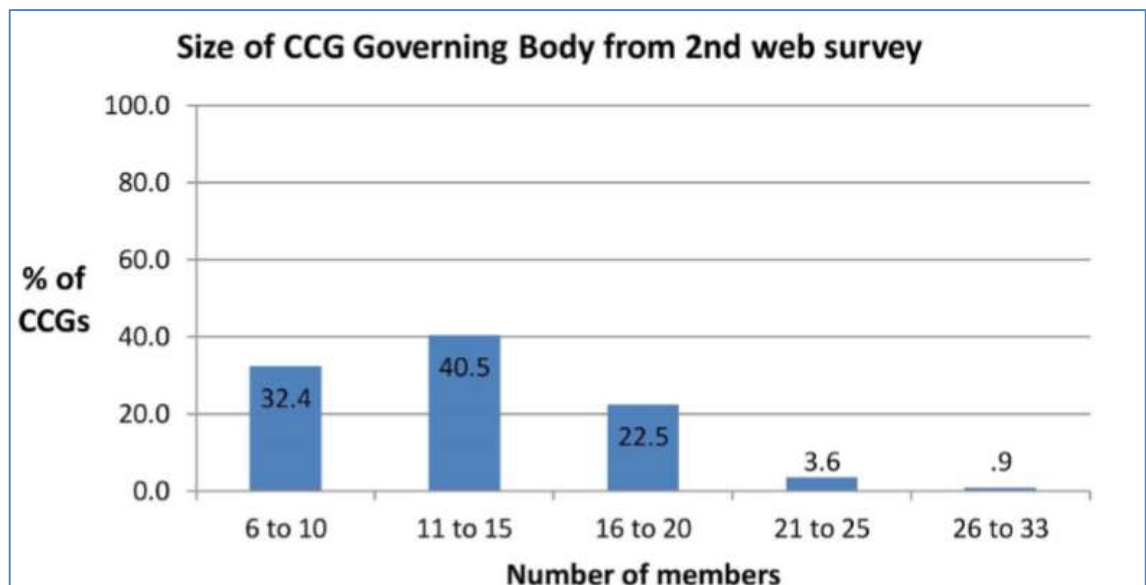


Figure 4.10 CCGs' Governing Body sizes (Source: Checkland et al. 2016)

Governing Body role in decision-making

Inspired by findings from McDermott et al. (2015) study in which different styles of operation at the committee level were discovered, the next question in the current study asked the participants about the way their Governing Bodies functioned in decision-making routines. Particular interest was on whether operational decisions

were actively made in the Governing Body or not. 58.8% indicated that their Governing Bodies were structured to receive reports and suggested decisions for endorsement from other committees. This was by far the largest method of decision-making approach across the CCGs which were represented in the survey. Meanwhile, 25.5% stated that their Governing Bodies actively participated in primary decision-making routines in which operational discussions were made while 15.7% indicated that their Governing Bodies functioned differently from the two above mentioned methods. Figure 4.11 shows a breakdown of these different decision-making approaches.

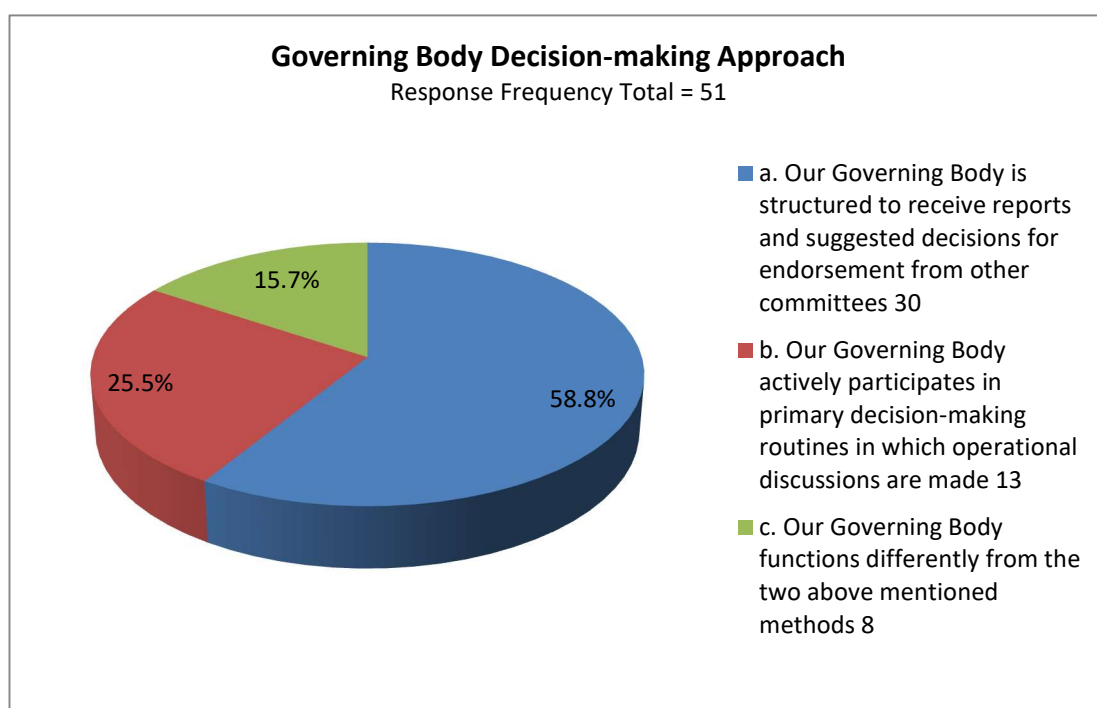


Figure 4.11 Governing Body decision-making approach (Source: Analysis of survey data)

The question of how Governing Bodies function is reviewed at length by Checkland et al. (2016) and McDermott et al. (2015). Aspects like how the meetings are held and where they are held, public or private, and at what frequency rate per given timeframe, are discussed in those articles with supporting empirical evidence of example sites supplied. While the current study did not go into the same level of detail, the results demonstrated in the current study are in accordance with the findings reported by McDermott et al. (2015, p.25) who discovered that some Governing Bodies sign “off decisions made elsewhere ... while others are involved in substantive discussions and operational decisions”. From the results of the current study, it is clear that most of the CCGs’ Governing Bodies are not “involved in

substantive discussions and operational decisions”. This is useful to know as it helps to understand the extent of engagement that the Governing Bodies have in the whole question of decision-making, and therefore to deduce the level of influence that the GPs are likely to have on the decisions made.

GP proportion in the Governing Body

The participants were then asked about the proportion of the GPs in the Governing Body when compared to the rest of the membership. Linked with latent variable *GP Proportion*, this question sought to disclose any possible disproportions within the individual Governing Bodies’ internal structures from the perspective of numeric balance between GPs and other professionals. A bulk of 56.9% indicated that GPs constituted “Between 25% and 50%”. At the same time, there was an equal proportion of 21.6% for each of the other two segments that the question specified. These were GP membership representation of “Below 25%” and GP membership representation of “Between 51% and 75%”. None of the Governing Bodies had a GP proportion of more than 75%. These results tie well with previous studies wherein “the percentage representation of GPs on GBs ... showed considerable variation” (Checkland et al. 2016, p.4). A breakdown of these proportions is displayed in Figure 4.12. It does not appear like the proportion of GPs in the Governing Body has been considered in previous studies.

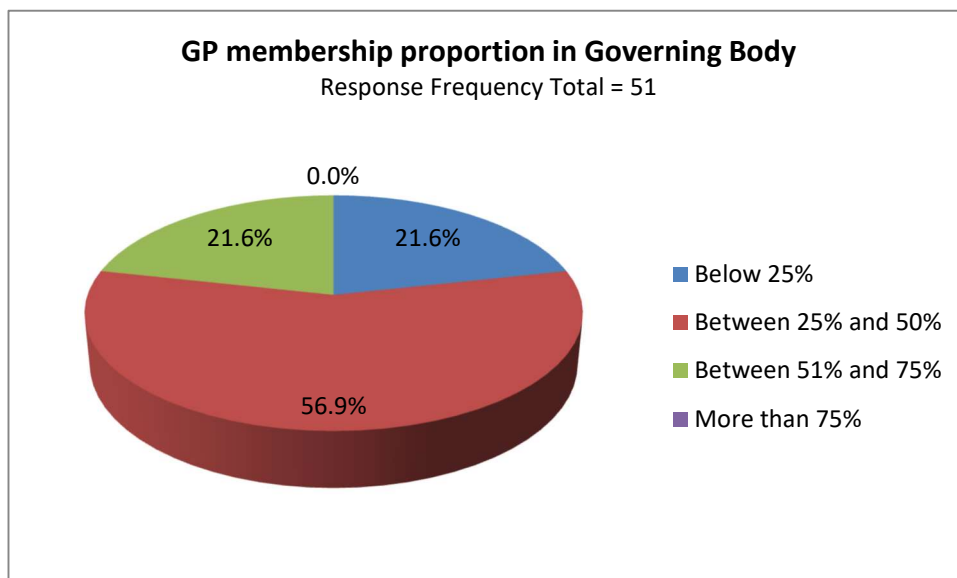


Figure 4.12 GP membership proportion in Governing Body (Source: Analysis of survey data)

Perceived GP level of influence

The participants were then asked to rate the level of influence that they thought the GPs had in their local Governing Bodies in decision-making routines. This question had two links to the conceptual framework discussed in Chapter 2, Section 2.5. Firstly, it linked to the latent variable *GP Influence*, and secondly, it linked to the proposition, “The level of GP influence in the Governing Body will cause a difference in the effectiveness of the decision-making process”. The perceived influence was set to be rated on a scale of 1 to 5, where 1 represented “Minimum Influence” and 5 represented “Maximum Influence”. Most of the respondents thought that the GPs had an above average influence, with a combined total of 52.9% rating the GPs’ influence at 4 or better (see Figure 4.13). While most of the GPs thought their degree of influence was significant, the paradox in this perception is that previous research discovered that the “GPs on governing boards tended to be the least convinced that GPs were influential in the redesign of services” (Storey et al. 2018, p.35). Besides, empirical evidence has indicated that managers, in general, were perceived to be more influential than GPs in committee meetings (Storey et al. 2018; Holder et al. 2016; Naylor et al. 2013).

Turning back to the current study results, a combined total of 11.8% of respondents thought that the GPs did not have significant influence as they rated that level of influence at 1 and 2, depicted in Figure 4.13. The interesting thing worth noting is that just over a third (35.3%) of the respondents rated their views at 3 on the Likert scale, which could be translated as being not sure about the level of influence that their local CCG GPs had.

Combined, the findings of the current study and the previous research discoveries appear to suggest that although the GPs may think that they are significantly influential, that capacity may be overshadowed by other actors in the field such as the managers. Storey et al. (2018, p.87) corroborate this insinuation citing the observations that they made that; “there were a significant number of cases where managers acted as the most influential players”. This does not negate the influence that the GPs in the current study thought they had, a perception substantiated by Storey et al. (2018) who observed that “GPs sitting on the governing bodies were seen

as the most influential of the GP categories” (Storey et al. 2018, p.24). What is more, this same observation is augmented by the comment that “inside the CCGs, respondents were just as likely to judge managers as being the most influential as to judge clinicians as wielding the influence” (Storey et al. 2018, p.93).

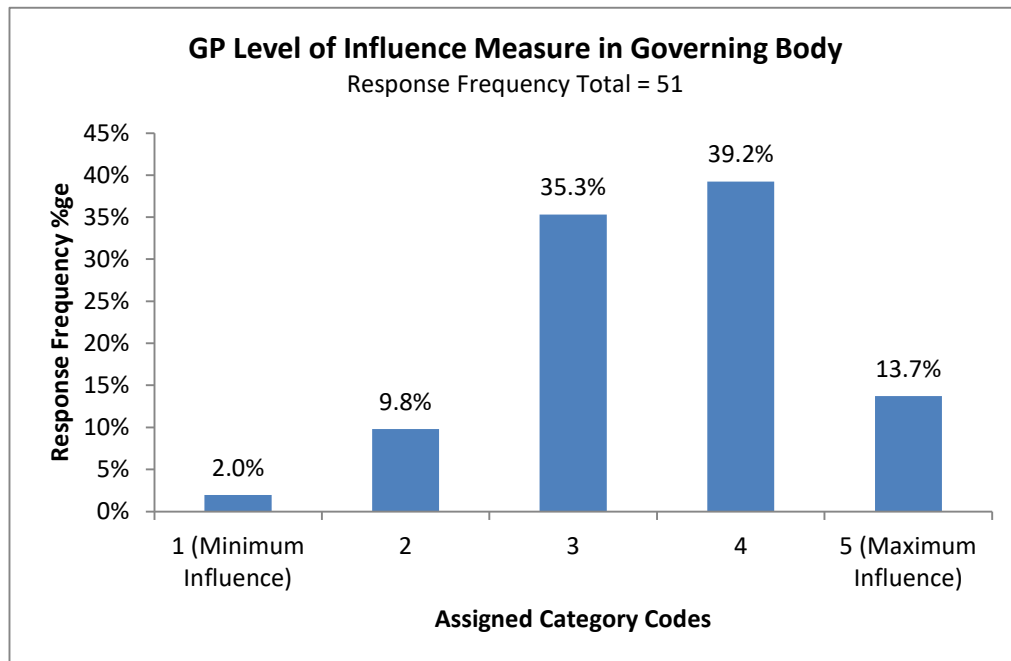


Figure 4.13 GP Level of influence measure in Governing Body (Source: Analysis of survey data)

Is my Governing Body dysfunctional?

Another Likert scale of 1 to 5 was presented to the participants so that each could rate how he or she felt regarding the suggestion that his or her local Governing Body was dysfunctional. The purpose of considering this factor was designed to ascertain the level of attitude that the respondents had about their Governing Bodies which, arguably, may indicate the strength of their local decision-making processes. 1 represented “Strongly Disagree”, and 5 represented “Strongly Agree”. A combined bulk of 76.5% respondents disagreed with the suggestion. This was constituted by those who strongly disagreed in conjunction with those who mildly disagreed, depicted by ratings of 1 and 2, respectively. Figure 4.14 shows a distribution of these ratings. Conversely, 15.7% respondents neither agreed nor disagreed with the suggestion as they rated it at 3, while 7.9% agreed with the suggestion. None of the previous studies that the researcher reviewed seems to have attempted to investigate the views of the GPs regarding the factor of dysfunctionality.

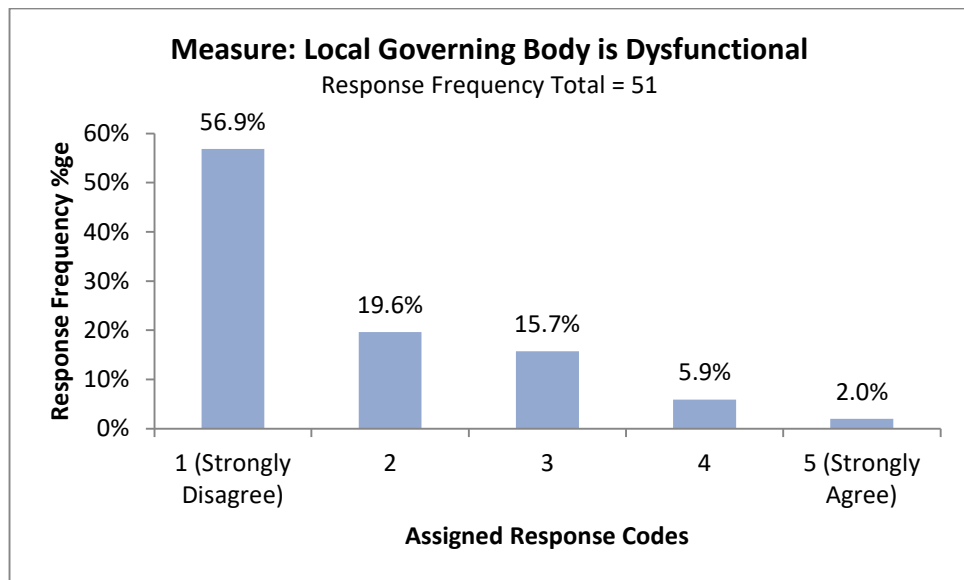


Figure 4.14 Measure: Local Governing Body is dysfunctional (Source: Analysis of survey data)

Are decisions in my Governing Body influenced by a few?

Next, the participants were presented with yet another statement in which they had to express their feelings on a 5-point Likert scale, where 1 represented “Strongly Disagree” and 5 represented “Strongly Agree”. The statement suggested that a few strong personalities influenced decisions in the Governing Bodies of the participants’ respective CCGs. The implied meaning was that if a few strong personalities can influence decision-making in the Governing Body, then that board could be dysfunctional – that is, not balanced in its decision-making approach. A combined total of 52.9% of respondents disagreed with this statement, thereby suggesting a balanced decision-making process. 25.5% of the respondents, however, rated their views at 3 on the Likert scale, which was interpreted as being not sure about the suggestion made. On the other hand, a combined total of 21.6% respondents agreed with the statement, in which 7.8% expressed that they strongly agreed by giving a rating of 5 while 13.7% mildly agreed by giving a rating of 4. Figure 4.15 displays a distribution of these ratings.

There is no evidence in the existing studies that the researcher has reviewed indicating that this factor has been investigated before.

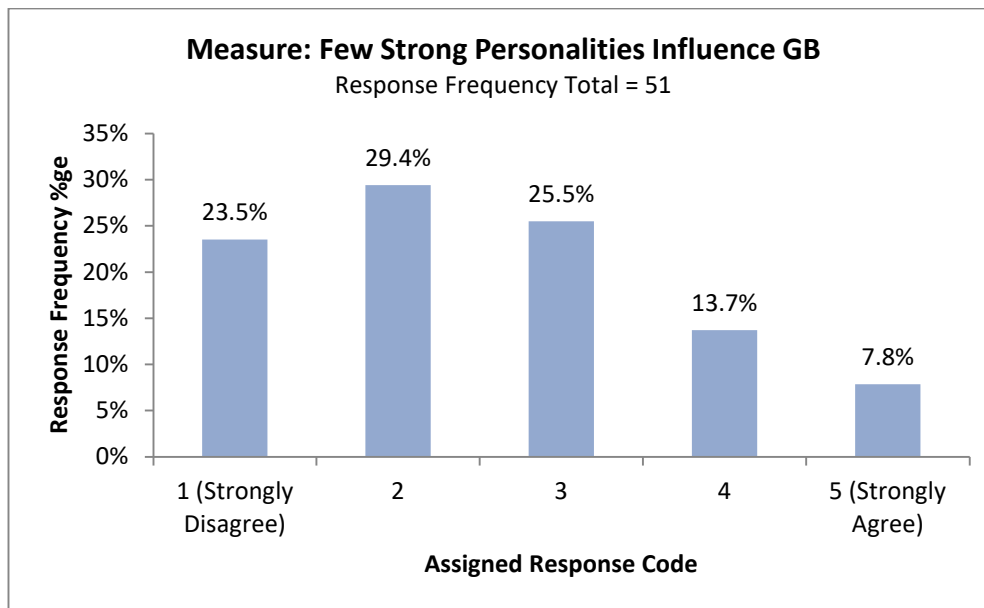


Figure 4.15 Measure: Few strong personalities influence GB decisions (Source: Analysis of survey data)

Do some GB members yield their views to others easily?

Another statement seeking the opinions of the respondents was presented with the suggestion that, to avoid being perceived as violating trust, some members in the participants' respective Governing Bodies yielded their views to their colleagues' choices even if they did not agree with them. While there is no evidence in the existing studies that this factor has been examined before, the desire to establish if some Governing Body members yield their views easily was driven by a discussion in the literature of shortcomings that self-managing teams, organisational setups which CCGs have been likened to in this study, have. For example, some decentralised configurations are said to have a potentially 'crippling' weakness called "negative groupthink" (Pautz & Forrer 2013, p.1), in which the team can fall into the trap of "group decision biases" (Janis 1982, cited in Langfred 2004, p.386). This happens especially in teams where there is a strong cohesion of members. As such, some members who may hold different views to their colleagues' choices may yield their views even if they do not agree with what has been tabled to avoid being perceived as violating trust.

Regarding this factor, respondents in the current study had to rate their opinions on a 5-point Likert scale, in which 1 represented "Strongly Disagree" and 5 represented "Strongly Agree". A combined total of 72.6% disagreed with this suggestion, which

implies a healthy atmosphere of decision-making. The interesting thing is that of all the loci on the Likert scale which were presented to the respondents, the highest incidence of response was on those who disagreed strongly as they rated their opinion on 1, constituting 43.1%. Another interesting observation was that, while there were indications of this phenomenon taking place in some CCGs, such was relatively very low in relation to the whole sample data in this study, with a combined proportion of 15.7%. A distribution of these ratings is displayed in Figure 4.16.

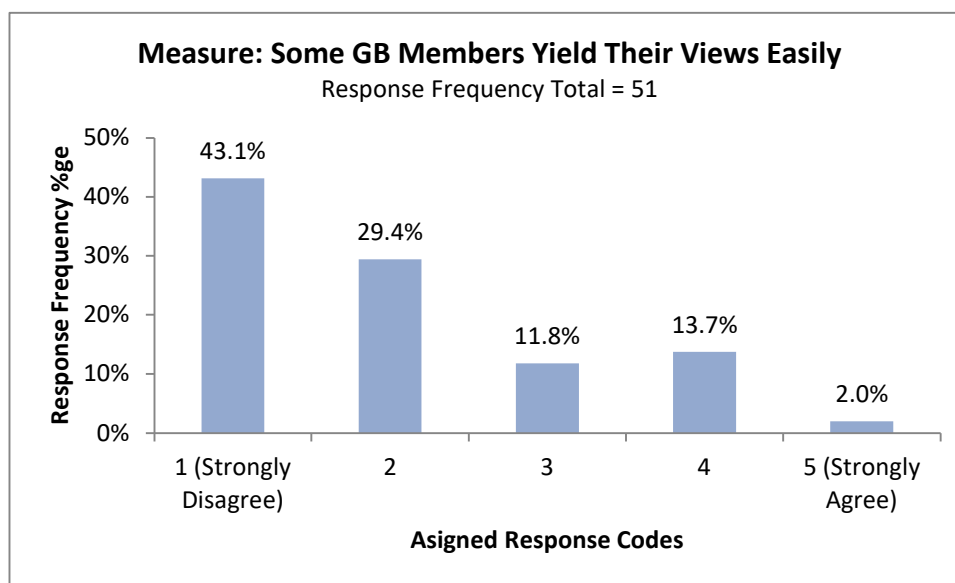


Figure 4.16 Measure: Some GB members yield their views easily (Source: Analysis of survey data)

Are decisions vetoed by senior officials?

When the participants were asked if there was ever a time, to their knowledge, where a senior authority or a government official used his or her power to veto decisions that their Governing Body made, 86.3% said no while 13.4% said yes (see Figure 4.17). Linked to the latent variable *Higher Authority Control* (Chapter 2, Section 2.5), the purpose of this question was to ascertain if senior authorities exercised bureaucratic control by interfering with the decision-making process at the step of authorisation of decisions, as per Mintzberg (1979) control of decision-making process continuum (see Figure 2.7). The imposition of decisions by a higher authority is a characteristic of a top-down bureaucratic control style. The existence of senior authorities imposing their agenda on the CCGs' decision-making processes has been discovered in the most recent research. Storey et al. (2018, p.60) revealed that, in some instances, senior managers in the CCGs' context are "empowered to take the lead in an assertive way"

crowding out the “bottom-up, clinician-led approaches to service redesign” with top-down plans which consequently are prioritised.

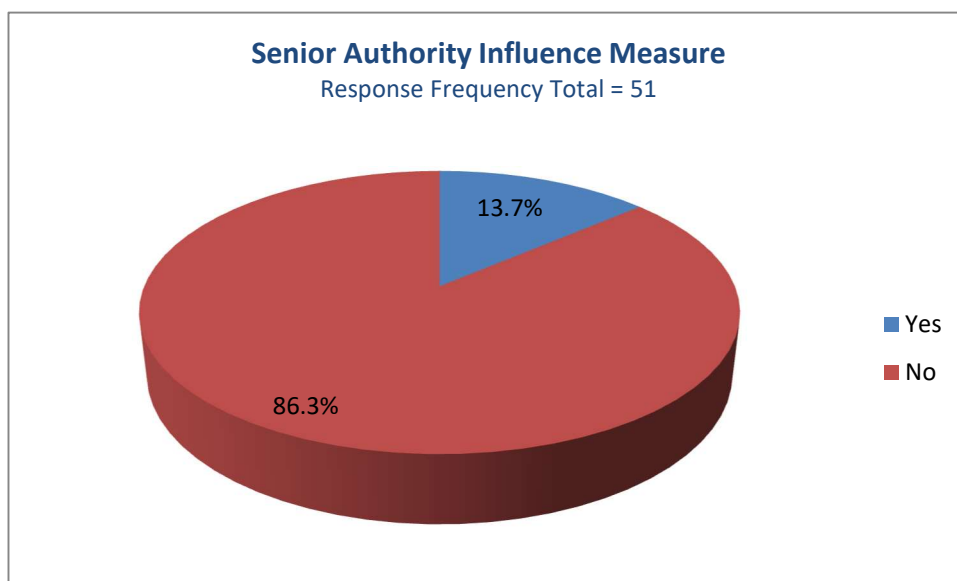


Figure 4.17 Senior authority influence measure (Source: Analysis of survey data)

Existence of unfriendly decisions

Another question was asked in which the participants were to confirm or reject if their respective local Governing Bodies had ever made decisions in the past that they felt were unfriendly to their profession. This question was prompted by previous research conducted a year after the CCGs were launched where it was discovered that the GP Practices were not happy with the policies that the CCGs made. The GP Practices perceived the CCGs as creating policies that “adversely affected their ability to care for patients” (BMA 2014a). As such, the purpose of this question in the current study was to examine if the CCGs still made decisions perceived as unfriendly to the GP profession – that is, decisions which the GPs thought hindered efficient delivery of health care service in the primary care sector. The results indicated that 37.3% of the respondents thought their Governing Bodies made decisions that they perceived as unfriendly (Figure 4.18). It is worth mentioning that at the time, BMA conducted its study on a sample taken from all the GPs, at which point about 30% of the respondents felt that the CCGs were unfriendly to their profession whereas in this study, with a sample from a subset of GPs (those with active involvement in CCGs), the same feeling has persisted. The difference is that the current findings suggest that the percentage of GPs expressing this sentiment has gone up.

Findings from recent studies suggest that there may still be differences between the CCGs and the clinical division of the primary care sector. For example, following their research, Storey et al. (2018) made recommendations which included a closer working relationship between the managers and the GPs. In those recommendations, the managers were proposed to formulate the policies while the GPs would support the process with clinical input.

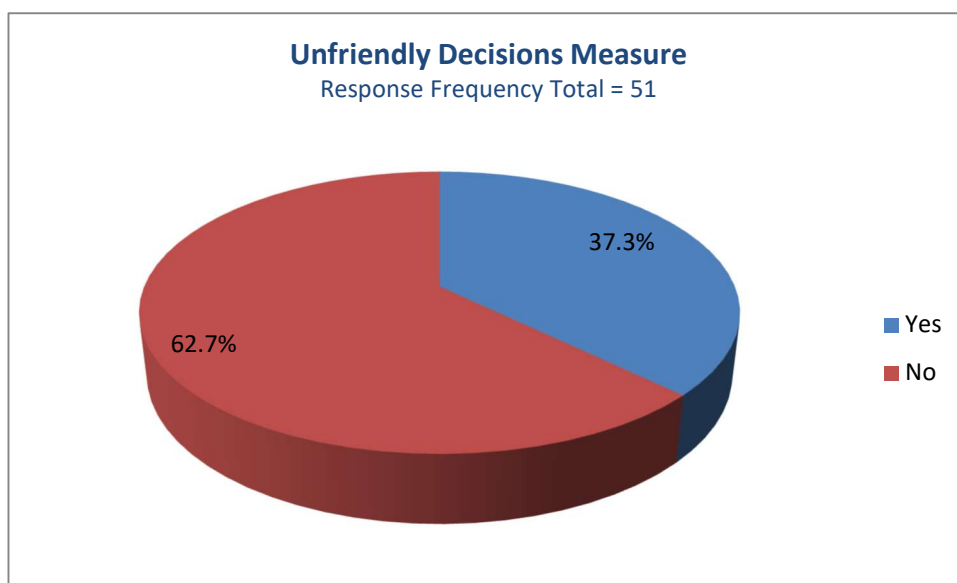


Figure 4.18 Unfriendly decisions measure (Source: Analysis of survey data)

The respondents who indicated that they felt their local CCGs have, in the past, passed decisions that were unfriendly to the GP profession were then asked in an open-ended question to describe the decisions in question. Alongside this, the respondents were asked to define the impact that they thought such decisions had on patient care or in any other aspect in the primary health care delivery. 18 participants responded to this question from which 30 codes were extrapolated after the responses were quantified. Two themes emerged from the responses – namely, reasons for unfriendly decisions and the perceived impact that such decisions may have.

On the reasons for unfriendly decisions, an incidence of 14 codes was observed, with the principal reason being finance (FINANCE), where a proportion of 42.9% was received, as illustrated below in Figure 4.19. Research has repeatedly revealed that the CCGs struggle with budgets (HFMA 2018; HFMA 2017; Wood & Heath 2014), which may explain why unfriendly decisions describing finance as the

context of such are made. At the same time, subsequent research has also indicated “external political pressure ... as a cyclical factor” (Checkland et al. 2018, p.387) subverting the autonomy of the CCGs, a factor which the current study discovered as being the second most described context for unfriendly decisions. Political pressure (PP) had a 28.6% ratio on the described reasons with the other codes being OTHER and Self-interest (SI), constituting 14.3% and 7.1%, respectively. The description attributed under the code “OTHER” included, for example, “Contractual issues around Primary Care” (Respondent 73). Some responses to the question could not be categorised under any usable codes and were thus labelled as not applicable (N/A), accounting for a proportion of 7.1% as displayed in Figure 4.19.

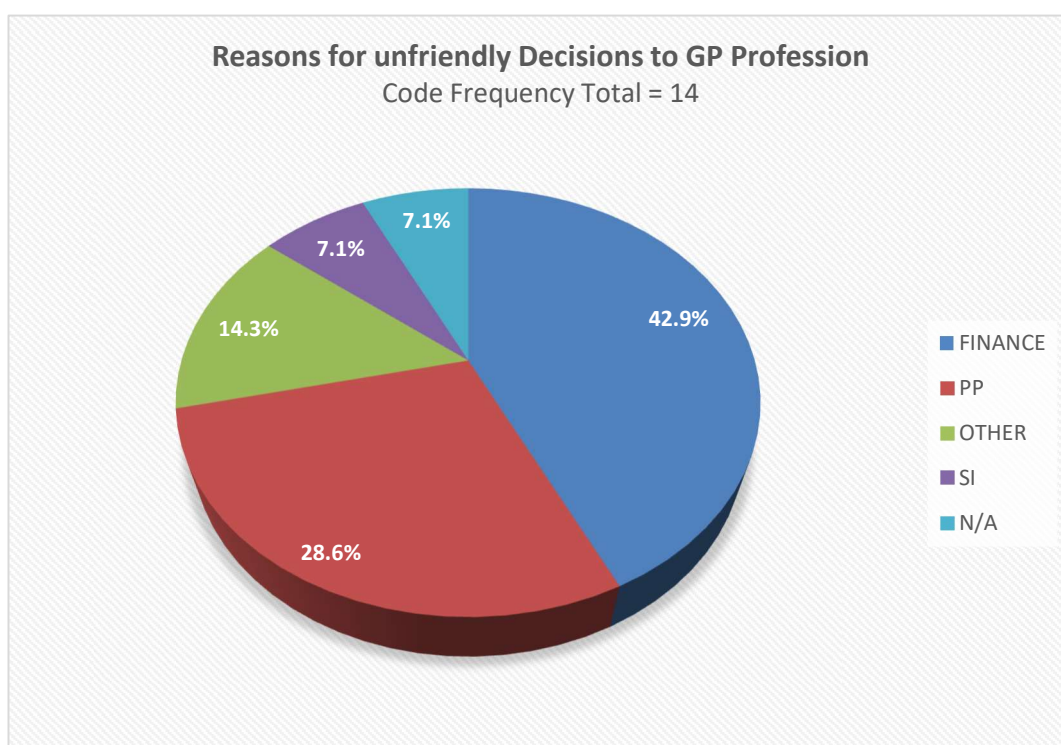


Figure 4.19 Reasons for unfriendly Decisions to GP Profession (Source: Analysis of survey data)

Concerning the perceived impacts that the unfriendly decisions were likely to have, 16 occurrences of the extrapolated codes, which were two in number, were identified. The leading perceived impact was detriment to patient care (PTNTCARE), which accounted for a proportion of 62% of the respondents’ views, as demonstrated below in Figure 4.20. The other perceived impact was jeopardy to doctors (DOCJPD), with a

proportion of 38%. A detailed list of unfriendly decisions, along with the associated comments linked to the supplied codes, can be found in Appendix 7.3.

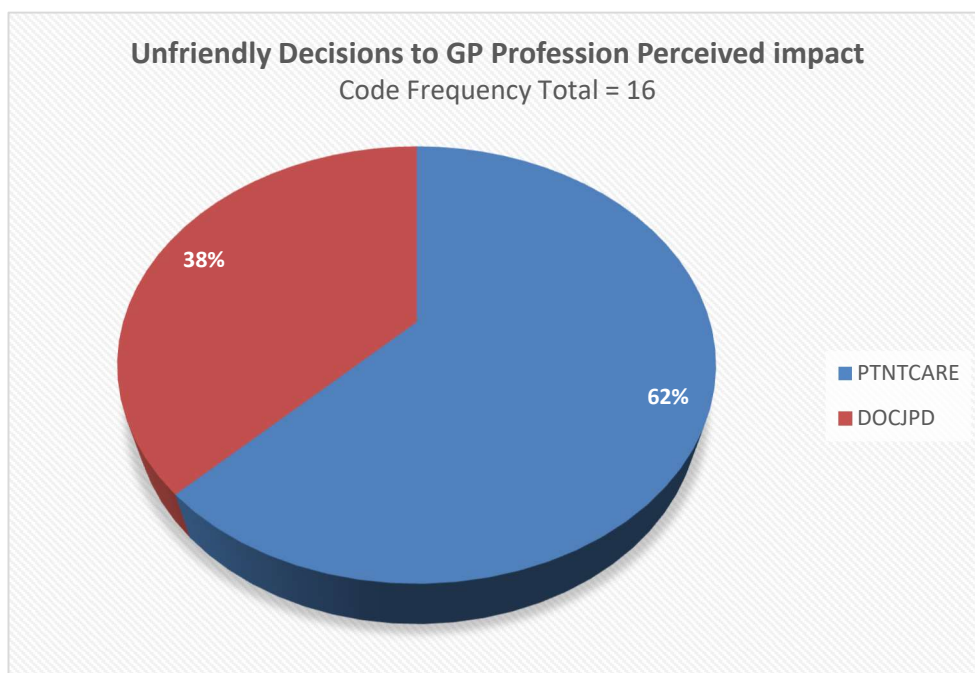


Figure 4.20 Unfriendly Decisions Perceived Impact (Source: Analysis of survey data)

Reasons for unfriendly decisions to GP profession

Another open-ended question explicitly asked the participants about what they thought the reasons for decisions that they identified as being unfriendly and potentially detrimental to the GPs' profession were. When the responses were quantified, most had answers which were categorised under the code financial causes (FINANCE), with that accounting for a proportion of 33.3% in the codes pool. This high incidence attributing finance as the leading cause of unfriendly decisions substantiates the specific descriptions of the same that the respondents gave in the previous question. As alluded earlier, CCGs have been found to operate under severe financial strain. Following financial reasons, the next code that had the highest frequency rate was other (OTHER), with a proportion of 22.2%. Items which were collected under this code were those that were mentioned only once in the received answers. They included aspects such as lack of leadership, patient safety, hitting of targets, and excessive scrutiny that the primary care receives from the statutory bodies. Code, lack of clinical understanding (LCU), was also identified on the answers as a reason for unfriendly decisions, with that receiving a proportion of 18.5%. LCU had to do with

decisions that ignored the clinical factor. This is worth considering seeing that in previous studies (BMA 2014a) the CCGs were perceived as making it difficult for the GP Practices to deliver their patient care efficiently. Political control (POLCNTRL) and misbalanced authority (MA) were also identified on the answers, with these respectively accounting for 14.8% and 7.4% proportions on the codes pool. Finally, there was a proportion of 3.7% of the responses which were categorised as not applicable (N/A), as they were unusable in the context of the current question. Figure 4.21 displays a breakdown of these distributions.

A detailed list of the codes of the reasons that were supplied along with the related comments can be seen in Appendix 7.4.

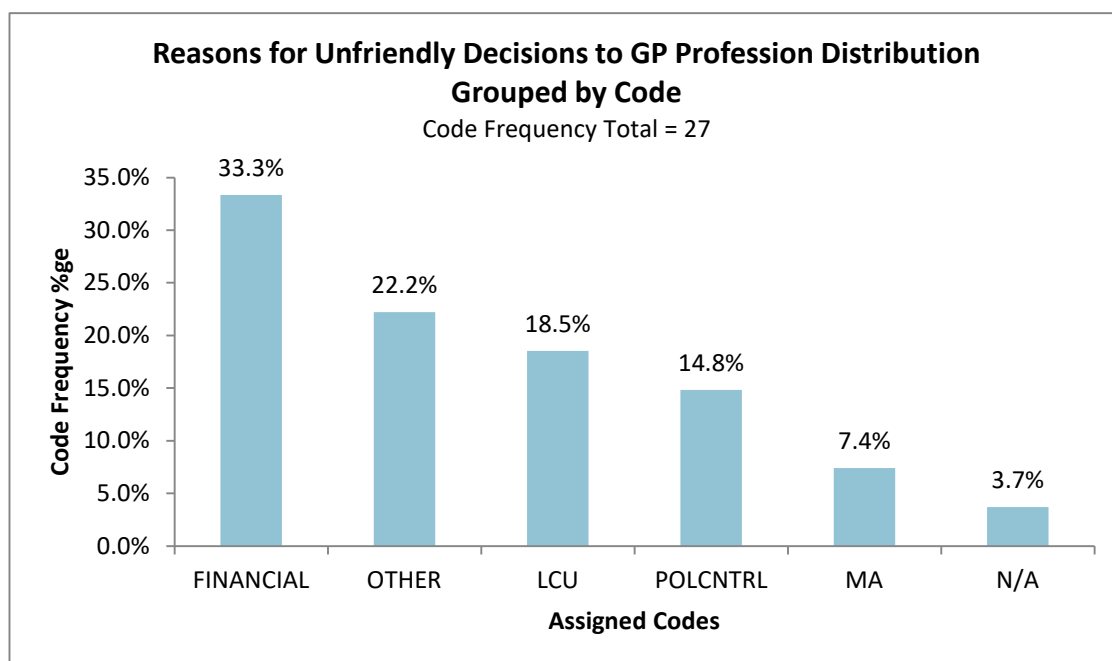


Figure 4.21 Unfriendly decisions to GP profession by codes (Source: Analysis of survey data)

4.2.1.3 General questions on decision-making

The questions which were asked from this point on were each answered in their entirety by 73 participants, Governing Body members and non-Governing Body members alike. These questions were intended to gather the data to complement the findings collected from questions which were specific to the Governing Body members.

Mechanisms for moderating dominating characters in decision-making routines

First, an open-ended question was asked in which the participants were to describe the mechanisms that they had in place to check that no persona or office in their CCG domineered others in decision-making routines. When the responses were quantified, 13 codes were extrapolated (see Table 4.5), all jointly appearing 113 times in the answers that the respondents gave. Most of the derived codes fell under the category where no mechanisms (NONE) in participants' CCGs were in place to deal with domineering personalities. This accounted for a 20.4% proportion, as displayed in Figure 4.22. Next in the ratings was code 'Overseen by Leadership' (OBL) with 16.8% frequency rate. Examples of checking mechanisms in this code included things such as "An alert chair who ensures all voices are heard", and "Exceptional AO [Accountability Officer]". Most of the responses under this code (OBL) mainly related their mechanisms to the aptitude of the chairperson. These views are consistent with what previous studies have discovered. For example, McDermott et al. (2017, p.7) identified the importance of good leadership, about which they argue that it proffers "a facilitative environment which assures GPs that it is safe and easy to express their concerns, and contribute to or attend meetings". The rest of the codes and the related ratings can be seen in Figure 4.22.

A detailed list of the codes derived from the answers to this question along with the related traits from individual responses of the participants is in Appendix 7.5.

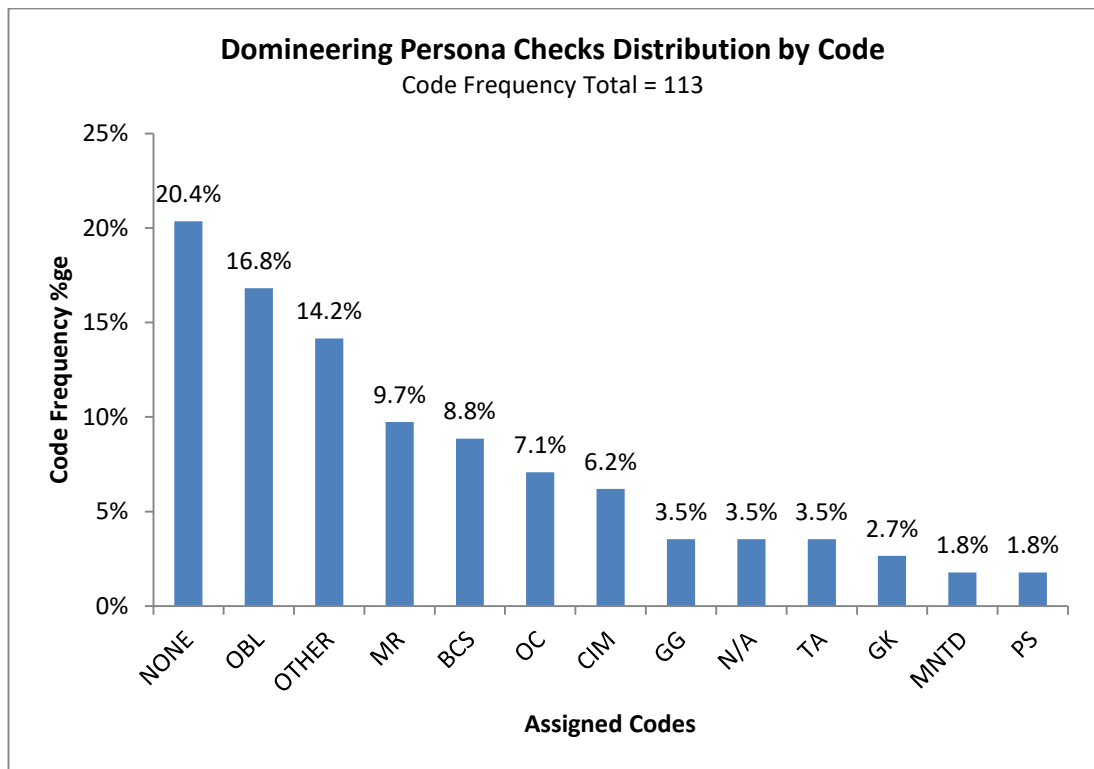


Figure 4.22 Domineering Persona Checks (Source: Analysis of survey data)

Table 4.5 Domineering persona checks code list (Source: Analysis of survey data)

Question 17 Assigned Code	Code Description
BCS	Balanced Committee Structure
CIM	Conflict of interest management
GG	Good governance
GK	Gate Keeping
MNTD	More needs to be done
MR	Mutual Respect
N/A	N/A
NONE	None
OBL	Overseen by Leadership (e.g. Chairperson/Accountability Officer)
OC	Open Culture
OTHER	Other
PS	Procurement Support
TA	Tiered Approach

Member practice wishes versus CCG decisions

The respondents were then asked to express their opinions regarding whether the decisions made by their local CCGs reflected the wishes of their CCGs' members (GP Practices). This question acted as a follow-up probe to the BMA (2014a) study findings where it was discovered that the GP Practices perceived the CCGs as formulating policies that "adversely affected" the ability to provide effective patient care. A 5-point Likert scale was given where 1 represented "Strongly Disagree", and 5 represents "Strongly Agree". A bulk of 41.1% of respondents indicated that they neither agreed nor disagreed with this suggestion by giving a rating of 3. From this, it appears like most of the GPs' decisions were in the middle, which was construed as being not sure if decisions made at their local CCGs were reflective of the wishes of the GP Practices which they represented. Other than this, most of the GPs indicated that they agreed with the opinion that decisions made by their CCGs reflected the wishes of their members. Of these, a combined proportion of 36.9% agreed with the suggestion, with 2.7% of that lot strongly agreeing as they gave a rating of 5 while 34.2% gave a rating of 4. In contrast, those who disagreed – that is, 'Strongly Disagree' and 'Mildly Disagree', had a combined percentage of 21.9%. The intriguing thing worth noting about this whole question is that there were more GPs who strongly disagreed with the statement that the decisions that their CCGs made reflected the wishes of the member practices than those which strongly agreed, with their percentage shares being 8.2% and 2.7% respectively. It is, nonetheless, possible that these observed differences may not be significant if the same question is applied to bigger sample size. Figure 4.23 shows a breakdown of these ratings. Previous research does not show any evidence of specific investigation of this phenomenon except for the inferences derived from the BMA (2014a) findings outlined in the Background section of this thesis in Chapter 1, where CCGs were blamed by GP Practices.

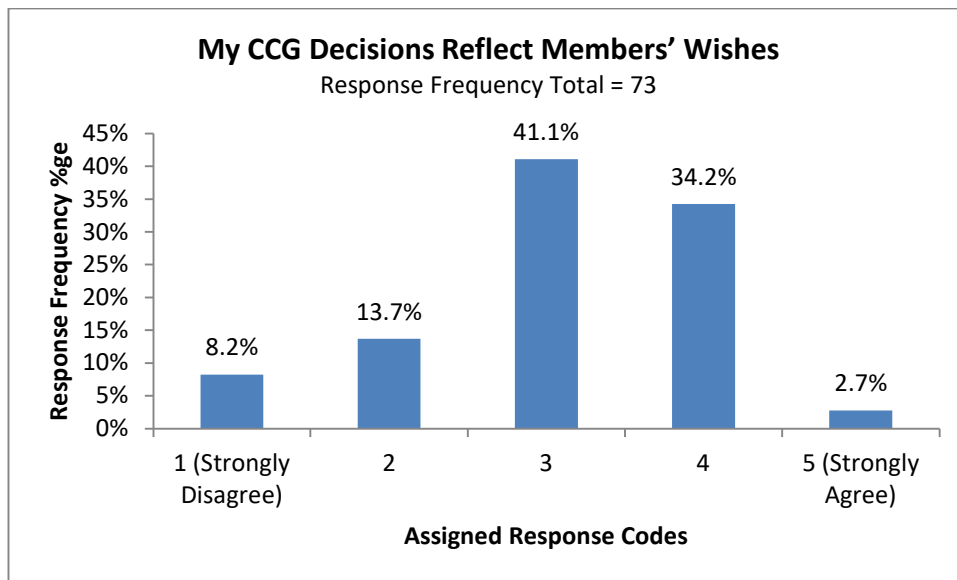


Figure 4.23 My CCG Decisions Reflect Members' Wishes (Source: Analysis of survey data)

Satisfaction about decision-making

Another question based on a 5-point Likert scale sought the respondents' opinions about their level of satisfaction concerning the way decisions were made at their local CCGs. This question was linked to the latent variable *Satisfaction*. It stressed that the kind of decisions referred to did not only apply to those made by the Governing Body but to other decision-making processes as well. Most respondents (61.7%) expressed that they were satisfied. Of these, 9.6% indicated that they were very satisfied as they rated their level of satisfaction at 5, while 52.1% gave a rating of 4, as Figure 4.24 shows.

Getting around two-thirds of the respondents giving positive feedback about the level of satisfaction that they had regarding the way decisions were made in their CCGs is a significant finding. This is so, especially when considered from the standpoint of the BMA (2014a) survey where about 30% of the GP Practices perceived the CCGs as creating policies that "adversely affected their ability to care for patients". A similar sentiment was repeated in the current study by a slightly increased percentage of almost 40%. The striking thing about this is a discernible counterbalance between the two opinions, satisfaction (approximately 60%) and perceived unfriendly decisions (approximately 40%).

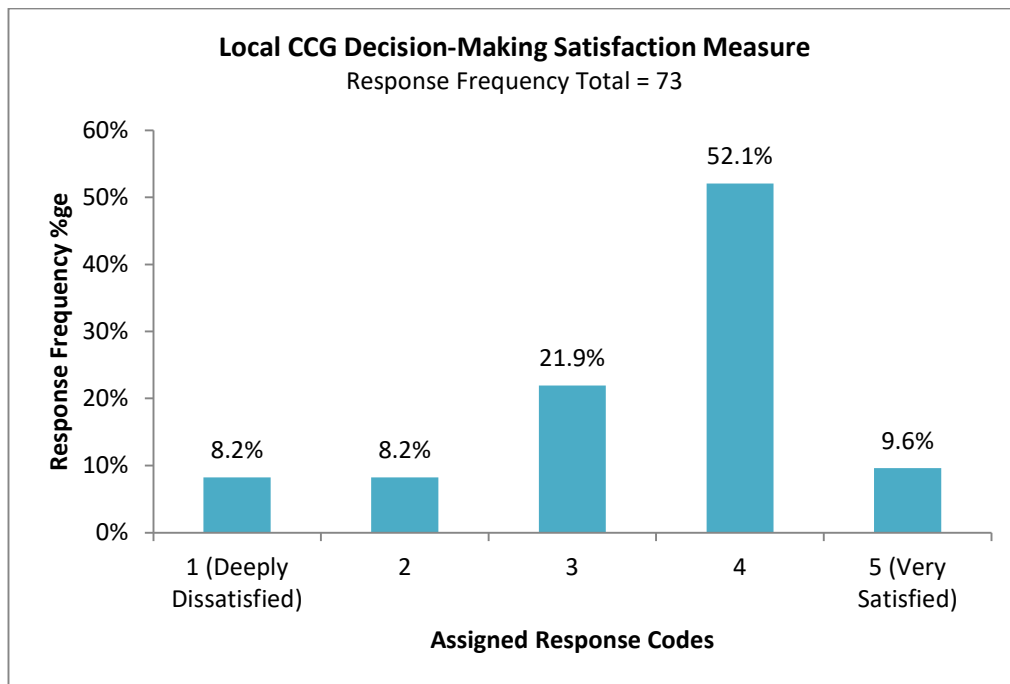


Figure 4.24 Local CCG Decision-making satisfaction measure (Source: Analysis of survey data)

On the surface, the portrayed impression could be that the respondents who perceived their CCGs as making decisions unfriendly to the GP profession are the same who expressed dissatisfaction concerning the way decisions are made at their local CCGs. To establish if that was the case, I performed a simple descriptive analysis, results displayed in Figure 4.25. Contrary to the inferential statistical sense, I have used the term “Correlation” shown in the graph to simply denote if there is a pattern in the way the respondents answered the question about decisions unfriendly to the GP profession and the question about the degree of satisfaction. Table 4.6 shows the description of the correlation statuses used in the x-axes of Figure 4.25.

Table 4.6 Correlation Status Description

Correlation Status	Description
Correlated_DUDE	Correlated – Dissatisfied and Unfriendly Decisions Experienced
Correlated_SNUDE	Correlated – Satisfied and No Unfriendly Decisions Experienced
NonCorrelated_DNUDE	Noncorrelated – Dissatisfied and No Unfriendly Decisions Experienced
NonCorrelated_SUDE	Noncorrelated – Satisfied and Unfriendly Decisions Experienced
Indeterminate	Not possible to establish correlation status

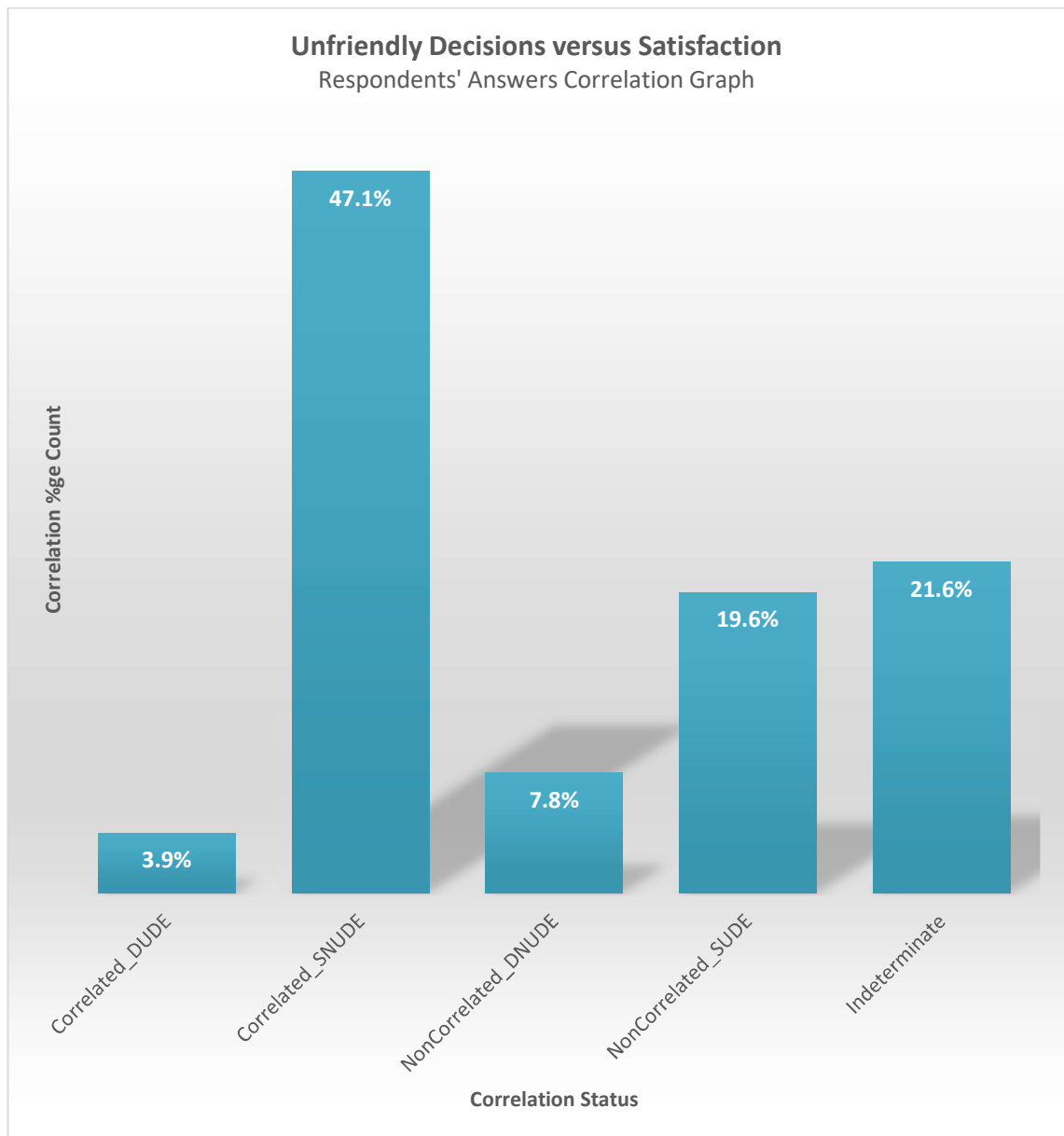


Figure 4.25 Unfriendly Decisions versus Satisfaction (Source: Analysis of survey data)

The results demonstrate that most respondents (51%) either (1) were satisfied with the way decisions were made at their CCGs, and had, along with this, never experienced decisions unfriendly to their profession (47.1%), or (2) they had experienced decision unfriendly to their profession, and, along with this, were dissatisfied with the way decisions were made at their CCGs (3.9%). The results also demonstrate that a sizeable minority (27.4%) had either (1) not experienced decisions unfriendly to their profession yet were dissatisfied with the way decisions were made in their CCG (7.8%), or (2) had experienced decisions unfriendly to their profession yet they were happy with the way decisions were made at their CCG (19.6%). The last group classified under “Indeterminate” are the respondents who selected locus 3 on

the Likert scale on the question about the level of satisfaction. Locus 3, in this case, was seen as denoting “Neither Satisfied nor Dissatisfied”; hence the degree of correlation with the question of decisions unfriendly to the GP profession was interpreted as “Indeterminate”.

An optional open-ended question followed the question about the degree of satisfaction in decision-making explained above. The open-ended question asked the participants to give whatever comments they had about decision-making at their local CCGs. 31 respondents attempted the question. The responses were quantified from which 15 distinct codes were derived, outlined in Table 4.7. The key finding from Table 4.7 is that, although the previous question indicated more respondents were satisfied than dissatisfied, almost all the comments are negative, except ‘Collaborative Decision-making Approach’ (CDA) and ‘Good approval ratings’ (GAR). Of particular note is ‘Member practice GPs disregarded or poorly engaged’ (PMGDPE), which was leading in frequency rate, accounting for 14.3%. Examples of views expressed in that code included “There is no good involvement from practices”, “Our CCG seems to disregard GP views...”, and “We have become disconnected to GP practices”.

Next on the rating was code ‘Imbalanced approach to decision-making’ (IARM) with 11.9% share. Here, respondents expressed views such as “Decisions are made at top level with little consultation and feedback”, “Biased by the people attending, if one person objects I do not feel that their difference in opinion is factored into the final decision that is made”, and “GPs can be excluded from decision making in view of ‘conflict of interest’ but when an officer is making a decision that he knows will affect his future career this isn’t regarded as a conflict of interest”. The rest of the code ratings based on the codes pool of this question can be seen in Figure 4.26.

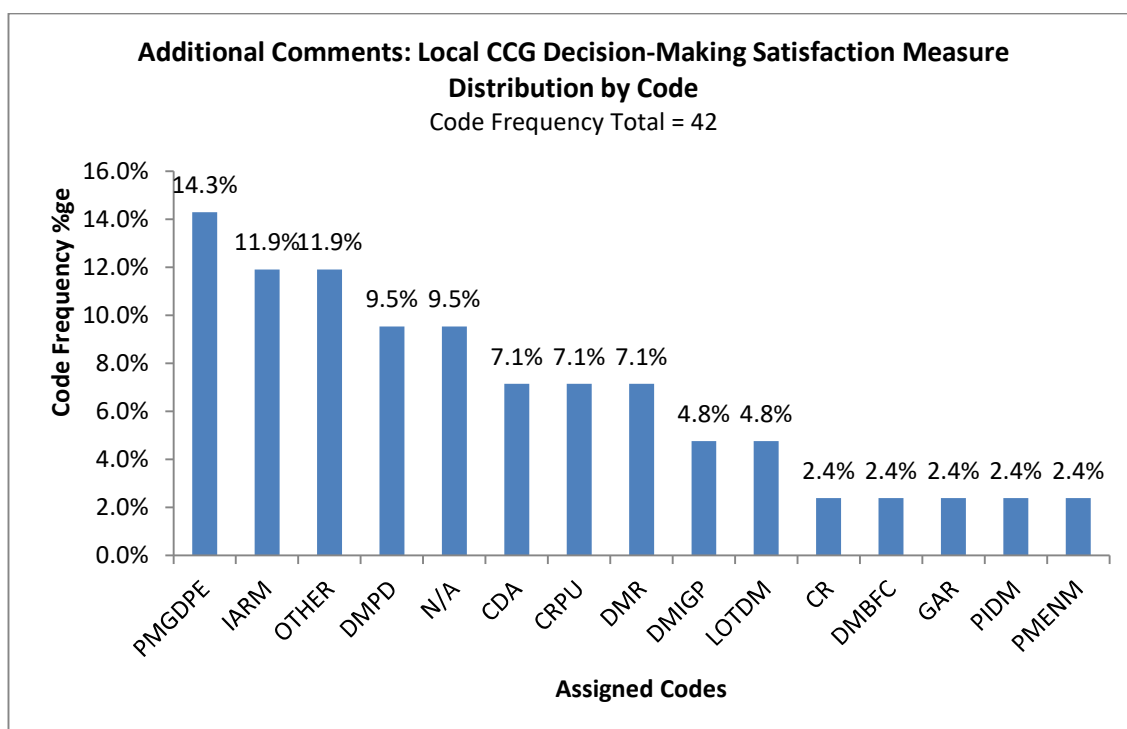


Figure 4.26 Additional comments: Decision-making satisfaction Format 1 (Source: Analysis of survey data)

Table 4.7 Additional comments: Decision-making satisfaction code list (Source: Analysis of survey data)

Question 20 Assigned Code	Code Description
CDA	Collaborative Decision-making Approach
CR	Commissioning responsibility not clear between NHSE and CCGs
CRPU	CCG role poorly understood
DMBFC	Decision-making based on financial constraints
DMIGP	Decision-making influenced by government policy
DMPD	Decision-making politically driven
DMR	Decision-making rushed or poor due to time constraints
GAR	Good approval ratings
IARM	Imbalanced approach to decision-making
LOTDM	Lack of transparency in decision-making
N/A	N/A
OTHER	Other
PIDM	Partially informed decision-making
PMENM	Member practice expectations not met
PMGDPE	Member practice GPs disregarded or poorly engaged

Is my local CCG GP led?

Next, the participants were asked to indicate their feelings concerning this statement, “I feel that my local CCG is GP led as defined in the Health and Social Care Act 2012”. A 5-point Likert scale was provided through which the participants were to express their opinions. 1 represented “Strongly Disagree” with the statement and 5 represented “Strongly Agree” with the statement. A combined total of 49.3% participants agreed with the statement, of which 19.2% gave a rating of 5, while 30.1% gave a rating of 4. Just over 50% of the respondents neither agreed nor disagreed or flatly disagreed with the idea that their CCGs were GP led. A breakdown of these responses is demonstrated in Figure 4.27.

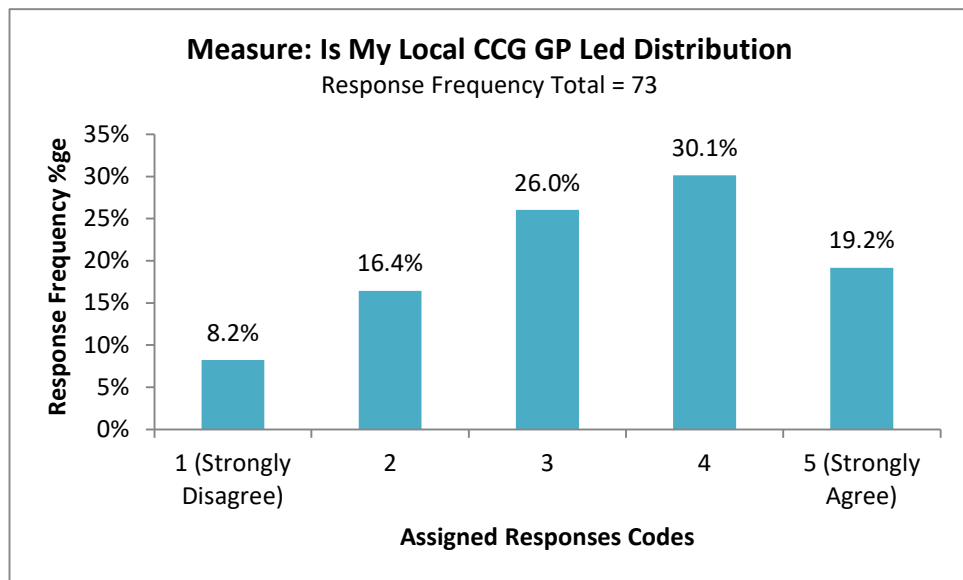


Figure 4.27 Is my local CCG GP led measure (Source: Analysis of survey data)

Commenting on the subject of “GP representation on CCGs being eroded”, published in Pulse website which produces news on British primary health care monthly, one respondent who identified himself or herself as a GP Partner decried the CCGs, arguing that they are not GP led (Rosser 2018). The article in question demonstrated how GP representation in the CCGs is declining over the years, as demonstrated in Figure 4.28 below. This is a useful insight into the current study, notwithstanding that the current study was not focused on indicating trends over time. Meanwhile, studies by Kings Fund and Nuffield Trust are reported to have revealed that some CCGs are purposely “scaling back their GP representation” (Checkland et al. 2016, p.7), with the roles that

the GPs should play increasingly being occupied by managers. Drake (2016) also reports about the same phenomenon of decreased GP representation in the boards. This leaves a question that, if the GP representation is low in the CCGs committees, are the CCGs truly GP led?

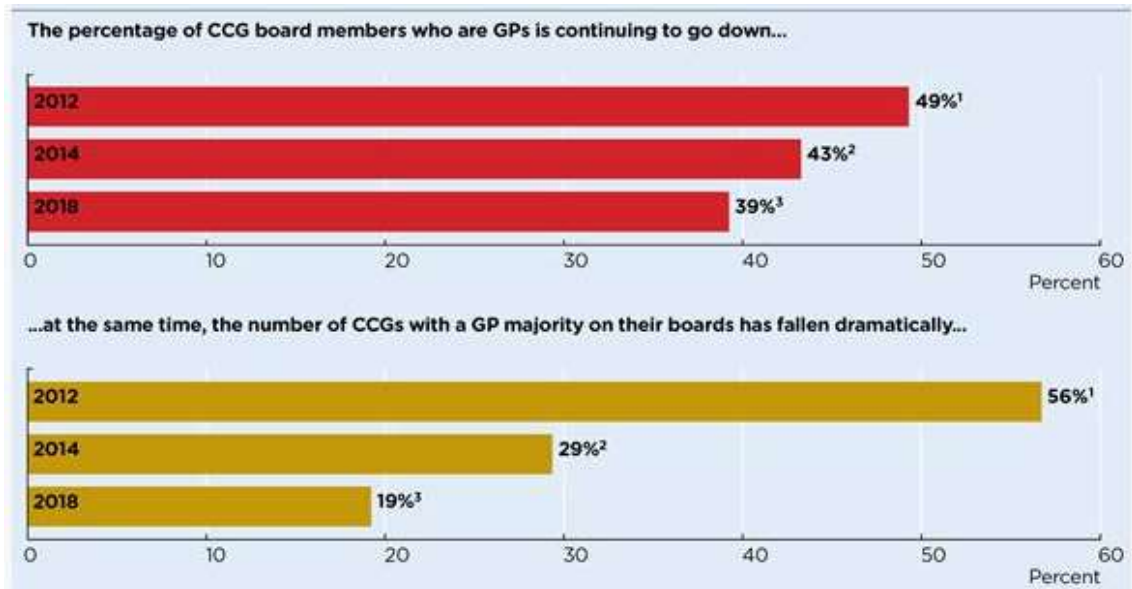


Figure 4.28 Declining GP representation in CCGs (Source: Rosser 2018)

Professional background of the Accountable Officer

The last question in the quantitative strand asked the respondents to indicate the professional background of the Accountable Officer in their local CCG. As discussed in Chapter 2, Section 2.3.7, an Accountable Officer is one of the two shared overall leadership positions in the CCG, the other being that of a Chair. This can be occupied either by a clinician or a manager. For this question, the participants were given four options to select from, and these were “GP”, “Clinician other than a GP”, “Manager”, and “Other”. A majority of 60.3% of respondents stated that their Accountable Officer was a Manager. This was followed by a tie between “GP” and “Clinician other than a GP”; with each option receiving 16.4% responses. Subsequent research has found the same pattern, which reveals that “the number of accountable officers who are GPs has been in steady decline across the country” (Storey et al. 2018, p.50). The same study indicated how rewarding and credible it might be for the clinicians to have a GP in this position. Notwithstanding, the feeling of one respondent cited in that study (Storey et

al. 2018) noted the challenges that this position carries for clinicians, alleging that clinicians are not trained for leadership.

A breakdown of the professional background of the Accountable Officer is shown in Figure 4.29.



Figure 4.29 Accountable Officer professional background (Source: Analysis of survey data)

An option was given to the respondents who indicated their Accountable Officer as being “Other” on the close-ended question to specify what the professional background of that Accountable Officer was. This was to be done on an open-ended question. Five respondents whose answers were “Other” completed this question. The responses were quantified, and two codes were derived. These were “post currently unfilled” (PCU) and other (OTHER). Two respondents contributed to OTHER (Figure 4.30), with one of the answers indicating that their Accountable Officer was a “Former accountant” while the other said they used to have an Accountable Officer “Many years ago”.

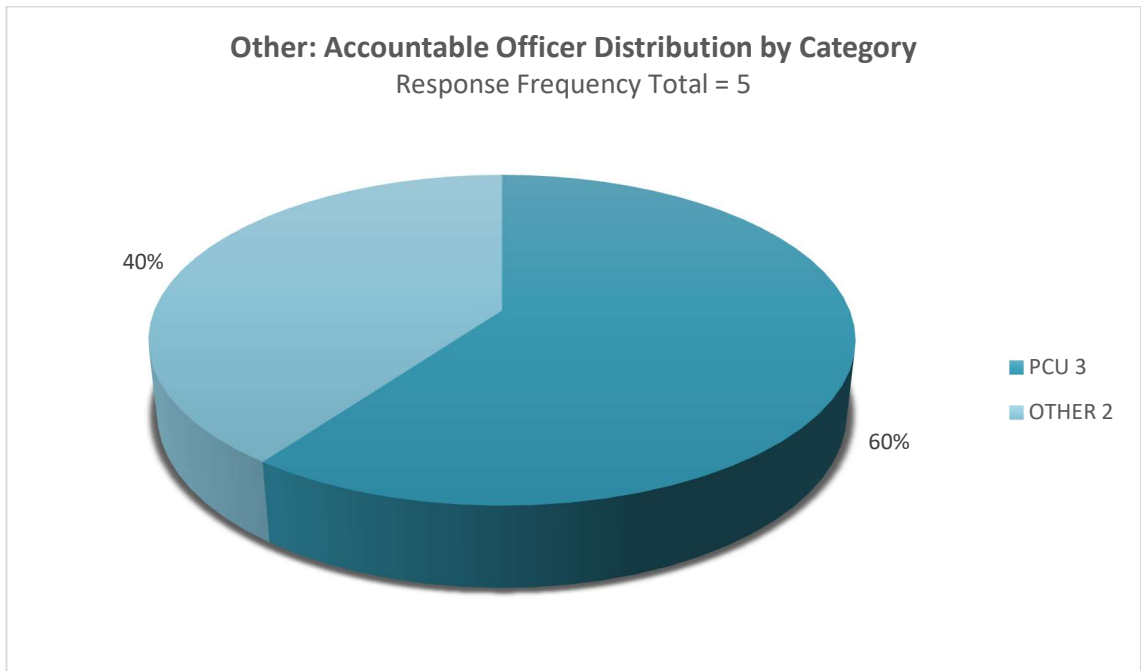


Figure 4.30 Other: Accountable Officer Background (Source: Analysis of survey data)

4.2.1.4 Correlation matrix

Table 4.8 shows correlation coefficients across the different latent variables of the path model developed for this study (see Section 3.6.1.2). Pearson’s correlation, one of the widely used statistical estimators, is here employed. Each value in the matrix represents “the degree of linear relationship between two variables” (Colman 2015). The values range “from 1.00 for perfect positive correlation, through zero for uncorrelated variables, to –1.00 for perfect negative correlation” (ibid). Table 4.9 outlines the criteria, adapted from Hinkle et al. (2003), for interpreting the correlation coefficients. Only positive correlations are defined in Table 4.9. Leading with a very high positive correlation are variables *GP Proportion* and *Decision-making Process Effectiveness* (0.932). A high positive correlation is also demonstrated between variables *GP Proportion* and *GP Influence* (0.837) as well as variables *GP Influence* and *Decision-making Process Effectiveness* (0.800). Also, of interest is a moderate positive correlation between variables *Member Practice Wishes Met* and *GP Influence* (0.572). The rest of the remaining correlations have either low positive or negligible positive correlations or have altogether a negative correlation as demonstrated in Table 4.8.

Table 4.8 Correlation matrix (Source: Analysis of survey data)

	Decision-making Process Effectiveness	GP Influence	GP Proportion	Member Practice Wishes Met	GP satisfaction
Decision-making Process Effectiveness	1.000	0.800	0.932	-0.092	0.031
GP Influence	0.800	1.000	0.837	0.112	0.357
GP Proportion	0.932	0.837	1.000	-0.118	0.055
Member Practice Wishes Met	-0.092	0.112	-0.118	1.000	0.572
GP satisfaction	0.031	0.357	0.055	0.572	1.000

Table 4.9 Correlation matrix interpretation (Source: Adapted from Hinkle et al. 2003)

Correlation size	Interpretation: Strength of linear relationship
1	Perfect positive
0.900 to 1	Very high positive correlation
0.700 to 0.900	High positive correlation
0.500 to 0.700	Moderate positive correlation
0.300 to 0.500	Low positive correlation
0.00 to 0.300	Negligible correlation

4.2.1.5 Summary of descriptive analysis findings

A summary of the descriptive statistics is here presented in three parts – namely confirmatory findings, new findings, and subsequently published findings. Confirmatory findings are the findings in this study that confirm the results of the existing studies. New findings are the findings that, to the best knowledge of the researcher, have never been published before. On the other hand, subsequently published findings are those that were published after the fieldwork for this study but, all the same, have been included in the arguments in support of the related results.

Confirmatory findings: firstly, the current study confirmed a recurrence of what the BMA (2014a) study described as GP Practices perceiving the CCGs as creating

policies that “adversely affected their ability to care for patients”. Secondly, also confirmed was a low number of new GPs taking up formal roles in the CCGs as observed by Checkland et al. (2014), who attributed this occurrence to a lack of enthusiasm. Thirdly, in line with previous findings, the current study discovered that some Governing Bodies sign “off decisions made elsewhere ... while others are involved in substantive discussions and operational decisions” (McDermott et al. 2015, p.25). Fourthly, is the question of pressurised budgets, which, in the current research was identified as a leading cause for decisions perceived as unfriendly to the GP profession, while in previous and subsequent studies it has repeatedly been revealed as a point of struggle to achieving smooth running of the CCGs (HFMA 2018; HFMA 2017; Wood & Heath 2014). Finally, the current study confirmed the importance of good leadership, which McDermott et al. (2017, p.7) discovered that it provides “a facilitative environment which assures GPs that it is safe and easy to express their concerns”. In this study, good leadership was explicitly mentioned from the position of curbing of domineering personalities from destabilising the decision-making process.

New findings: (1) while previous research has observed aspects like a lack of enthusiasm in GPs taking up formal roles in the CCGs (Checkland et al. 2014) as well as a decline of GP representation in CCGs (Rosser 2018; Storey et al. 2018; Checkland et al. 2016; Drake 2016), there is no awareness in the existing knowledge accessed at the time of this study about the length of time that the GPs have served at their local CCG. This study discovered that most GPs (65.8%) had served their CCGs for more than three years. (2) The current study delivered insight about the perceived estimated weight of responsibilities that individual GPs have at their local CCGs. This awareness was achieved through the computation of (a) the number of roles that individual GPs occupy, and (b) the number of committees that the same sits in. It was discovered that the GPs held between one and more than five roles per person with most of the respondents (53.4%) holding one role. Similarly, the number of committees that individual GPs sat on ranged between one and more than five, with most of them sitting on one committee (43.4%). (3) Contrary to the findings in the previous studies (Holder et al. 2016; Naylor et al. 2013), most GPs (52.9%) in the current study indicated that they felt that their level of influence was high in their CCGs’ Governing Bodies. The afore-cited previous studies state that managers were, instead, more influential. The

difference is that the current study did not compare the level of influence between the two groups. (4) The study also investigated the suggestion that the Governing Bodies' decision-making processes were influenced by a few domineering personalities, with most of the respondents (52.9%) rejecting that idea. (5) It was also discovered that most respondents (72.6%) did not think that their Governing Bodies had a problem of negative groupthink as they disagreed with the suggestion that some of their members yielded their views to their colleagues' choices even if they did not agree with them. (6) Also discovered was a pattern demonstrating either that, (a) the respondents who indicated that they experienced decisions unfriendly to the GP profession at one point also expressed dissatisfaction about the way decisions were made at their local CCG, or (b) that if they (respondents) had never experienced decisions unfriendly to the GP profession from their local CCG, they also indicated that they were happy with the way their CCG made decisions.

Subsequently published findings: Firstly, while the current study discovered that, overall, most respondents thought that the decisions made by their Governing Bodies are not vetoed by senior authorities, subsequent research (Storey et al. 2018, p.60) has revealed that senior managers, in some instances, are "empowered to take the lead in an assertive way" crowding out the "bottom-up, clinician-led approaches to service redesign". Secondly, external political pressure, identified in the current study as a second leading cause of decisions unfriendly to the GP profession, was observed and described by Checkland et al. (2018, p.387) as being "a cyclical factor" subverting the autonomy of the CCGs. Thirdly, the current study found that GPs regard themselves as having high influence in the Governing Body, a view substantiated in a subsequent research by (Storey et al. 2018, p.93) where they state that "inside the CCGs, respondents were just as likely to judge managers as being the most influential as to judge clinicians as wielding the influence".

4.2.2 Quantitative study strand: Inferential analysis

I achieved inferential analysis using Partial Least Squares Structural Equation Modelling (PLS-SEM). The reasons for adopting this technique are described and detailed in Chapter 3, Section 3.6.1.1. Analysis results in this chapter are split into two segments which represent the journey that transpired to arrive at the final path model that I used to draw conclusions. It is because the structure of the model had to change along

the way after I performed statistical testing for model fitness ('goodness-of-fit'). As explained in Chapter 3, Section 3.6.1.3, model fitness testing in PLS-SEM is done on the outer and inner models. Latent and observed variables which fail the test are removed from the model, under the recommendations for this technique (Lowry & Gaskin 2014). The model is rearranged and retested, with this cycle repeated until the 'goodness-of-fit' tests are passed.

Considering the above 'goodness-of-fit' tests, I refer to the first attempt model as an "early phase model", while the model that I ultimately used for the study outcome is referred to as the "final phase model". For this reason, I have divided the layout for statistical tests into two broad parts; early phase model and final phase model. The former is designed to inform the reader about the reasons which led to the change of the early phase model while the latter contains the results from which the findings and conclusions of the study were partly drawn. Before describing statistical tests, the sample size had to be validated.

4.2.2.1 Sample size validation

The sample size had to be validated first to ascertain if the sample was suited for the required tests described in Chapter 3. To achieve this, the rule of thumb test by Barclay et al. (1995) was used. To recapitulate – the rule of thumb states that the minimum sample size should be either ten times the maximum number of outer model paths on a latent variable affiliated with the maximum count of indicators, or ten times the number of the maximum inner model relationships directed at single latent variable, depending on whichever is larger (Hair et al. 2012; Henseler et al. 2009). Figure 4.31 below reiterates a general view of the components that constitute a typical path model, with full details of what the inner model and outer model are, described in Chapter 3, Section 3.6.1.

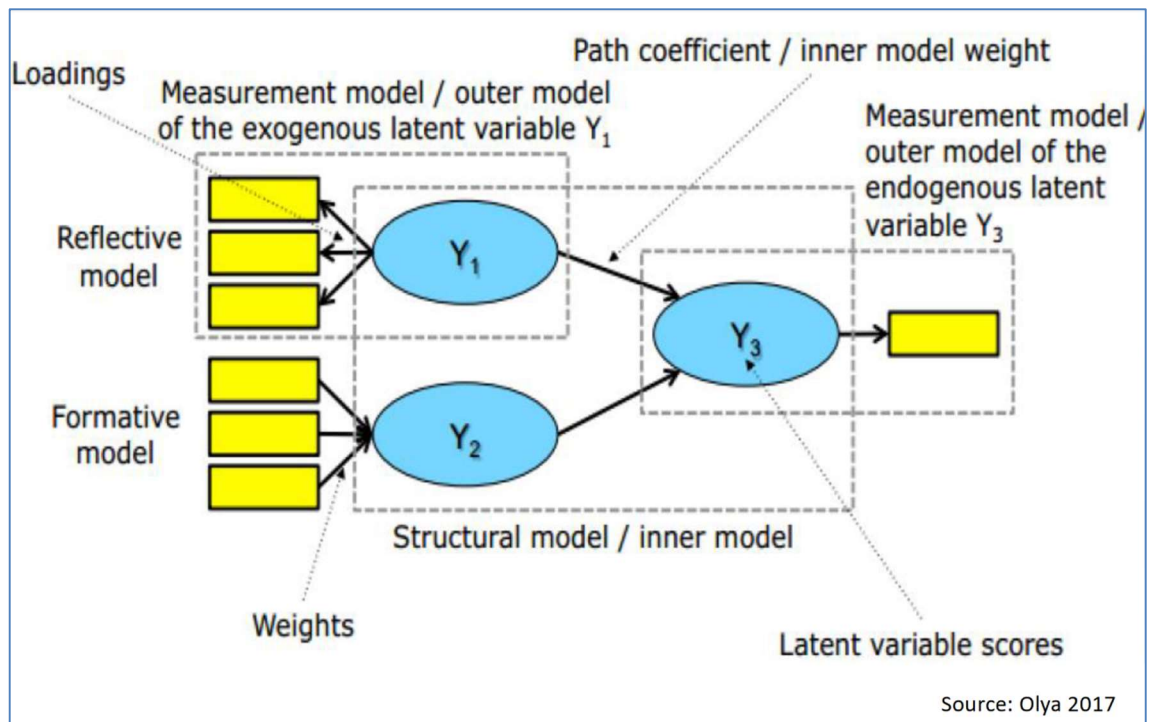


Figure 4.31 Path model illustration

Early phase PLS-SEM path model sample size validation: First, the indicators affiliated with one latent variable in this path model was larger than the number of inner relationships directed at a single latent variable, as shown in Figure 4.32 below. The former had a count of four, latent variable *GP Influence*, while the latter had a count of three, latent variable *Satisfaction*. Therefore, according to the rule of thumb test, the minimum sample size required for the early phase model would be four times ten, which is 40, while the current study had a sample size of 73.

Final phase PLS-SEM path model sample size validation: Like the early phase model, the minimum sample size required for the final phase model was also 40, while the current study had a sample size of 73. The indicators affiliated with one latent variable in this path model was larger than the number of inner relationships directed at a single latent variable, as shown in Figure 4.34 below. The former had a count of four, latent variable *Decision-making Process Effectiveness*. Meanwhile, the maximum inner model relationships directed at a single latent variable was two, and there are two occurrences of this – which are, (1) directed at latent variable *Satisfaction* and (2) directed at latent variable *Decision-making Process Effectiveness*. Therefore, according to the rule of thumb test, the minimum sample size required for this model would be four times ten, which is 40.

4.2.2.2 Early phase model analysis – why the change was necessary

To appreciate the discussion in this section, the reader is referred to the early phase path model illustrated below in Figure 4.32. The early phase path model was first tested for validity and reliability.

Outer Model: Reflective measurement model

The model successfully passed all the reliability and validity tests on the reflective measurement model except for one. The test that failed was the validity test – that is, the convergent validity test which in SmartPLS 3 is referred to as Outer Loadings. To pass this test, a reading of at least 0.5 should be attained, thereby demonstrating that the latent variable being considered “is able to explain more than half of the variance of its indicators on average” (Henseler et al. 2009, p.299). In this study, three indicators had a reading of less than 0.5. The indicators in question were “AccOffBG”, “LenInCCG”, “YieldOpin” (see below Table 4.10 for the description of what these indicators were intended to measure). Two actions were taken to address this issue. First, all possible combinations of latent variable to indicator were tried and tested, after which indicator “YieldOpin” was found to be compatible with the latent variable *Decision-making Process Effectiveness*.

The other two indicators were not successful in all the combinations that could be possibly created. As such, those two had to be removed from the model in line with PLS-SEM procedures where the recommendation is that items that fail the test should be removed from the model (Lowry & Gaskin 2014).

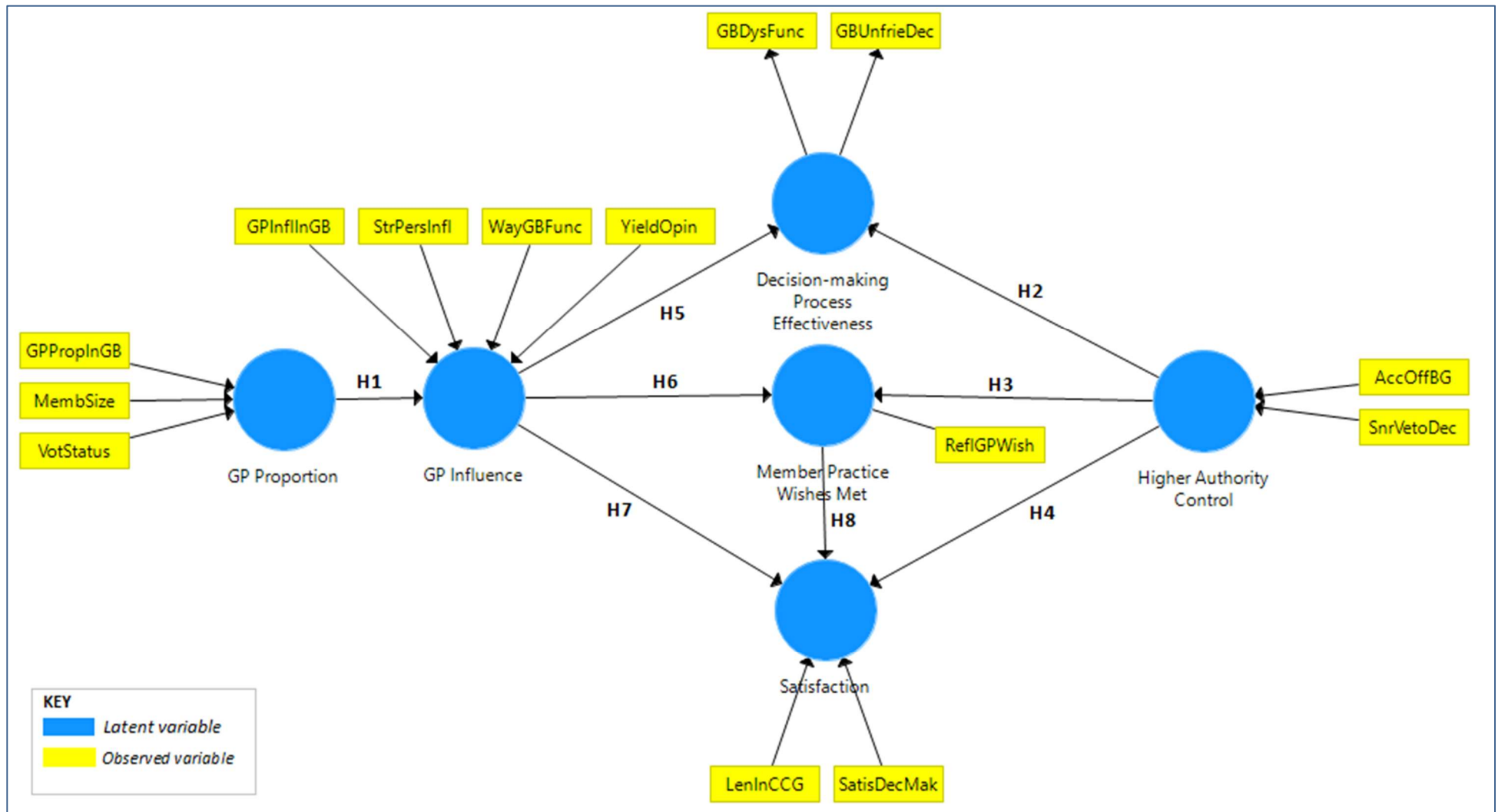


Figure 4.32 Early Phase PLS-SEM Path Model (Source: Author's own 2019, unpublished)

Table 4.10 Early phase model (Reflective): Reliability and validity test affected indicators

INDICATOR	ITEM MEASURED
AccOffBG	Accountable Officer Professional Background
LenInCCG	Length of Service In CCG
YieldOpin	Governing Body Members Yield Opinions to Others to Avoid Contention

Outer Model: Formative measurement model

Validity only, was tested on formative measurement model. The formative measurement model is an occurrence when the measured indicators are considered to be the cause of the latent variable (see below Figure 4.33).

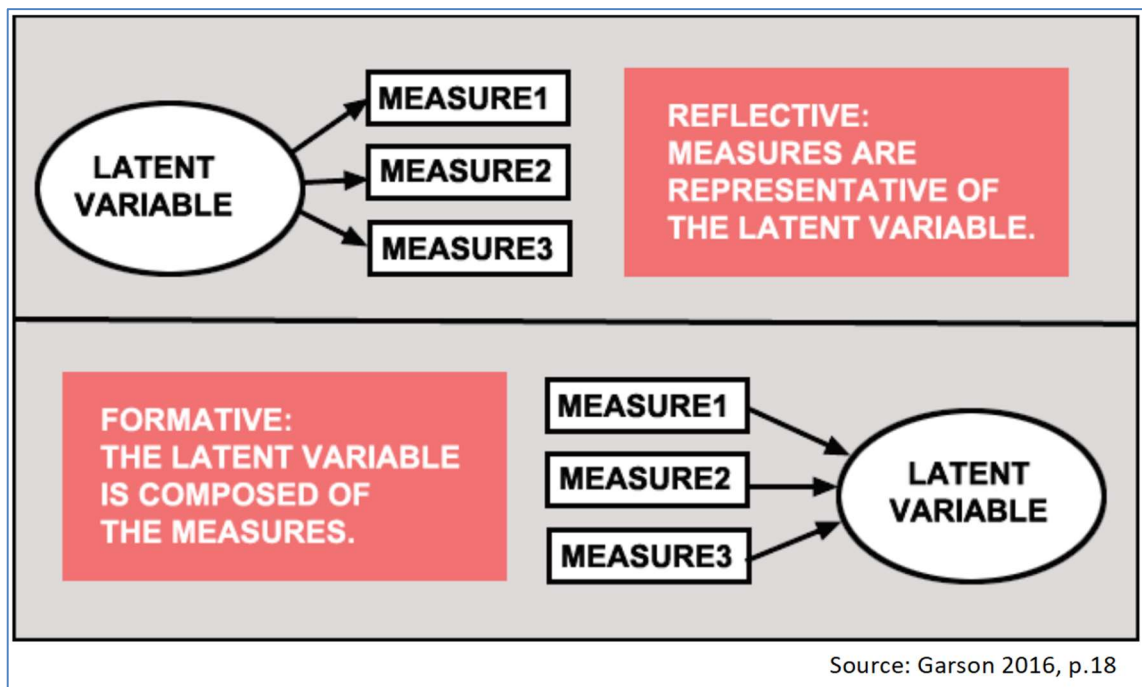


Figure 4.33 Reflective versus Formative models

Of the two validity tests that were performed on the formative measurement model – that is, test for indicator relevance and test for multi-collinearity between indicators, there was a failure on the latter. To pass the test, the indicators should have a reading of variance inflation factor (VIF) of not more than 10. Two of the indicators demonstrated high collinearity between themselves. These were “MembSize” and

“VotStatus”, which both had a relationship with the latent variable *GP Proportion* (see below Table 4.11 for a description of indicators in question). Indicator “VotStatus” had to be removed as indicator “MembSize” showed stronger relevance to the latent variable *GP Proportion*.

Table 4.11 Early phase model (Formative): Validity test affected indicators

INDICATOR	ITEM MEASURED
MembSize	CCG Governing Body Membership Size
VotStatus	Governing Body Voting Status

If the model is altered in any way, such as removing one or more indicators, the whole model evaluation should be done again in line with PLS-SEM path model assessment recommendations. This applies to all cases of inner and outer model structures given “the highly interrelated nature of variables in SEM analyses” (Lowry & Gaskin 2014, p.137). Respecting the current study, a successful path model displayed in Figure 4.34 below was created after several test runs and recompilations. The test results of that path model are described and detailed next.

4.2.2.3 Final phase model analysis

To appreciate the discussion in this section, the reader is referred to the final phase path model illustrated below in Figure 4.34. After test computations on the path model using SmartPLS 3, the results that were returned are displayed in the path model in Figure 4.34. The results indicated incorporate different kinds of tests which were computed simultaneously in a single run. The evaluation results are described in the next sections starting with the outer model.

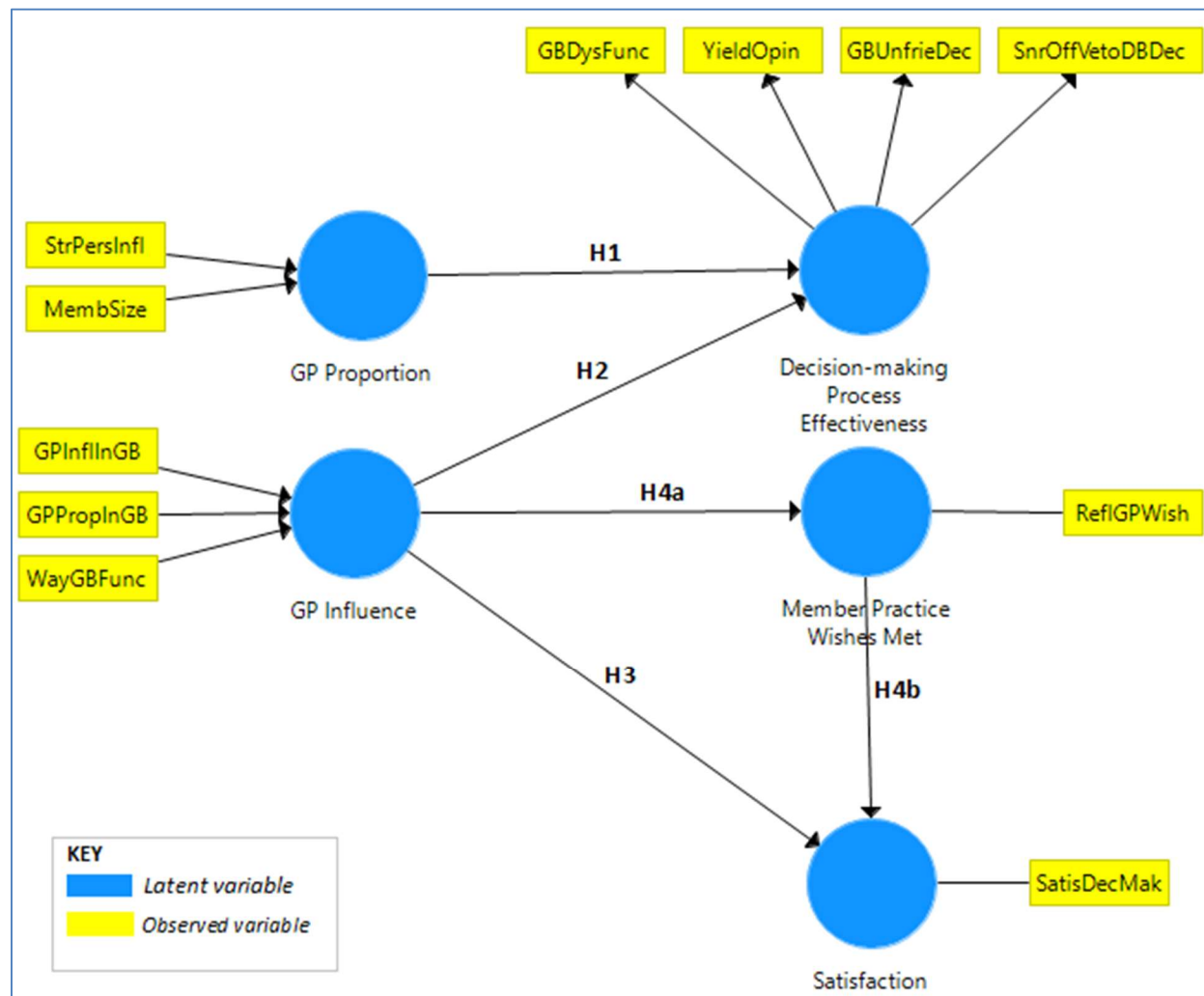


Figure 4.34 Final Phase PLS-SEM Path Model (Source: Author's own 2019, unpublished)

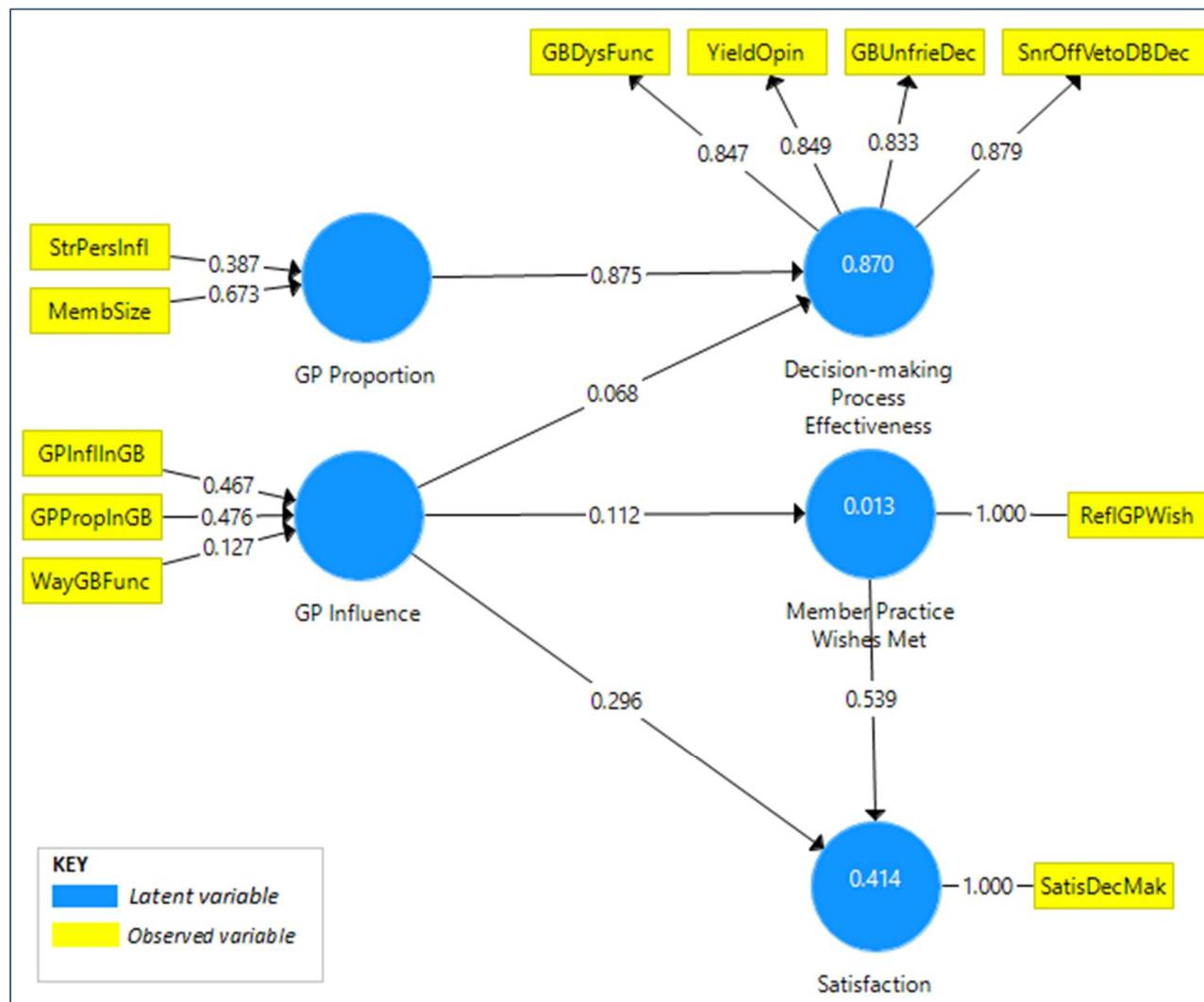


Figure 4.35 Path model results summary

Outer path model evaluation

The outer model evaluation was designed to verify the validity and reliability of the path model to ensure the fitness of the model. The first check was performed on the reflective outer model items, beginning with “Composite Reliability” (see Figure 4.33 to establish how reflective model components look like). Table 4.12 shows the results for “Composite Reliability” evaluation.

Table 4.12 Reflective outer model: Composite Reliability evaluation

Latent variables	Indicators	Loading	Composite Reliability
Decision-making Process Effectiveness	GBDysFunc	0.847	0.914
	YieldOpin	0.849	
	GBUnfrieDec	0.833	
	SnrVetoDec	0.879	
Member Practice Wishes Met	ReflGPWish	1.00	1.00

As can be seen, all the results demonstrated a high level of internal consistency reliability for the two latent variables, with all individual readings higher than the acceptable level of at least 0.6 (Hamid et al. 2017). Similarly, the results for convergent validity evaluation demonstrated a high degree of indicator correlation on both latent variables as the latent variables’ Average Variance Extracted (AVE) was higher than the recommended minimum of 0.5 (Henseler et al. 2009). The convergent validity evaluation results are shown in Table 4.13.

Table 4.13 Reflective outer model: Convergent validity evaluation

Latent variables	Indicators	Loading	AVE
Decision-making Process Effectiveness	GBDysFunc	0.847	0.726
	YieldOpin	0.849	
	GBUnfrieDec	0.833	
	SnrVetoDec	0.879	
Member Practice Wishes Met	ReflGPWish	1.00	1.00

The final check for reflective outer model fitness was to confirm the discriminant validity. I used Heterotrait-monotrait (HTMT) correlation coefficient method. The literature suggests that “HTMT ratio should be below 1.0” (Garson 2016, p.70), an argument supported by experts in the field like Henseler et al. (2015), who specifically argue that the level of acceptance should not be greater than 0.85. If the ratio is greater than 0.85, then “there is a lack of discriminant validity” (Henseler et al. 2015, p.121). The results derived from the current study’s evaluation demonstrated latent variable distinctiveness as all the ratios were below 0.85, as displayed in Table 4.14.

Table 4.14 Reflective outer model: Heterotrait-monotrait evaluation

	Decision-making Process Effectiveness	Member Practice Wishes Met	Satisfaction
Decision-making Process Effectiveness			
Member Practice Wishes Met	0.215		
Satisfaction	0.176	0.572	

The next set to be evaluated on the outer path model was the fitness of the formative measurement model. Under this set, indicator weights had to be considered in which the check for indicator multicollinearity was performed. This was achieved by use of Variance inflation factor (VIF). As can be seen in Table 4.15, no indicator multicollinearity was identified in the model, notwithstanding the borderline reading of indicator “GPInflnGB” which fell just below what Garson (2016, p.72) calls the “lenient criterion of 5.0”. See Table 4.16 below for the description of the indicator names listed in Table 4.15.

Table 4.15 Formative outer model: Variance inflation factor evaluation

Indicator Name	VIF
GBDysFunc	2.632
GBUnfrieDec	2.479
GPInflnGB	4.798
GPPropInGB	3.479
MembSize	2.398

Indicator Name	VIF
ReflGPWish	1.000
SatisDecMak	1.000
SnrVetoDec	2.901
StrPersInfl	2.398
WayGBFunc	2.280
YieldOpin	2.602

Table 4.16 Final phase model: Description of indicators

INDICATOR	ITEM MEASURED
GBDysFunc	Governing Body Is Dysfunctional
GBUnfrieDec	Unfriendly Decisions
GPInflInGB	Level of GP Influence in Your Governing Body
GPPropInGB	The proportion of GPs In CCG Governing Body Membership
MembSize	CCG Governing Body Membership Size
ReflGPWish	Decisions Made by My CCG Reflect the Wishes of GP Practices That My CCG Serves
SatisDecMak	Level of Satisfaction About the Way Decisions Are Made at Your CCG
SnrVetoDec	Senior Member or Government Official Vetoed Decisions Made by Governing Body
StrPersInfl	Governing Body Influenced by Few Strong Personalities
WayGBFunc	The Way Your CCG Governing Body Functions
YieldOpin	Governing Body Members Yield Opinions to Others to Avoid Contention

Inner path model evaluation

Evaluation of the inner path model was designed to ensure the model's ability to predict the latent variables. Four tests were performed to that end. The first was the R^2 test to evaluate the endogenous latent variables' explained variance. Table 4.17 shows the results of this test. Given that the maximum number of inner paths joining to any given endogenous latent variables from exogenous latent variables in this study's path model was two, a test result of at least "moderate" R^2 had to be attained (Henseler et al. 2009). The test results were "substantial", "moderate" and "weak", as displayed in Table 4.17. While a "weak" result is said to be suggestive of doubtful "theoretical underpinnings" (Henseler et al. 2009, p.303) of the model, and thus meaning that the model may not be capable of explaining the implicated endogenous latent variable, I decided to retain that latent variable on purpose. As suggested by Garson (2016, p.80) on the question of less favourable readings, the "weak" reading obtained in this study may be a benchmark for future research, thereby affording the ensuing research to treat the reading "relative to the field". A "moderate" is acceptable considering that endogenous latent variable *Satisfaction* has only one inner path joining to the exogenous latent variable (Henseler et al. 2009).

Table 4.17 Inner model: R-Square evaluation

Latent Variable Name	R^2	Test Result
Decision-making Process Effectiveness	0.870	Substantial
Member Practice Wishes Met	0.013	Weak
Satisfaction	0.414	Moderate

The second test for the inner model fitness was performed to establish the effect size – that is, the magnitude of effect that exogenous variables have on endogenous latent variables. The results of this evaluation are displayed in Table 4.18. As can be seen, just like the other R^2 readings, the suggestion in these results is that the effect size across the latent variables ranged from "small" to "large". That is, exogenous variable *GP Influence* has a "small" effect size on two endogenous latent variables, *Decision-making Process Effectiveness* and *Member Practice Wishes Met*. On the other hand, the same exogeneous variable *GP Influence* has a "medium" effect size on endogenous

latent variable *Satisfaction*. A “large” effect size was realised on exogenous variable *GP Proportion* towards endogenous latent variable *Decision-making Process Effectiveness*. Another “large” effect size was noted on variable *Member Practice Wishes Met* towards variable *Satisfaction*.

Table 4.18 Inner model: Effect size

	Decision-making Process Effectiveness	GP Influence	GP Proportion	Member Practice Wishes Met	Satisfaction
Decision-making Process Effectiveness					
GP Influence	0.068			0.112	0.296
GP Proportion	0.875				
Member Practice Wishes Met					0.490
Satisfaction					

Next to be evaluated was the Q^2 prediction relevance which assessed the inner model’s capability to predict. The evaluation results are displayed in Table 4.19.

Table 4.19 Inner model: Prediction relevance

	SSO	SSE	$Q^2 (=1 - SSE/SSO)$
Decision-making Process Effectiveness	296.000	121.653	0.589
GP Influence	222.000	222.000	
GP Proportion	148.000	148.000	
Member Practice Wishes Met	74.000	74.068	-0.001
Satisfaction	74.000	46.257	0.375

According to the evaluation results, there was a high degree of predictive relevance for endogenous variables *Decision-making Process Effectiveness* and *Satisfaction*. On the other hand, endogenous variable *Member Practice Wishes Met* demonstrated no predictive relevance as it returned a reading less than 0.

The final fitness test of the inner model was to evaluate the significance of path coefficients. This test is designed to indicate the strength of relationships between latent variables. As shown in Table 4.20, all path coefficients indicated valid relationships between latent variables. The strongest relationship in this collection was between variable *GP Proportion* and variable *Decision-making Process Effectiveness* while the weakest relationship was between variable *GP Influence* and variable *Decision-making Process Effectiveness*.

Table 4.20 Inner model: Significance of path coefficients

	Decision-making Process Effectiveness	GP Influence	GP Proportion	Member Practice Wishes Met	Satisfaction
Decision-making Process Effectiveness					
GP Influence	0.068			0.112	0.296
GP Proportion	0.875				
Member Practice Wishes Met					0.539
Satisfaction					

4.2.2.4 Statistical hypothesis testing

Table 4.18 shows the results of hypotheses testing based on the statistical hypotheses discussed in Section 3.6.1.5. Since the hypotheses were nondirectional, two-tailed tests were used, as the results of each test had two possible directions – namely, Null Hypothesis (H_0) and Alternative Hypothesis (H_A). I achieved this by calculating p-values and confidence intervals using SmartPLS 3 in a single run where a bootstrap of 4,999 samples was performed.

- a) **p-values:** I set the significance of test results at .05, meaning that if the p-value was below this “pre-defined α -level” (Henseler et al. 2016, p.12) the coefficient path was regarded as significant as chance would be ruled out as a possible explanation. Similarly, if the p-value was above .05, this indicated an insignificant relationship meaning that we would not be able to rule out chance as an explanation for the result. The smaller the p-value, the stronger the probability that the results are not due to chance.
- b) **Confidence intervals:** I used this measure, which emphasises estimation over testing (Wasserstein & Lazar 2016), to supplement the p-value method. That is, confidence intervals provide a range of values which contain the actual population mean for the parameter of interest being measured. The range should not cross zero (0) for the confidence interval to be regarded as significant. The confidence interval for the current study was set at 95%.

Hypotheses testing results, along with other related statistical implications, are described next.

Causal Hypothesis 1 (H1): A high proportion of GPs in the Governing Body committee will influence the decision-making process effectiveness.

Ho: There will be no change in the decision-making process effectiveness as a result of a high proportion of GPs in the Governing Body committee.

RESULTS: The test for this hypothesis yielded a p-value of 0.000. Since this p-value < 0.001; that is, smaller than $\alpha=0.05$, it is unlikely that the sample results happened by chance. Therefore, the Null Hypothesis (Ho) stating that “There will be no change in the decision-making process effectiveness as a result of a high proportion of GPs in the Governing Body committee” is rejected. A mean of 0.879 (95% Confidence Interval between 0.660 and 1.078) has been shown in the current study sample.

INTERPRETATION: These results suggest that a proportion of GP in the governing Body committee is positively associated with the effectiveness of the decision-making process.

Table 4.21 Hypotheses 1 to 3 results

Hypotheses 1, 2, and 3 Paths	Original Sample (O)	Sample Mean(M)	Standard Deviation (STDEV)	T Statistics (O/STDEV)	P Values	Supported?	Why?	Confidence Intervals (95%)	Supported?	Why?
H1: GP Proportion → Decision-making Process Effectiveness	0.875	0.879	0.107	8.200	0.000	Yes	P < 0.05	0.660 1.078	Yes	0 ∉ CI
H2: GP Influence → Decision-making Process Effectiveness	0.068	0.067	0.118	0.578	0.563	No	P > 0.05	-0.159 0.302	No	0 ∈ CI
H3: GP Influence → GP satisfaction	0.296	0.300	0.077	3.860	0.000	Yes	P < 0.05	0.132 0.437	Yes	0 ∉ CI

Causal Hypothesis 2 (H2): The level of GP influence in the Governing Body will cause a difference in the effectiveness of the decision-making process.

Ho: There will be no change in the effectiveness of the decision-making process as a result of the level of GP influence in the Governing Body.

RESULTS: For this hypothesis testing, the p-value was 0.563. Since this p-value is larger than $\alpha=0.05$, we cannot reject the null hypothesis that “There will be no change in the effectiveness of the decision-making process as a result of the level of GP influence in the Governing Body”. The mean for the sample is 0.067, with 95% Confidence Interval between -0.159 and 0.302.

INTERPRETATION: These results suggest that the level of GP influence in the Governing Body will not cause a difference in the effectiveness of decision-making process as the 95% confidence interval crosses zero, the line of no effect. Therefore, the p-value, mean, and 95% confidence interval suggest that the level of GP influence in the Governing Body is not significant to cause a difference in the effectiveness of the decision-making process.

Causal Hypothesis 3 (H3): A high level of GP influence in the Governing Body will impact the degree of GP satisfaction about decision-making.

Ho: There will be no change in the degree of GP satisfaction about decision-making as a result of a high level of GP influence in the Governing Body.

RESULTS: The test for this hypothesis yielded a p-value of 0.000. Since this p-value < 0.001 ; that is, smaller than $\alpha=0.05$, it is unlikely that the sample results happened by chance. Therefore, the Null Hypothesis (Ho) stating that “There will be no change in the degree of GP satisfaction about decision-making as a result of a high level of GP influence in the Governing Body” is rejected. A mean of 0.300 (95% Confidence Interval between 0.132 and 0.437) has been shown in the current study sample.

INTERPRETATION: These results suggest that GP influence in the Governing Body is positively associated with the degree of GP satisfaction about decision-making.

Table 4.22 Hypotheses 4 results - Indirect effects

Hypothesis 4 Paths	Original Sample (O)	Sample Mean(M)	Standard Deviation (STDEV)	T Statistics (O/STDEV)	P Values	Supported?	Why?	Confidence Intervals (95%)	Supported?	Why?
GP Influence → Member Practice Wishes Met	0.112	0.114	0.125	0.898	0.369	No	P > 0.05	-0.144 0.340	No	0 ∈ CI
Member Practice Wishes Met → GP satisfaction	0.539	0.533	0.090	5.999	0.000	Yes	P < 0.05	0.351 0.704	Yes	0 ∉ CI
GP Influence → Member Practice Wishes Met → GP satisfaction	0.060	0.059	0.068	0.893	0.372	No	P > 0.05	-0.076 0.194	No	0 ∈ CI

Causal Hypothesis 4 (H4): The level of GP influence in the Governing Body will impact the scale of member practice wishes being met, thereby causing a difference in the degree of GP satisfaction about decision-making.

Ho: There will be no change on the degree of GP satisfaction as a result of the level of GP influence in the Governing Body impacting the scale of member practice wishes being met.

RESULTS: This hypothesis was generated from a causal setting that involved a moderating latent variable which resulted in an indirect effect, giving rise to the results displayed in Table 4.22.

GP Influence → *Member Practice Wishes Met*: The test results for this causal relationship yielded a p-value of 0.369. Since this p-value < 0.001; that is, smaller than $\alpha=0.05$, it is unlikely that the sample results happened by chance. The mean for the sample is 0.114, with 95% Confidence Interval between -0.144 and 0.340.

INTERPRETATION: These results suggest that the level of GP influence in the Governing Body will not cause a difference in member practice wishes being met as the 95% confidence interval crosses zero, the line of no effect.

Member Practice Wishes Met → *Satisfaction*: The test results for this causal relationship yielded a p-value of 0.000. Since this p-value < 0.001; that is, smaller than $\alpha=0.05$, it is unlikely that the sample results happened by chance. A mean of 0.533 (95% Confidence Interval between 0.351 and 0.704) has been shown.

INTERPRETATION: These results suggest that member practice wishes being met is positively associated with the level of GP satisfaction.

GP Influence → *Member Practice Wishes Met* → *GP satisfaction*: For this hypothesis testing, the p-value was 0.372. Since this p-value is larger than $\alpha=0.05$, we cannot reject the null hypothesis that “There will be no change on the degree of GP satisfaction as a result of the level of GP influence in the Governing Body impacting the scale of member practice wishes being met”. The mean for the sample is 0.059, with 95% Confidence Interval between -0.076 and 0.194.

INTERPRETATION: These results suggest that GP influence will not cause a difference to the level of GP satisfaction by raising the scale at which the member practice wishes are met as the 95% confidence interval crosses zero, the line of no effect. Therefore, the level of GP influence in the Governing Body is not significant to cause a difference to the level of GP satisfaction by raising the scale at which the member practice wishes are met.

Overall, while the GP influence was found not significant in changing the scale at which the member practice wishes were met, the latter was, on the contrary, found to be positively associated with the level of GP satisfaction. In other words, latent variable *Member Practice Wishes Met*, and latent variable *Satisfaction* shared an antecedent cause of latent variable *GP Influence* which was incorrectly inferred as

being correlated. That inferred correlation turned out to be spurious, as revealed by hypothesis testing.

4.2.2.5 *Summary of inferential analysis findings*

To start with, the path model on which the inferential analysis was performed proved to be effective in giving reliable predictive results following the tests that were done to that effect. Notwithstanding, routine tests on different parameters consistently flagged out the latent variable *GP Influence* for different reasons which, in general, meant that this variable presented a point of weakness on the model. Accordingly, all the tests of hypotheses that returned insignificant effect levels were linked to latent variable *GP Influence*. While GP influence could be important in many aspects at CCG level, it would appear like when it comes to impacting decision-making process effectiveness or fulfilling the wishes of member practices in decision-making routines, it is insignificant, according to the hypotheses test results. This situation seems to be so regardless positive correlation in the correlation matrix (Table 4.8) of this variable with other implicated variables at issue. Conversely, the same factor, GP influence, was found to be significant in influencing the levels of GP satisfaction.

The Proportion of GPs in the Governing Body committee, on the other hand, was found to be crucial in influencing the perceived effective decision-making process. The relationship between the variables *GP Proportion* and *Decision-making Process Effectiveness* was demonstrated to be substantial by the model fitness tests. Another variable relationship of note that the model fitness tests as well as the hypothesis tests identified as having a considerable significance was between variables *Member Practice Wishes Met* and *Satisfaction*.

4.3 Qualitative Results

The qualitative data were drawn from the open-ended questions outlined below in Table 4.23. All the questions were attempted in full by all the eligible participants.

The interpretative phenomenological analysis (IPA) approach was used as a guide in the analysis of the qualitative data. Because IPA lacks a standardised formal approach as mentioned in the literature (Charlick et al. 2016; Gill 2014; Sloan & Bowe 2014), the approach that I used in my study is described in Chapter 3, Section 3.6.2.2.

In brief, the model consists of four steps, which are, (1) data familiarisation, (2) identification of emergent themes, with example quotes to illustrate the theme (3) elimination of repetitious themes, and (4) integration of themes.

In the interest of clarity, components in the text that are identified, or referred to, as “macro level” denote the wider influence that CCGs may receive emanating from offices outside the CCGs’ local level spheres. Example sources of such influence could be offices like NHS England and the Department of Health. In contrast, where the phrase “micro-level” is used, that will be denoting influences constrained by the CCGs’ local level domains.

Table 4.23 Outline of qualitative data questions

Question Number	Question
Question 13	If you have responded “Yes” to the previous question, please briefly describe the unfriendly decision in question and the impact that you think it had (or will have) on patient care or any other aspect in the primary health care delivery.
Question 14	What would you attribute the reason for unfriendly decisions to? That is, what possibly fuelled or facilitated such unfriendly decisions to be passed?
Question 15	Give up to three aspects that you feel your Governing Body is good at in decision-making.
Question 16	Give up to three aspects that you feel your Governing Body is bad at in decision-making.
Question 17	Briefly describe the mechanisms that you have in place to check that no persona or office in your CCG domineers others in decision-making routines? If there is none, please say so.
Question 20	If you have any comments to make about the preceding question, please do so in the space provided below.
Question 22	How is GP Practice member engagement achieved in your CCG? In other words, how does your CCG engage different GP Practices falling under its remit?

4.3.1 Data familiarisation

The qualitative strand data analysis was started with an in-depth reading of all the participants' responses to the open-ended questions listed above in Table 4.23, which involved going through the textual data several times. After reading and rereading, interesting aspects in the data were identified, isolated, and classified as paradigm cases. Alongside these actions, the data were thematised accordingly on a question by question basis. The themes that were discovered are detailed in the next section.

It is worth mentioning that all the sorting and categorising of the data was done manually with no recourse to any software programme to assist me with those tasks. All data items were given equal attention in the analysis activity.

4.3.2 Discovering themes

The discovery of themes was an activity performed on a question by question basis on the responses to the open-ended questions listed above in Table 4.23. Of the themes that were discovered, there is one called 'Miscellaneous', a theme made up of insightful cases which did not fall under any of the main themes, as described in Chapter 3, Section 3.6.2.2.

Following on from Question 12, a close-ended question, where the respondents were asked to indicate if there were any decisions that their respective Governing Bodies had made in the past that they felt were unfriendly to the profession, a related open-ended question was asked, Question 13. This question was directed to the respondents who indicated that they felt unfriendly decisions were made in their local CCGs. An opportunity was given to those respondents to describe the unfriendly decisions in question. Table 4.24 outlines the themes that were developed from the responses that the respondents supplied.

Table 4.24 Themes for unfriendly decisions

THEME, DEFINITION	SUB-THEMES	EXAMPLE QUOTES
Financial Decisions that are influenced by financial concerns.	1. Financial gain	• <u>Respondent 20</u> : Asking GPs to do too much in order to win extra enhanced services and hence funding at a time when General Practice was beginning to really struggle.

THEME, DEFINITION	SUB-THEMES	EXAMPLE QUOTES
	2. Cost-savings	<ul style="list-style-type: none"> • <u>Respondent 62</u>: Cash incentives for reducing referrals to an arbitrary level ... is pernicious for the profession and may undermine patient trust in us.
Clinical Decisions with clinical implications. That is, if decisions are supportive of, or disregard GP interests for patient care.		<ul style="list-style-type: none"> • <u>Respondent 15</u>: We were forced to stop enhanced services, which has meant a reduction in service offer.
Bureaucracy Decisions influenced by the bureaucratic hierarchy.	1. The bureaucratic hierarchy at macro level	<ul style="list-style-type: none"> • <u>Respondent 40</u>: National guidance laid down by statute means that NHSE has undue influence over local decisions.
	2. The bureaucratic hierarchy at the micro level	<ul style="list-style-type: none"> • <u>Respondent 18</u>: A decision to push ahead with 7-day working in spite of initially saying they would oppose politic rhetoric without evidence of need.

The respondents were then asked, in Question 14, to give reasons for whatever purpose they thought their CCG made decisions unfriendly to the GP profession. The responses that were supplied led to the development of the themes displayed in Table 4.25.

Table 4.25 Themes for reasons of unfriendly decisions

THEME, DEFINITION	SUB-THEMES	EXAMPLE QUOTES
Financial Decisions that are influenced by financial concerns.	1. Financial considerations at a micro level	<ul style="list-style-type: none"> • <u>Respondent 32</u>: Lack of finance, desperation to make books balance.
	2. Financial considerations at a macro level	<ul style="list-style-type: none"> • <u>Respondent 62</u>: Finances and targets handed down by NHS England.

THEME, DEFINITION	SUB-THEMES	EXAMPLE QUOTES
Bureaucracy Decisions influenced by the bureaucratic hierarchy.	1. The bureaucratic hierarchy at the micro level	<ul style="list-style-type: none"> • <u>Respondent 69</u>: Partially strong influence of senior CCG officers and partially rules applying to FTs that allowed the secondary provider to 'hold to ransom' the CCG.
	2. The bureaucratic hierarchy at macro level	<ul style="list-style-type: none"> • <u>Respondent 18</u>: Political agendas dictated by DoH / Whitehall.
Clinical Decisions with clinical implications. That is, if decisions are supportive of, or disregard GP interests for patient care.		<ul style="list-style-type: none"> • <u>Respondent 20</u>: Poor understanding of what it is really like at the clinical front line.
Miscellaneous Marginal themes.		<ul style="list-style-type: none"> • <u>Respondent 73</u>: Sometimes Primary Care unduly examined compared to other providers.

The next question, Question 15, asked the respondents to give three aspects that they thought their CCG was good at. This question was designed to gather information about the positive aspects of the internal workings of the CCGs to extrapolate the enablers of decision-making from the supplied responses. Responses to this question led to the development of the themes displayed in Table 4.26.

Table 4.26 Themes for aspects local CCG good at

THEME, DEFINITION	SUB-THEMES	EXAMPLE QUOTES
Workplace culture Aspects to do with conscious or unconscious behavioural patterns within	1. Decision-making process	<ul style="list-style-type: none"> • <u>Respondent 20</u>: We have a well governed decision-making process.
	2. CCG internal membership relationships	<ul style="list-style-type: none"> • <u>Respondent 22</u>: Genuinely inclusive (e.g. lay members, Health watch on Board are very active and genuinely influential).

THEME, DEFINITION	SUB-THEMES	EXAMPLE QUOTES
the organisation, as described in Section 2.3.3.	3. Conflicts of interest	• <u>Respondent 20</u> : We have a well-rehearsed conflict of interest process.
	4. Review of issues	• <u>Respondent 34</u> : Our GB is very open and honest.
	5. Governance	• <u>Respondent 20</u> : We have a well governed decision-making process.
	6. Quality	• <u>Respondent 25</u> : Good and accurate summaries/figures are presented.
Clinical Decisions with clinical implications. That is, if decisions are supportive of, or disregard GP interests for patient care.		<ul style="list-style-type: none"> • <u>Respondent 22</u>: Clinically led. • <u>Respondent 25</u>: Clinical input to commissioning decisions is high. • <u>Respondent 67</u>: Recognition of the value of clinical input.
Miscellaneous Marginal themes.		• Respondent 62: The Lay members are poorly informed, but are bright and ask awkward questions quite often. The committee can be embarrassed into reconsidering things.

The respondents were also asked in Question 16 to give three aspects that they thought their CCGs were bad at in order to extrapolate the barriers to decision-making from the supplied responses. The respondents' responses gave rise to the themes displayed in Table 4.27.

Table 4.27 Themes for aspects local CCG not good at

THEME, DEFINITION	SUB-THEME	EXAMPLE QUOTES
Workplace culture Aspects to do with conscious or unconscious	1. Decision-making process	• <u>Respondent 18</u> : Some elements to be decided are too complex for a clinician to understand well (e.g. finance) and so a great deal of steer is taken from the managers / CFO in these areas.

THEME, DEFINITION	SUB-THEME	EXAMPLE QUOTES
behavioural patterns within the organisation, as described in Section 2.3.3.	2. Relationship with external bodies	<ul style="list-style-type: none"> • <u>Respondent 73</u>: Not enough holding [of the] Acute Trust to account.
	3. Conflicts of interest	<ul style="list-style-type: none"> • <u>Respondent 25</u>: Worries about conflict of interest whilst VERY important can potentially block some important clinical decisions.
	4. Preoccupied focus	<ul style="list-style-type: none"> • <u>Respondent 63</u>: Overwhelming focus on efficiency/cost-savings.
	5. Governance	<ul style="list-style-type: none"> • <u>Respondent 63</u>: Poor governance structure and lack of clarity on decision-making roles.
	6. Planning	<ul style="list-style-type: none"> • <u>Respondent 61</u>: Agenda is poorly designed and clunky.
	7. Communication	<ul style="list-style-type: none"> • <u>Respondent 73</u>: Not enough reporting back on commissioned schemes.
	8. Time	<ul style="list-style-type: none"> • <u>Respondent 56</u>: Decisions are pushed for lack of time. • <u>Respondent 68</u>: [Inadequate] time to have a good debate as there are so many things on the agenda.
Bureaucracy Decisions influenced by the bureaucratic hierarchy.	1. The bureaucratic hierarchy at the micro level	<ul style="list-style-type: none"> • <u>Respondent 63</u>: ultimately very hierarchical structure which particularly doesn't work as CCGs upscale with collaborations with other CCGs.
	2. The bureaucratic hierarchy at macro level	<ul style="list-style-type: none"> • <u>Respondent 50</u>: NHSE dictates often over-ride decisions already made.
Miscellaneous Marginal themes.		<ul style="list-style-type: none"> • <u>Respondent 45</u>: Reactive – i.e. 'firefighting' culture, not good at encouraging 'horizon scanning' • <u>Respondent 66</u>: Sorry too tired - doing this at past midnight after doing a 12 hour day at CCG and the practice and then 3 hours at home processing patient letters and test results.

The respondents were also asked, in Question 17, to briefly describe the mechanisms that their CCGs had in place to check that no persona or office in their CCG dominated others in the decision-making process. The themes in Table 4.28 were developed from the responses that were given.

Table 4.28 Themes about curbing domineering personalities

THEME, DEFINITION	SUB-THEME	EXAMPLE QUOTES
Workplace culture Aspects to do with conscious or unconscious behavioural patterns within the organisation, as described in Section 2.3.3.	1. Decision-making process	<ul style="list-style-type: none"> • <u>Respondent 40</u>: Quite a few on the GB are quite opinionated, so unpopular (with GPs)
	2. Governance	<ul style="list-style-type: none"> • <u>Respondent 52</u>: thorough attention to these potential problems in organisational development sessions and our regular informal meetings.
Miscellaneous Marginal themes.		<ul style="list-style-type: none"> • <u>Respondent 46</u>: I am not aware of 'mechanism' to avoid domineering but can say from experience that in practice it does not happen.

When the respondents were asked to rate their level of satisfaction about the way decisions were made in their local CCGs in Question 19, which was a close-ended question, a complementary open-ended question, Question 20, was also asked where the respondents were to say anything they liked regarding the idea of satisfaction mentioned in Question 19. The themes displayed in Table 4.29 were developed from the responses that were supplied. Also included in Table 4.29 are themes from a question, Question 22, which dealt with how the participants' local CCGs achieved GP member practice engagement. The GP Practice engagement question was designed to derive some of the possible factors influencing the perceived effective decision-making process by analysing the level of engagement that the CCGs gave to their member practices.

Table 4.29 Themes about decision-making satisfaction

THEME, DEFINITION	SUB-THEME	EXAMPLE QUOTES
<p>CCG role</p>	<p>1. CCG role poorly understood</p>	<ul style="list-style-type: none"> • <u>Respondent 24</u>: There is a wide misunderstanding of the role of the CCG by grass-roots GPs with frequent confusion of the role of NHS England with that of the CCG.
	<p>2. Member practice engagement</p>	<ul style="list-style-type: none"> • <u>Respondent 21</u>: All practices have a member representing them on a locality board. Hard to get every member engagement, as so big and daily life so busy. The 4 locality boards seem to have relatively little input into the whole CCG. • <u>Respondent 14</u>: Bulletins and newsletters. • <u>Respondent 46</u>: Regular meeting with GPs and Practice Managers, regular email communications. Annual events.
<p>Workplace culture</p> <p>Aspects to do with conscious or unconscious behavioural patterns within the organisation, as described in Section 2.3.3.</p>	<p>1. Decision-making process</p>	<ul style="list-style-type: none"> • <u>Respondent 36</u>: Decision making feels rushed, biased by the people attending, if one person objects I do not feel that their difference in opinion is factored into the final decision that is made, decisions are not based on high quality and relevant evidence. • <u>Respondent 68</u>: it is not always clear how the final decisions are made; the local GPs certainly feel that decisions are made behind closed doors.
	<p>2. CCG internal membership relationships</p>	<ul style="list-style-type: none"> • <u>Respondent 6</u>: CCG has been challenged on many occasions and has its own political agenda and doesn't value the local GPs.
	<p>3. Relationship with external bodies</p>	<ul style="list-style-type: none"> • <u>Respondent 74</u>: GPs and practice managers are deeply suspicious about how decisions are made by the CCG. I don't think they realise quite how supportive the CCG is of Primary Care and how aware folk are of the challenges. GP practices are often disappointed that the CCG cannot address their problems to the

THEME, DEFINITION	SUB-THEME	EXAMPLE QUOTES
		extent they would like. I would say that the CCG is often too slow at arriving at a response. There is still a lack of clarity about the division of commissioning responsibility between NHSE and CCGs.
Financial Decisions that are influenced by financial concerns.	1. Financial consideration enforced at a macro level	<ul style="list-style-type: none"> • <u>Respondent 40</u>: The difficulty with member practices is lack of understanding of the restrictions rules and regulations CCGs have to work to. In an ideal world, funding would be ample and we would have a chronic shortage of GPs in our area. Sadly the CCG has to make the books balance...
Miscellaneous Marginal themes.		<ul style="list-style-type: none"> • <u>Respondent 56</u>: Not enough staff to deal with agenda. • <u>Respondent 65</u>: NHSE Primary care commission is unresponsive.

4.3.3 Abstraction and integration of themes – Question

This phase was a detailed analysis for each theme, on a theme by theme basis. In the IPA approach that I used for this study, this phase is Phase 4, named ‘Abstract and integrate themes by use of related meanings across emergent themes’. Six themes, including the miscellaneous theme, emerged to explain how the GPs experienced the decision-making process in their local CCGs. Table 4.30 outlines a list of all the themes and sub-themes that emerged from all the qualitative questions outlined in Table 4.23, followed by a textual description of these themes.

Table 4.30 List of themes

THEME, DEFINITION	SUB-THEME
1. Financial Decisions that are influenced by financial concerns.	i. Financial gain
	ii. Cost-savings
	iii. Financial consideration enforced at micro level
	iv. Financial consideration enforced at a macro level

THEME, DEFINITION	SUB-THEME
2. Bureaucracy Decisions influenced by the bureaucratic hierarchy.	1. The bureaucratic hierarchy at the micro level
	2. The bureaucratic hierarchy at macro level
3. Clinical Decisions with clinical implications. That is, if decisions are supportive of, or disregard GP interests for patient care.	None
4. Workplace culture Aspects to do with conscious or unconscious behavioural patterns within the organisation, as described in Section 2.3.3.	1. Decision-making process
	2. CCG internal membership relationships
	3. Relationship with external bodies
	4. Conflicts of interest
	5. Review of issues
	6. Leadership
	7. Governance
	8. Preoccupied focus
	9. Planning
	10. Communication
	11. Time
	12. Liaison events outside local CCG
	13. Quality
5. CCG role	1. CCG role poorly understood
	2. Member practice engagement
6. Miscellaneous Marginal themes.	None

4.3.3.1 Theme 1: Financial (decisions that are influenced by financial concerns)

Decisions made because of financial concerns instead of a balanced approach were repeatedly reported. Five sub-themes were developed under this focus – namely, financial gain, cost-savings, financial consideration enforced at the micro level, and financial consideration enforced at the macro level. The recurrent challenges occasioned by insufficient funding, first reported scarcely a year from the inception of

the CCGs in 2013 (Wood & Heath 2014), subjected the CCGs to difficult choices, forcing some to make decisions that were perceived as being unfriendly to the GP profession. While the desire for cost-savings actuated some of such decisions, others were construed as being motivated by the pursuit for financial gain. For example, regarding the latter, some of the respondents expressed that they were asked “to do too much in order to win extra enhanced services” (Respondent 20). On the other hand, concerning cost-savings, some CCGs trod on the delicate ground by promoting to their GP Practice members “cash incentives for reducing referrals to an arbitrary level” (Respondent 62). What this means is that, the fewer the patients that the member practices sent for secondary and community services, the more money that the involved CCGs saved. Respondent 62 frowned at this attitude as being “pernicious for the profession”, identifying it as being a risk that “may undermine patient trust in us [(GPs)]”. On the same subject of cost-savings, several of the respondents indicated withdrawal of certain incentive schemes from member practices by their CCGs. Respecting this, Respondent 24 cited “removal of prescribing incentive scheme after the work had been done”. Unfortunately, when the CCG that Respondent 24 belongs to withdrew the prescribing incentives; that action damaged the relationships between the CCG and the member practices, taking “years for the relationships between certain practices and the CCG to improve” (Respondent 24).

When asked what they thought the reasons were, for such decisions which hinged on finance, thereby resulting in the unfriendly air to the GP profession, one principal cause mentioned related to bureaucratic control. That is, a higher authority, micro or macro, was implicated as having imposed the decisions. At a micro level, Respondent 24, for example, mentioned that his or her CCG reached such decisions because of “a finance director who was trying to balance the books and failed to recognise the implications of his decision”. Most of the reasons intimated the same cause, which was “lack of finance, [and] desperation to make books balance” (Respondent 32). These findings substantiate what was reported in HFMA (2017, p.3) study where it was discovered that “a total of 83 CCGs reported an overspend against plan at the end of quarter two”. Blocking or changing of the decisions by a higher authority is a recognised occurrence in the Mintzberg’s continuum of control over the decision-making process (Mintzberg 1979), where this exercise of power is attributed

to bureaucratic control. This study had, however, an outlier reason ascribed to financially connected unfriendly decisions in which one respondent stated that the system had “underlying suspicion the GPs [are] over paid and underworked” (Respondent 53).

Regarding the macro level control, the general tone in responses was about the hand that NHS England had in influencing decision-making. Respondent 62 put the reason simply as, “finances and targets handed down by NHS England”. This appears to be the case, especially when considering the assessment framework that the CCGs must regard, in which their financial health statuses are appraised (NHS England 2016). In the same vein, Respondent 40 gave a more detailed response in which he or she stated that “being put into directions by NHSE for being overdrawn dramatically increases the workload for CCG staff; merely to provide assurance that something is being done. Unfortunately, NHSE and NHSI do not run to the same rules, so providers can go over budget and the CCG has to pay”. Put differently, NHS England dictates the course of direction for overdrawn CCGs, and this decision is unfriendly to the GPs as it results in increasing their workload to cope with limited funds. The paradox about the whole thing that Respondent 40 notes is that other sectors within the health care service are dealt with leniently while the CCGs receive a heavy hand. To this, Respondent 40 exclaimed that “The system is a nonsense”.

4.3.3.2 Theme 2: Bureaucracy (Decisions influenced by bureaucratic hierarchy)

To start with, decision-making bureaucracy is normally characterised by being “impersonal and rational” (McAuley et al. 2014, p.76). Considering this, it appears like there is obvious bureaucracy at a micro level, as Respondent 62 mentioned, citing that his or her CCG was “Led by a few people, where genuine power resides”. Considering that, it is unclear whether decisions unfriendly to the GP profession are pushed by these “few people” commanding authority. For example, Respondent 18 indicated that in his or her CCG senior authorities reached “a decision to push ahead with 7-day working in spite of initially saying they would oppose politic rhetoric”. The generally expressed view was that senior CCG officers had immense influence. It is not clear if the officers in question were managers in their everyday jobs as previous and subsequent studies have found that managers were more influential than clinical staff (Storey et al. 2018; Holder et al. 2016; Naylor et al. 2013) and that positions of

leadership like Accountable Officer were mostly occupied by managers (Checkland et al. 2016).

At a macro level, NHS England was conveyed as the arm through which the grip of bureaucracy was experienced. Respondents voiced about “too much pressure from NHS England” (Respondent 13). Most respondents decried the undue influence that NHS England had over the way that they had to make decisions. Regarding this, sentiments such as, “NHSE dictates often over-ride decisions already made” (Respondent 50), “pressure from the centre to dictate operational matters and sometimes even infringe on our decision-making abilities” (Respondent 60), and “need to produce the expected answers for NHS England rather than what we truly believe is the right thing. Our autonomy is limited, and constraints are significant” (Respondent 52), were expressed. The challenge with such methods of bureaucratic control is that the leaders wielding power could simply have an ill-defined view of the primary purpose of the organisation while at the same time acting as tunnels of “bureaucratic virtuosos” (Bauman 1989, p.253, cited in McAuley et al. 2014, p.76). It is possible that such interference by NHS England may have compelled the CCGs to produce decisions unfriendly to the GPs. This perceived meddling by the centre appears to be eroding the supposed liberation from the top-down control that the introduction of the CCGs was claimed to bring. Instead of “decision making [brought] closer to the patient” (McDermott et al. 2017, p.4), it seems like it is being taken back to the centre.

4.3.3.3 Theme 3: Clinical implications (Are decisions supportive of, or disregard GP interests)

One of the central factors in the formulation of CCGs was to realise improvement in patient care by increasing accountability since the clinicians who were informed about the local health care needs directed the system (NHS England 2015; Talbot 2014; United Kingdom Government 2012). On the contrary, some decisions that the CCGs made undermined this tenet, as perceived by the respondents. For example, Respondent 15 reported, “we were forced to stop enhanced services, which has meant a reduction in service offer”. Some of the CCGs reported about a reshuffle in the way some of the schemes were run, hitherto, with one CCG pursuing

“a particular model for unscheduled care that resulted in the contract being placed entirely with a secondary care provider that was hostile to the local GP OOH [out-of-hours services] co-operative and in turn resulted in the ending of that organisation. The secondary care provider subsequently failed to deliver the promised model and, combined with the loss of the long-established OOH co-operative, this has been detrimental to patient care since and will continue to be because it is difficult to re-establish what has now been lost” (Respondent 69).

Notwithstanding the abovementioned weaknesses, several respondents reported a positive “recognition of the value of clinical input” (Respondent 67) by their CCGs. The sentiments ranged from, “clinical input to commissioning decisions is high” (Respondent 25) to the confirmation by Respondent 22 that his or her CCG was “clinically led” while, in the same vein, (Respondent 60) mentioned, “GP voice is heard and strong representation from NEDs as lay members”. One CCG was even cited as being “prepared to back funding decisions that promote primary care” (Respondent 61).

4.3.3.4 Theme 4: Workplace culture (Aspects to do with patterns of behaviour and generally observed norms)

Culture in this context was considered from the second and third levels of Schein’s levels of culture (Schein 2017), which bore relevance to this study. The second level entails standards and protocols defining the behaviour of the organisation internally and externally while the third level involves shared unconscious behaviour. For example, when the respondents were asked about the aspects that their CCGs were good at, some responses gave an interesting insight into behavioural patterns observed in decision-making processes. Views expressed included statements such as, “all issues are thoroughly discussed and a consensus decision arrived at” (Respondent 41), “we have a well governed decision-making process” (Respondent 20). Some respondents mentioned that their “GP members of GB [were] given equal opportunity to contribute and also feedback from members they represent” (Respondent 41).

In some CCGs, the reported practice appeared sloppy in similar subjects while in others bureaucracy weakened the system. Sloppiness was typified by sentiments such

as, “Decision making is based upon brief discussion rather than in-depth knowledge” (Respondent 18) while bureaucratic patterns were described in Respondent 17’s account as, “decisions are made at top level with little consultation and feedback”. Some respondents noted that due to the complexity of decisions that ought to be made – that is, non-clinical related decisions, the tendency that the GPs assumed when faced with such was to roll-over decision-making onus to the management officers. This scenario is well illustrated in Respondent 18’s reaction, “Some elements to be decided are too complex for a clinician to understand well (e.g. finance) and so a great deal of steer is taken from the managers / CFO in these areas”. In some cases, discussions that the committees had were reported as being too specialised, thus resulting in unintentional exclusion of some committee members, as observed by Respondent 72 who stated that, “GB debate has been too heavily focussed resulting in some non-clinical members, particularly lay members feeling temporarily “outside the loop””.

Other reported practices included an evasive culture in which there was “a tendency to put any controversial matter in the private business, so keeping it out of the public meeting and minutes” (Respondent 62). Further, some CCGs were noted as simply ignoring the contributions made by other committee members (Respondent 5). For example, Respondent 36 indicated that “If one person objects, I do not feel that their difference in opinion is factored into the final decision that is made”. Also, some processes were reported to be characterised by ‘blind’ decision-making, “not based on high quality and relevant evidence” (Respondent 36). A disregard of clinical advice (Respondent 69) in some instances with decisions made being “politically motivated (Respondent 49) was also described. It is possible that such patterns of behaviour could be due to opinionated committee members, a conduct which Respondent 40 indicated as being unpopular with GPs. Additionally, such personalities were reported as thrashing decisions “out either before they get to board or at board” (Respondent 40). On the contrary, instead of a plain disregard of clinical advice, the sentiment was expressed that “it is not always known what the wishes of the members are” (Respondent 54).

To avoid protracted discussions, possibly, and to achieve efficiency, some respondents reported a tiered approach to decision-making in their local CCGs. This

especially pertained to decisions that have clinical connotations which were left to be dealt with by experts in the field – that is, clinicians. For example, to this end, Respondent 24 indicated that his or her CCG had “Tiered approach to discussions – decisions are made at clinical board or locality level first then representations made at governing body”. One interesting observation about the whole puzzle of decision-making is expressed in Respondent 68’s description, that “it is not always clear how the final decisions are made; the local GPs certainly feel that decisions are made behind closed doors”. A similar sentiment is also echoed by Respondent 74 who stated that “GPs and practice managers are deeply suspicious about how decisions are made by the CCG ... GP practices are often disappointed that the CCG cannot address their problems to the extent they would like. I would say that the CCG is often too slow at arriving at a response”.

Closely linked to the decision-making practices, with regards to culture, were planning, communication, and time. For example, regarding planning, there were reported occurrences in which the agenda was described as “poorly designed and clunky” (Respondent 61). Such big agendas resulted in superficial deliberation over the agenda items owing to time constraints (Respondent 68). Consequently, “Decisions are pushed for lack of time” (Respondent 56). In the same regard, time factor, the respondents complained about the little time was allocated “to clinicians to read papers in detail before meetings” (Respondent 18), which Respondent 24 criticised as being “Unrealistic scheduling which fails to recognise the need for preparation time prior to meetings”. Additionally, other CCGs were noted for “Not planning for adequate monitoring of implementation and effectiveness of services to review whether to continue with the chosen course” (Respondent 69). Respecting communication, there are cases where the relevant members in decision-making committees were reported as not receiving “enough reporting back on commissioned schemes” (Respondent 73). In the same vein, communication, one respondent bemoaned presentations that he or she characterised as being “too long and people ... not good at expressing succinct points” (Respondent 68). On a positive note, several of the respondents expressed that their CCGs had open culture nurturing “transparency and openness” (Respondent 72) to encourage free communication, thereby allowing members to be “able to professionally challenge” (Respondent 13) anything. This

includes challenging of persons with a domineering disposition, something which the respondents were asked about regarding how their CCGs handled such occurrences.

The communication channels identified from the respondents' answers under the subtheme of communication included "regular email communications", "weekly Hot Topics communication", regular briefings from the leadership, and "direct communication with the practice managers". Open culture is reinforced by several other behavioural patterns such as "Regular membership consultation" (Respondent 19) and members being polite and respectful to each other as well as "informal briefings and development sessions to explore ideas and tensions" (Respondent 45). What is more, the role of the chairperson in ensuring was widely mentioned by several respondents.

Moving to the way that the respondents perceived the way their local CCG members related with one another; on the one hand, some respondents felt that there was cooperation in their CCGs, a scenario best expressed in the response from Respondent 22 who talked of a "genuinely inclusive (e.g. lay members, Health watch on Board are very active and genuinely influential)" behavioural pattern. On the other hand, some CCGs were reported as working at variance with the local GPs. This sentiment is summarised in Respondent 6's statement which states that "CCG has been challenged on many occasions and has its own political agenda and doesn't value the local GPs". As a result, some CCGs "have become disconnected to GP practices" (Respondent 17). Regarding such environments, which can be viewed as politicised, Drake (2016, p.126) cautions that they may present "a risk of being a deterrent to some GPs engaging in a committee role". About the relationships with bodies external to their local CCGs, some respondents observed that they had "stable GP Commissioner Community, so the relationships are good between GB member GPs which helps with discussion and decision-making" (Respondent 24), while others indicated that they worked "with other organisations in partnership" (Respondent 4).

The other interesting pattern of behaviour pertained to the way that Conflicts of interest were dealt with. In general, those who reported positive patterns gave a picture represented in Respondent 20's answer which stated that "We have a well-rehearsed conflict of interest process". On the other hand, the culture of reviewing

issues that were generally portrayed as a positive, had sentiments such as, “Our GB is very open and honest” (Respondent 34) and “We encourage robust and healthy debate” (Respondent 72). Of note, some CCGs have been portrayed as being overly concerned about the subject of conflicts of interest in their approach to the extent that such guarded culture “can potentially block some important clinical decisions” (Respondent 25). In the same vein, Respondent 38 noted that “Conflict of interest sometimes [is] overplayed in reality”.

Complex as CCGs may be, some members reported “a well governed decision-making process” (Respondent 20) in their groups. Relatedly, Respondent 43 reported about his or her CCG having “clearly understood” governance structure, a view which was also echoed by Respondent 60 who added that his or her CCG had “clear lines of accountability and decision making”. On the contrary, some CCGs reported their setups as having a “poor governance structure and lack of clarity on decision-making roles” (Respondent 63). Regarding quality, the culture which was reported largely pertained to reports where for example, participants like Respondent 25 indicated that their CCG supplied “Good and accurate summaries/figures” while Respondent 48 stated that they had “Good quality papers”.

The ‘preoccupied focus’ was another established pattern of behaviour that the respondents reported. For example, Respondent 2 described his or her CCG as being “Distracted by STP!” while Respondent 53 stated that his or her CCG “Concentrates too much on secondary care”. On the other hand, one of the CCGs was reported as being “Overwhelming focus[ed] on efficiency/cost-savings” (Respondent 63). All these forms of behaviour can potentially stifle a balanced approach to decision-making.

4.3.3.5 Theme 5: CCG role

The CCG role was viewed from two perspectives; the way CCG role was understood by member practices and the way that the CCGs engaged with their member practices. Views were expressed that some of the member practices did not fully understand the concept and the role of the CCGs. To this end; Respondent 24 mentioned that “there is a wide misunderstanding of the role of the CCG by grass-roots GPs with frequent confusion of the role of NHS England with that of the CCG”. Still, in the same vein but from a different angle, Respondent 34 observed that in his or her CCG the question of

commissioning decisions was a source of tension. The GPs thought that commissioning was there only to 'serve' their (GPs) interests when in the actual fact CCGs had "to make decisions which serve our patients well too" (Respondent 34). Such a mix-up about CCGs could be indicative of poor CCG member practice engagement, a feature of the CCGs which is discussed next.

Engagement of the CCGs with their member practices is a vehicle through which the CCGs reach out to their member practices to get to know their requirements and communicate things like policy and other related issues to them. Some CCGs were perceived as being "unable to achieve GP engagement" (Respondent 53), a phenomenon consistent with what has been found in previous research that CCGs struggle to engage "with all GPs in a local area" (Robertson et al. 2016). To those that had active engagement with their member practices, several avenues used to that end were identified by the respondents. Engagement was identified as being either direct from the CCG through either personnel who are members of the Governing Body or using media, or indirect through intermediate committees like locality boards. The frequency of engagement ranged from weekly, monthly, and quarterly. The different forms of engagement were represented in the following responses: "Bulletins and newsletters" (Respondent 14), "Regular meeting with GPs and Practice Managers, regular email communications. Annual events" (Respondent 46), "GP Board members liaise very closely with Localities, and all practices are regularly visited by Board members" (Respondent 52), "Direct communication with the practice managers" (Respondent 54), "All practices have a member representing them on a locality board [which inputs to the CCG]" (Respondent 21), and "meetings open to all GPs and Practice Managers" (Respondent 69). These results go beyond previous reports about the method of engagement identified in Chapter 2, Section 2.4.3.

Owing to time constraints and work pressure, some GPs from member practices were identified as not being able to attend meetings through which they can convey their opinions to the CCG, as observed by Respondent 21 where he or she states that it is "Hard to get every member engagement, as so big and daily life so busy". What is more, some of the relevant bodies that are designed to represent the member practices at CCG level were reported to be somehow aloof as illustrated in Respondent 21's response, "The 4 locality boards seem to have relatively little input into the whole

CCG". This could be one of the possible reasons that some CCGs expressed a desire to fulfil their member practices' needs but did not know their wishes as exclaimed by Respondent 54, "The CCG makes many decisions, and it is not always known what the wishes of the members are. Where those wishes are sought the CCG tries to abide by them".

4.3.3.6 Miscellaneous theme

Items that fell into this group did not have any bearing on the main themes but had relevant and insightful subjects that played "a significant role in adding to the background detail of the study" (Nowell et al. 2017, p.8). For example, when asked about the reasons why they thought their CCGs made decisions unfriendly to the GP profession, Respondent 73 stated that "sometimes Primary Care [is] unduly examined compared to other providers". On the question of the aspects that they thought their CCGs were good at, Respondent 13 mentioned about his or her CCG "standing up to the stupidities of NHS England". In the same regard of good aspects, some respondents did not have anything to say about their CCGs, with one simply responding, "None specifically" (Respondent 29). Several respondents mentioned the balancing factor to the decision-making committees that the lay members had, albeit their lack of proficient knowledge in some things. For example, Respondent 62 indicated that "the lay members are poorly informed, but are bright and ask awkward questions quite often. The committee can be embarrassed into reconsidering things". One of the responses of note served as an indication of the typical GP's life, which is being overworked. Instead of inputting the relevant answer, Respondent 66 said, "sorry too tired - doing this at past midnight after doing a 12-hour day at CCG and the practice and then 3 hours at home processing patient letters and test results".

On the question of the aspects that they thought their CCGs were bad at, insightful responses were given. Respondent 45, for example, mentioned that his or her CCG was "reactive – i.e. 'firefighting' culture, not good at encouraging 'horizon scanning'". On the other hand, some CCGs were put across as having distracted focus, perceived as concentrating "too much on secondary care. Seems unable to achieve GP engagement" (Respondent 53).

Because of the intuition that wherever people gather, there is bound to be overbearing individuals, the participants were asked to describe the arrangements that their CCGs had in place to curb such characters. Several of the respondents indicated that they either did not know or there were no such arrangements in place at all. One respondent gave an observation that such personalities presented a challenge “‘behind the scenes’ in influencing what is presented to meetings in terms of content and recommendations” (Respondent 69).

The other thing that the respondents were asked about was to give their views about the level of satisfaction that they had concerning the way that decisions were made in their local CCGs. One respondent intimated to the fact that they were returning to be a PCT even though he or she did not say in what sense. In that scheme, the respondent stated that they had “to make decisions for the greater good balancing priorities across the health economy, not necessarily for any particular provider or professional group. Damned if we do, damned if we don’t probably summarises it!” (Respondent 13). Support mechanisms were also highlighted as a cause for concern, while other respondents thought that some of the interconnected committees moved slowly, which possibly stifled the overall progress in decision-making. Although NHS England elsewhere was characterised as being dictatorial, one respondent noted that “NHSE Primary care commission is unresponsive” (Respondent 65).

Concerning the way that the CCGs achieved GP member practice engagement, some CCGs indicated that they struggled, while one said they “used to hold three monthly meetings and now nothing” (Respondent 6). On a positive note, one respondent mentioned that his or her CCG conducted an annual survey in which “GP practices are formally asked ... to comment on CCG” (Respondent 25). To such, Respondent 25 said, “The feedback is strongly positive with high approval ratings”.

4.4 Conclusion

In conclusion of this chapter, data analysis has been performed on quantitative and qualitative data. First, the descriptive statistical analysis of quantitative data has been presented. Alongside this, some of the qualitative data have been quantified and analysed quantitatively using descriptive statistical analysis. Quantification of qualitative data, which is viewed as being a form of mixing in a mixed methods

methodology by some scholars (Creamer 2011), was the first step of mixing performed in this study. The results of the descriptive statistics have been presented with the aid of graphs and charts for visual illustration. A discussion of the results has also been made in which a comparison of the current study results with the findings from the literature has been made.

The next section has been inferential analysis where the causal hypotheses have been tested using the Partial Least Squares Structural Equation Modelling (PLS-SEM). Before that, the fitness of the PLS-SEM path model had to be established in line with the PLS-SEM procedures, which prescribe that the outer model should be tested first followed by the inner model. If the outer model fails the test, the latent variables and observed variables should be rearranged, and the whole model retested, which was the case in the current study. While the outer model involves testing of relationships between the observed variables and their connected latent variables, the inner model tests involve testing of relationships between the latent variables. It is at this point that testing of causal hypotheses is done. There are four causal hypotheses which were tested in this study.

The qualitative data were analysed under the guidance of interpretative phenomenological analysis (IPA). Five key themes have been identified from the data. These are the financial theme, bureaucracy theme, clinical implications theme, workplace culture theme, and CCG role theme. The data with further insights that did not fall into any of the abovenamed themes have been put into a sixth theme, called 'miscellaneous' theme. Like the quantitative data, a discussion of the qualitative data has been made. Interpretation of the qualitative data has also been done from the researcher's understanding of the data, in line with the interpretive phenomenology approach discussed in Chapter 3, Section 3.6.2.2.

CHAPTER 5

CONCLUSION

5.1 Summary of the research

This chapter provides a summative account to give insight into how I developed my study and how the results thereof contribute to, and have implications for, theory and practice. Also included is a discussion of the implications for practice and research limitations, along with the recommendations for future research based on the findings of my study.

Synthesis of complementary quantitative and qualitative data, referred to as mixing under the mixed methods design, a methodology that I adopted for this study, is performed in this chapter. The employed strategy is merging (Creswell & Plano Clark 2011), a basic mixing approach that Creamer (2011) identifies as linking or juxtaposing of two types of data with no data transformation conducted. This mixing is the second form in the current study. The first form was performed at the analysis phase in Chapter 4, where quantification of qualitative data, referred to as quantitisation in this thesis, was done. Quantitisation of qualitative data is a form of mixing approach advanced by Creamer (2011).

While mixing of the quantitative and the qualitative findings can “offer insights that could not otherwise be gleaned” (Bryman 2007, p.9), not all cases presented in this chapter constitute combined findings. The reason for this goes back to the original formulation of my study, where, at the onset, I privileged quantitative research strand above the qualitative research strand. The conceptual framework, described in Chapter 2, Section 2.5, demonstrates this. In this arrangement, the approach was set to inform the quantitative research questions first, which were then supplemented by the qualitative research questions. Privileging the quantitative study above the qualitative study in a mixed methods research has been frowned upon by some scholars who perceive mixed methods as relegating qualitative research to a secondary status, a mind-set that Creswell et al. (2006) sought to redress, as that is not always the case. The eminent value of qualitative study in a mixed methods research is demonstrated in this study, as it turned out, subsequently. That is, although I originally

designed this study to be quantitatively driven, it turned out that the findings from the qualitative data were highly nuanced and provided fine-grained insights that were subsequently used to contextualise the quantitative strand results. This occurrence led the conclusions to be qualitatively driven, relegating the quantitative strand findings to be mainly used in support.

5.1.1 Recap of research problem

The focus of this study was decision-making in the CCGs of the English NHS. CCGs are entities which resulted from the reforms introduced in 2012, to provide local autonomy in the commissioning of the secondary and community health care services by decentralising authority to the clinicians who know their local population needs, with the aim of improving patient care (Moran et al. 2017b; NHS England 2015; Talbot 2014; United Kingdom Government 2012). Interest in the CCGs followed the findings of a survey by the British Medical Association (2014a), which suggested that the CCGs have failed to “deliver overall improvements to patient care or involve more GPs in the running of services” (British Medical Association 2014a). The GPs at the practice level perceived the policies that the CCGs produced as being restrictive to the efficient service delivery, thereby implicating decision-making. For this reason, the current study primarily aimed to identify the factors that influence the effective decision-making process in the CCGs as perceived by the GPs. To achieve the primary aim, I developed a hypothesised conceptual model demonstrating factors at play in the decision-making process, based on perceived reality in terms of a network of causal effects across different latent variables extrapolated from the literature. Secondly, investigation of the CCGs was of interest because previous research identified limited awareness of GPs’ activities and roles in their respective CCGs (Checkland et al. 2016; McDermott et al. 2015).

5.1.2 Recap of research methodology

Mixed methods, a methodology that performs quantitative and qualitative investigations in one study, was considered ideal for the current study consistent with the literature claims that it facilitates “a more complete understanding of [the phenomenon of study]” (Creswell & Plano Clark 2011, p.77) by synthesising complementary quantitative and qualitative data. In this arrangement, the

quantitative strand provided a predictive framework while the qualitative strand provided an interpretive framework. A philosophical position of pragmatism underpinned the entire research design. This study considered pragmatism through the lens of Morgan (2007) whose technique known as the pragmatic approach is stripped of the weight of philosophical knowledge on related underpinnings, only embracing the fundamental epistemological implications supporting the general approach assumed by the researcher. Emphasis is placed on how the epistemological implications of the knowledge generated by the research relate to the methods used to produce that knowledge. In this respect, the quantitative strand in the current study was aligned with post-positivism which argues that a researcher can discover only partial knowledge of reality due to their human limitations (Mertens 2009). By contrast, the qualitative strand was aligned with interpretive phenomenology which aims to “interpret the embedded meaning in a lived experience” (Charlick et al. 2016, p.207). Aligning a single study with multiple philosophical positions can arguably open accusations of inconsistency, a phenomenon recognised by the proponents of mixed methods as being a source of criticism of this methodology (Creswell & Plano Clark 2011; Mason 2006). This question is addressed in more detail with specific focus on the current study in Chapter 3, Section 3.2 and Section 3.3.

I collected the data for my study using a survey for both strands, quantitative and qualitative. Analysis of quantitative data, in which the hypothesised conceptual model was tested, was achieved by the use of Partial Least Squares Structural Equation Modelling (PLS-SEM) whereas the qualitative data were analysed under the guidance of interpretative phenomenological analysis (IPA) method. The qualitative strand was supported by the research question, “How do the GPs describe their individual experiences at their local CCGs regarding the process of decision-making”. At the same time, the quantitative strand sought to test the following nondirectional hypotheses:

Causal Hypothesis 1: A high proportion of GPs in the Governing Body committee will improve the decision-making process effectiveness.

Causal Hypothesis 2: The level of GP influence in the Governing Body will cause a difference in the effectiveness of the decision-making process.

Causal Hypothesis 3: A high level of GP influence in the Governing Body will increase the degree of satisfaction about decision-making.

Causal Hypothesis 4: The level of GP influence in the Governing Body will cause a difference in the degree of GP satisfaction about decision-making dependent on the member practice wishes being met, such that satisfaction is more likely to be positive if member practice wishes are seen as being met.

5.1.3 Summary of research findings

The summary of the research findings outlined in this section is split into two main segments in line with the research aims, the primary and the secondary aims described in Chapter 1, Section 1.1. The primary aim sought to explore decision-making profiles and associated processes within the CCGs to identify factors influencing effective decision-making process based on GPs' views whereas the secondary aim simply sought to assess the formal roles occupied by the GPs in the CCGs. The findings summary for the latter is presented first in Section 5.1.3.1 under the header of "GP roles", as the secondary aim informs the primary aim. The summary of the findings on the primary aim are then subsequently presented in Section 5.1.3.2, under the header of "Factors influencing perceived effective decision-making". Before that, an overview of the CCGs as decentralised entities within the English NHS is made in the interest of recapitulation of the study's contextual background.

First, since the CCGs were granted autonomy to run their affairs, I considered these entities as decentralised bodies, as per Mintzberg (1979) position in this regard. Mintzberg (1979, p.181), considers decentralisation (and centralisation) based "exclusively in terms of power over the decisions made in the organization", which, in the case of CCGs, decision-making power for commissioning routines was devolved to the local level. Even so, in the concept of decentralisation, the outcome of decision-making can be influenced by different persons wielding power at different stages of the decision-making process, ranging from the stimulus to the execution of the decisions made (see Figure 2.7). Regarding the CCGs in this respect, the autonomy granted them means that they can collect their information from their local interested parties. They can analyse that information themselves and determine the best choice from the available options. They do not need to seek authorisation on the choice that

they make, as they are the implementers of the decisions made. It is from this mix that the GPs in the BMA (2014a) study expressed discontent owing to the policies that the CCGs produced.

There is, however, another dimension to note in this equation. While the CCGs can be styled as self-managing teams at micro-level, at macro-level, they receive strategic direction along with the allocation of financial resources from NHS England in a top-down method (Department of Health 2012; NHS Commissioning Board 2012b). This degree of formalisation along with stated autonomy makes CCGs to be identified with the professional model in the Mintzberg's framework of organisational structures (Mintzberg 1979). It is across this organisational structure divide, macro and micro-level, in the CCGs, that my study sought to identify the factors influencing the perceived effective decision-making process.

5.1.3.1 GP roles

Previous studies have discovered several things, which still apply, regarding the roles occupied by GPs in the CCGs. First, was the complexity of the CCGs from the standpoint of the variability of roles that the GPs occupy. There are numerous roles that the respondents mentioned in their answers, so many that some of the respondents did not even bother listing them, but instead, just stated, "too many", in their responses. As suggested by McDermott et al. (2015, p.30), this study validated the assertion that "asking what the role of GPs is or should be in CCGs is a complex question with as many answers as there are CCGs". There is, however, an additional, and previously unaddressed, area which this study investigated. This was ascertainment of the number of roles occupied by individual respondents, which this study equated with the weight of responsibilities borne by the GPs. Weighting was equated to the number of roles that each GP occupied by quantifying the free text answers that the respondents gave detailing their roles. It is not the content, but just the quantity in terms of the numerical count of the roles, that this study considered in the estimation of the inferred weight of responsibilities. In this regard, it was discovered that most GPs held only one role (53.4%) while just over a third of the respondents (38.4%) held either two or three roles. There was a 'handful' of exceptions of those who held five or more roles (8.2%).

Also identified in this study were the committees that the GPs sat on. Additional to the three mandated by statute that every CCG should have – namely, Governing Body, Remuneration, and Audit, there were numerous types of other committees that the respondents listed. Most corroborated the previous findings, but there were new names not mentioned in the previous studies that were reviewed in preparation for the current study. They included roles such as “House of Care Programme Board” and “Clinical Senate Council”. The diversity of the committees is vast so much that one of the respondents even stated that his or her CCG “Committees have strange names” (Respondent 61).

Like the approach used in the roles occupied by the GPs, the presumed weight of commitments that the GPs had was also considered. I did not look into the content of the committee, but just the numerical count of committees GPs sat on. The analysis discovered that the number of formal roles that a GP has is not necessarily equal to the number of committees that the same GP sits on. For example, after quantising the free text, Respondent 2 was found to be occupying two roles while the same respondent reported sitting on four committees. A significant proportion of the respondents said that they sat on one committee (43.4%); a more substantial proportion indicated that they sat on three or more committees (50.9%).

The rationale for inferring weight to the number of committees and roles that GPs occupied assumes that these can be used to estimate the time that they are likely to spend in their CCG assignments. GPs’ time is expensive and as such should be used prudently, as McDermott et al. (2015) noted. McDermott et al. (2015) discovered that there was a conflict of interest over time allocation to the GPs with formal roles in the CCGs to perform their CCG work, thereby resulting in GPs working in the evenings and weekends, and in some cases with some of the practitioners altogether leaving their practice jobs to work full time in the CCG. As a result, in the recommendations that they made to the policymakers, McDermott et al. (2015) mentioned the element of GPs’ expensive time, which should be used wisely.

Also discovered about the formal roles that the GPs occupied was that a third of the GPs did not sit on the Governing Body. It is, therefore, unclear what impact they have on the perceived effective decision-making process when considered from the

standpoint of this study. Another interesting finding is the relatively small proportion of the GPs (34.3%), who indicated that they had served their CCGs for up to three years, when compared with those who had served for more than three years (65.8%), as discussed in Chapter 4, Section 4.2.1.1. The observed small proportion of new GP entrants to the CCGs corroborates previous studies which identified a lack of enthusiasm in the GPs taking up roles in the CCGs (Checkland et al. 2014) as well as a decline in GP representation within the CCGs with the roles that the GPs should play increasingly being occupied by managers (Rosser 2018; Checkland et al. 2016; Drake 2016).

5.1.3.2 Factors influencing perceived effective decision-making

This section presents a summary of findings regarding factors influencing perceived effective decision-making in the CCGs, from the perspective of GPs. These factors are by no means exhaustive. This is especially true when considering the diversity of the CCGs which research has established that “no two are exactly the same” (McDermott et al. 2017, p.10). Also, these factors should not be viewed as being independent of each other as some overlap, thereby supporting each other. For example, financial considerations have been demonstrated to be affected by bureaucratic “rules, regulations, and procedures”. Another thing worth mentioning is that the qualitative data yielded unanticipated insights which are typically conveyed unmixed as there may not be any quantitative data to complement them. These include factors such as communication and time.

1) GP Proportion

Studies on CCGs have not attempted to consider the role that GP proportion plays in the decision-making process. The current study sought to determine the significance of this factor through testing of hypothesis, which was initially developed in the conceptual framework in Chapter 2 and refined at the analysis phase in Chapter 4. Here, inference regarding the import of the GP proportion in the Governing Bodies was made. Proportion here relates to the number of GPs in the Governing Body when compared with professional backgrounds of other Governing Body members. It is crucial to state that core insights about GP proportion and its impact on decision-making in this study were drawn from a purely quantitative measure.

The existing literature mentions that the GPs have been perceived to be relatively less influential in meetings when compared to the managers (Holder et al. 2016; Naylor et al. 2013). As such, the current study sought to understand that, since GPs are perceived as being less influential in the Governing Body meetings, does the proportion of their numbers in the platform have any significance on decision-making? It should be noted that there are no guidelines in the relevant legislation which was enacted at the inception of the CCGs about the proportion of GPs concerning the size of the Governing Body. Instead, only key specific roles like Accountable Officer, Chair, and Clinical Lead along with the corresponding candidate attributes for those roles, are outlined (NHS Commissioning Board 2012a; United Kingdom Government 2012). Outside the specific roles identified in the guidelines, GPs, in a narrow sense, are only described in the literature at representation level of the GP member practices with no defined formula on how that should be achieved in the sense of GP numbers or proportions. That aspect was left to individual CCGs' discretion, as mentioned in Andrew Lansley's letter to the CCGs' clinical and managerial leads (Lansley 2012). In this respect, Checkland et al. (2016, p.4) discovered that "the percentage representation of GPs on GBs [Governing Bodies] ... showed considerable variation".

The observations from hypothesis testing and correlation matrix (Table 4.8) in the current study established a very high positive correlation between the perceived relationship of the latent variable *GP Proportion* and latent variable *Decision-making Process Effectiveness*. However, there is a caveat to this. This is when it comes to voting for specific items in the Governing Body as not all GPs can do that in line with procedural regulations depending on the other committees that they sit on, which may result in the conflicts of interest (Moran et al. 2017a). Also, the significance of this observation may be weakened by other factors such as strong personalities influencing the decision-making process and negative groupthink, if these aspects are not adequately managed.

Overall, the reason for the observation that GP proportion has a positive influence on decision effectiveness, as discovered in this study, could be linked to findings from previous studies. Leading in this is the reason which led to the investigation of GP proportion – that is, a relatively low level of GP influence in meetings when compared to the managers, as described at the beginning of this

section. Logically, GP proportion is a means to achieve influence, which impliedly means, the higher the GP proportion, the greater will be the GP influence. This assertion is substantiated by the correlation matrix results (Table 4.8) which show a high positive correlation between variables *GP Proportion* and *GP Influence* (0.837). However, as studies have shown, GP representation in the CCGs has been in decline, with the roles that the GPs should play increasingly being occupied by managers (Rosser 2018; Checkland et al. 2016; Drake 2016)?

2) Workplace culture

Workplace culture, discussed in Chapter 2, Section 2.3.3, is here viewed from Schein's levels of culture (Schein 2017). The levels relevant to this study were level two and level three. To recapitulate, the second level, referred to as 'Espoused Beliefs and Values', encompasses standards and protocols about the behaviour of the organisation, to represent the character of the organisation internally and externally. The third level, referred to as 'Basic Underlying Assumptions', is about shared assumptions manifested through unconscious behaviour. Existing studies have shown that culture may obscure "the rationality of decision-making processes" (Strutton & Carter 2013, p.2). A range of contextual factors falling under the umbrella of culture influencing the perceived effective decision-making process, has been identified in this study, based on GPs' views. These include leadership, governance, communication, and time factor; and are described next.

Leadership: It is self-evident that leadership is a "critical determinant of success" (Williams & Brown 2014, p.11). NHS Leadership (2014) portrays the same thought with the words, "without the correct leadership and organisation, the NHS would fail to provide the services it is required and expected to do". The idea about the potency of leadership to organisational success as well as its import in influencing decision-making is described in the literature elsewhere (Storey et al. 2018; Tyssen et al. 2014; Rolfe 2011; Avolio et al. 2004). This thesis has also reviewed this concept in Chapter 2, Section 2.3.7.

The respondents in the current study cited good and strong leadership qualities as being pivotal in enabling perceived effective decision-making process. These qualities were discovered to be pertinent in facilitating orderly meetings, encouraging

open communication, curbing strong personalities from domineering during the meetings, to mention but a few. The study asked about the background of the Accountable Officer in order to ascertain the possible direction that the decisions might take. The study revealed that a majority of 60.3% of respondents' CCGs had a manager occupying the position of the Accountable Officer while just over 30% of the respondents said a clinician occupied this position in their local CCG. While the literature discusses how rewarding it might be to the clinicians to have a GP in this position (Storey et al. 2018), it is not clear why in the current study a relatively lower proportion of clinicians were found to occupy this position. Could it be that the clinicians are not keen on leadership positions as they are not trained for such roles, as observed in the current study (Respondent 63) as well as reported in the subsequent study (Storey et al. 2018)? The most recent research shows other obstacles that may discourage the GPs from taking leadership roles – namely, lack of time, lack of incentives, and “lack of influence” (Storey et al. 2018, p.30). Could it, therefore, be the case that decisions blamed on CCGs by member GP Practices are promulgated by having non-clinical persons in key leadership positions like Accountable Officer, seeing how important leadership is to decision-making? An inference from subsequent research by Storey et al. (2018) suggests that this blame may not be apportioned to managers only, but GP leaders as well. In that study, GPs who accepted leadership roles were characterised by their colleagues as being “in danger of switching their identity and their allegiances from being first and foremost ‘a working GP’ to a rather different stance of being ‘leader–manager–clinician’” (Storey et al. 2018, p.50). Meanwhile, the GPs caught in this dilemma are actively encouraged by the system to view themselves as leaders of the CCGs – that is, commissioners, as opposed to the voice of GP member practices (Baird et al. 2016).

There is another aspect not exposed in the data from the current study which will be addressed with the insights drawn from other settings in the CCGs sector because of its relevance to the decision-making process. It is leadership behaviour. Recently, Collins (2019) reported about a situation regarding leadership in the Sheffield CCG that has the leadership attributes of destructive leadership behaviour, described in the literature (Einarsen et al. 2007). Collins (2019) report uncovered a culture of “bullying, favouritism, and harassment” administered by the Accountable Officer and

other senior CCG staff as being widespread, which led to the breakdown in relationships. Furthermore, “poor relationships between members of the governing body” were also reported. It would be difficult to achieve perceived effective decision-making in such “toxic” environments, as a review of Sheffield CCG commissioned by NHS England confirms. One of the key findings from that review was an occurrence of poor decision-making processes. A case in point to note here is the office of leadership, specifically the Accountable Officer, which the literature characterises as having power, together with the Chair, to steer the strategic direction of the local CCG (Storey et al. 2018). Could it be the destructive leadership behaviour of the Accountable Officer which produced the situation in Sheffield CCG? The report says the problems started at the time when the incumbent Accountable Officer was appointed. Can that kind of behaviour, destructive behaviour, be classed as a leadership style? Some scholars argue that leadership cannot be called destructive as it is only characteristically positive (Yukl & Van Fleet 1992 cited in Schyns & Birgit 2013, p.139). Instead, it is the behaviour of the leader which is destructive not the office as such. Notwithstanding, it would be interesting to establish if there is any correlation between the leadership style of different CCGs’ top leadership (Accountable Officer and the Chair) and the perceived effective decision-making process, given the key position that leadership occupies in determining the success of the organisation.

Governance: Governance was also identified as influencing the perceived effective decision-making process, something that Williams et al. (2018) also alluded to. Governance, which Williams et al. (2018) identified with leadership, was likewise recognised by one of the respondents in the current study, Respondent 60, who regarded “Strong governance and effective leadership” as being one of the areas that his or her CCG was strong at. It appears that wherever respondents mentioned good governance as being one of the areas that a CCG was strong at, a retinue of other positive attributes which support perceived effective decision-making was also named alongside. This is possibly due to the involved CCGs taking this phenomenon beyond formal lines of performance management, but also to the political practicalities which entail “coalition-building, stakeholder engagement and securing the acceptance and legitimisation of decisions” (Robertson et al. 2011, p.63). The positive attributes aligned with good governance discovered in this study include balanced representation

from all committees, the existence of non-agenda meetings to voice any concerns, issues discussed beforehand in other committees before the Governing Body sits, patient voice being heard, and member practice and GP views considered.

It is fitting to reiterate that the effective decision-making process in this study was viewed as being any action that supports efficient delivery of health care service within the CCGs' decision-making process continuum (see Figure 2.7), as per Mintzberg (1979). While the concept of effective decision-making was considered in terms of GPs' perspective, thereby referring to it as perceived effective decision-making, describing the technicalities of measuring or testing the predicted outcome was outside the scope of this study. Therefore, the attributes mentioned above which were identified as being connected to good governance can be viewed as enablers to achieving the perceived effective decision-making process. To realise good governance, Drake (2016, p.128) proposed that "GP involvement and clear communication" should be fostered. Also, establishing "where responsibility for decision implementation lies [is vital,] as this will influence the decision making process" (Williams & Brown 2014, p.15). The notion about the involvement of the GPs draws attention to the question of GP proportion in the Governing Body, in the case of the current study. That is, the higher the proportion of GPs, the higher the involvement will be. This could be aligned with the results of hypothesis testing which established a positive correlation (0.932) between the proportions of GPs in the Governing Body and perceived decision-making process effectiveness.

Turning to the question where respondents stated their CCGs as being inadequate in governance, it was discovered that this occurrence was associated with a lack of clarity on decision-making roles. What is more, one respondent expressed doubts in his or her CCG decision-making effectiveness because of indistinct governance, remarking that their decision-making is constrained by forces which are "not always easily visible to the wider membership" (Respondent 31). Relatedly, poor governance was also blamed at macro-level because of unclear lines of accountability between NHS England (NHSE) and NHS Improvement (NHSI). In this respect, one respondent stated that, "Unfortunately NHSE and NHSI do not run to the same rules, so providers can go over budget and the CCG has to pay" (Respondent 40). Other aspects that were identified as influencing the perceived effective decision-making

process under the question of poor governance included the “lack of clarity about the division of commissioning responsibility between NHSE and CCGs” (Respondent 74) which could speculatively lead to uncertainty in decision-making.

Communication: Communication has been highlighted in the previous studies as being pertinent to success, particularly when considering the complexity of the CCGs, as discussed in Chapter 2, Section 2.3.8. In this study, insights into communication were drawn from the qualitative data. The participants in the current study identified excellent communication in their responses as being an enabling factor for the perceived effective decision-making process. For example, one respondent mentioned that in their CCG they “have a weekly Hot Topics communication, the CEO sends out a regular briefing” (Respondent 20). Communication mattered both within and without the CCGs. Regarding the former, the respondents stressed that open culture enables professional challenge of anything that concerns the CCG, including persons with a domineering disposition. The latter commanded a stable and strong relationship between the Governing Body and the GPs at the practice level, which in turn aided understanding of the respective local needs by the CCGs. Closely connected with this is an environment that affords persons in various committees equal opportunity to contribute and feedback from member practices they represent. This is consistent with what has been found in the McDermott et al. (2017, p.55) study where good communication was pointed out as being a mechanism “which enable clinicians knowing which forums to address their concerns”. In addition, the two-way communication approach demonstrated here resembles what Grunig and Hunt (1984) labelled as “the most effective way of communicating” (cited in Park et al. 2014, p.542) which promotes a mutual understanding in resolving conflicts and establishing respect within the organisational persons.

Poor communication, on the other hand, was identified as hampering perceived effective decision-making at different levels. The current study discovered that poor communication stemmed from the leadership who were singled out for not being proactive in conveying information in a timely and comprehensive manner on aspects like agenda matters. Such affected the efficiency of meetings. Studies have revealed, “that employees who felt that their organizations did a poor job of communicating with them were 7 times more likely to be dissatisfied at work” (Drake et al. 2005, cited

in Park et al. 2014, p.542). Poor communication was also observed on some of the ordinary Governing Body members in the current study. They were said to lack presentation skills and blamed for taking disproportionately too much time on the task. All this culminated in yet another factor influencing the perceived effective decision-making process, time.

Time factor: Numerous respondents indicated time as being a grave concern because it was said to be insufficient in many respects. This factor was first identified in 2013, the year that the CCGs were launched. For example, a study by Naylor et al. (2013) discovered that the GPs pointed out time as being one of the unfavourable elements under which CCGs began. Respecting this, the current study discovered that meetings were perceived as being rushed and not enough time given to examine presenting issues properly. Closely related to this were two observations. One was about the agendas which were perceived as being 'clunky' while the other related to the poor communication skills discussed above in which some members made too many long presentations. Unrealistic scheduling of meetings which did not recognise the need for the clinicians to prepare by giving them enough time to review relevant materials beforehand exacerbated the question of the time factor. As a result, decision-making ended up being based on superficial and insufficient knowledge.

3) Conflicts of interest

One of the crucial factors identified was the conflicts of interest which may render some GPs to be unable to vote in the Governing Body. This topic is reviewed in Chapter 2, Section 2.4.4. There are two essential things that the results from the quantitative data analysis revealed that have a significant import to the question of the conflicts of interest. One pertains to GP proportion in the Governing Body, which hypothesis testing indicated a positive correlation between variables *GP Proportion* and *Decision-making Process Effectiveness*. The other is about the voting capacity of the GPs in the Governing Body of which the quantitative results indicated that most of the GPs who said that they sat on the Governing Body also mentioned that they were voting members. That is, of the 69.9% who indicated that they sat on the Governing Body, 98% said they were voting member in the same committee. The setback that the management of conflicts of interest brings is that, notwithstanding a high proportion of GPs having the voting status, and in some instances constituting a high proportion in

the Governing Body, it does not always follow that they can vote in all cases as indicated in the current and previous studies (Moran et al. 2017a; Holder et al. 2016). In consequence, this situation could be a barrier to the perceived effective decision-making process on the part of the GPs who may not be able to represent their clinical interests in full measure if they happen to be flagged as conflicted.

The question of the conflicts of interest was in some instances characterised as being overlaid to the detriment of clinical decisions, as noted from some of the respondents' free text answers (Respondent 38). Even so, while the question of conflicts of interest is crucial to influencing the perceived effective decision-making process, overall, there were relatively fewer concerns expressed by the respondents about this being mishandled than there were about good and well-rehearsed processes and procedures to handle it (Respondent 13; Respondent 20; Respondent 27; Respondent 33). There is, though, a paradox of note about the question of the conflicts of interest that one respondent exposed. The dilemma is that, while the GPs were excluded from participating in the voting process if they were found to be conflicted, the non-clinical officers who could be equally in the same predicament were reported as being exempted from the rule that conflicted persons should not vote (Respondent 37). This kind of behaviour was said to occur when decisions that affected the future career of the non-clinical officers were in the balance. To illustrate this, an insight derived from an incident outside this study, not directly connected with commissioning decision-making process, but, all the same, occurred within a CCG setting, will be used. Recently, the Health Service Journal reported about a Chair from Crawley CCG who breached the conflict of interest rule when he advocated "for a technology company that had paid his consultancy firm £35,000" (Clover 2019). A case in point about this incident is that, notwithstanding the alleged breach, the Crawley CCG Governing Body is reported as having attempted to protect him, a form of behaviour which demonstrates Respondent 37's view cited above. It would appear like; appropriate action is taken if GPs are conflicted, whereas when an officer is conflicted, the conflict of interest rules are not always enforced accordingly.

4) Bureaucracy

While the formation of the CCGs was claimed to rid the primary health care system of the central blueprint (Checkland et al. 2016), thereby dubbed by some authorities as

locating “the headquarters of the NHS ‘in the consulting room and the clinic’ (The King’s Fund 2018), this study has discovered that bureaucracy still plays a significant part in the CCGs at a macro and micro level. To this end, some of the respondents commented about “pressure from the centre to dictate operational matters and sometimes even infringe on our decision-making abilities” (Respondent 60). Also, “decisions ... made at top level with little consultation and feedback” (Respondent 17) were reported.

Numerous respondents deplored how their CCGs were controlled by higher authority both at the micro and macro levels on financial matters. For example, at micro-level, financial directors were perceived as imposing decisions in an effort to balance their books. Mintzberg (1979) identifies this kind of control in the decision-making process continuum with bureaucracy, where senior managers exercise their power to approve, block, or change decisions (see Figure 2.7). At the macro level, NHS England was said to be dictating the course of direction for the CCGs whose budgets happen to be overdrawn. Could these actions be a result of the requirements outlined in the assurance framework against which the CCGs are measured, as discussed in Chapter 2, Section 2.3.6.2? The consequence of this could be a shift back towards the bureaucratic model (Mintzberg 1979) as that removes the macro-scale government initiative of professional having a key decision-making role.

Given the ‘draconian’ measures occasioned by the assurance framework, CCGs may find themselves with no choice but to pass the same severity to their member practices in the form of commissioning policies that they produce if they are to meet the expectations of NHS England. Considering this, someone may question if CCGs are really autonomous or just “a delivery vehicle for NHS England”, as Respondent 62 remarked. Are the CCGs genuinely decentralised? In one sense, yes, with respect to the NHS. In another, no, because of the high formalisation prescribed by the centre. As mentioned above, there may be a shift from the macro-scale government initiative of professional model to bureaucracy model (Mintzberg 1979). This view is reinforced by a widespread dissolution and merging of CCGs, discussed in Chapter 2, Section 2.3.6.1. The predicament that could be raised by this move regards the degree of decentralisation and member practice representation that this change will achieve. Essentially, because of this exercise, a few centres of CCGs ‘dotted’ around England

where decisions are made may remain, thereby indirectly moving the system back to the centralised bureaucratic model (Mintzberg 1979) that the PCTs operated under.

The challenge with bureaucracy is that usually, it dampens “moral impulses” of the decision-makers, resulting “in the most horrific acts” (Bauman 1989, cited in McAuley et al. 2014, p.76). Bauman (1989, p.253, cited in McAuley et al. 2014, p.76) characterises the leaders that disproportionately wield the bureaucratic power as having an ill-defined view of the primary purpose of the organisation while at the same time acting as tunnels of “bureaucratic virtuosos”. Could this be the root of the reasons why some CCGs come up with decisions that are perceived as unfriendly to the GP profession, a phenomenon substantiated by the PLS-SEM model observed variable “GBUnfrieDec”? In this respect, more than a third of the respondents indicated that their CCGs have, at one point, come up with decisions that were perceived as unfriendly. Apart from this, the PLS-SEM model demonstrated the attributes of bureaucratic control through the reflective latent variable *Decision-making Process Effectiveness*. Three observed variables symbolising bureaucracy seemed to reliably reflect the bureaucratic impact on the decision-making process. The variables in question are SnrVetoDec (Senior Member or Government Official Vetoed Decisions Made by Governing Body), GBUnfrieDec (Unfriendly Decisions), and GBDysFunc (Governing Body Is Dysfunctional).

Because CCGs were given much latitude over their decision-making structures, some may find it more comfortable to return to bureaucracy. This notion is confirmed by one of the respondents who stated that, “In effect we are returning to being a PCT, but ours locally was well managed and effective” (Respondent 13).

5) Financial considerations

The aspect of financial consideration featured significantly in both quantitative and qualitative data. In both instances, the picture of this factor was not positive. To begin with, in the free text responses the question of finance was discovered as implicating financial gain, cost-savings, micro-level impact, and macro level impact. The root cause of all the problems associated with the financial question was identified by the respondents in all areas as insufficient funding, which is consistent with the established observations reported in the existing literature (Wood & Heath 2014). As a

result, this subjected the CCGs to difficult choices which influenced decision-making. For example, the respondents accused financial directors of forcing certain decisions in “desperation to make books balance” (Respondent 32). In one instance, a finance director was portrayed as “trying to balance the books and failed to recognise the implications of his decision” (Respondent 24), a typical reason widely ascribed to the perceived unfriendly decisions. It was discovered that when the free text of the respondents’ answers to the question of the causes of unfriendly decisions that the CCGs made was quantitised, financial constraints emerged as a leading cause in the descriptive statistics. Additionally, unfriendly decisions also featured in, and were supported and sustained by, the PLS-SEM model as being a valid observed variable to reflect the perceived character of the latent variable that denoted the decision-making process effectiveness. Could the finance question be the case why the Devon CCG was reported on the news as having announced that it was going to restrict all routine surgery for obese patients and smokers as well as restrict all routine shoulder surgery for all patients (The Guardian 2015)?

6) Member practice engagement

Engaging with the local GP Practices, a subject reviewed in Chapter 2, Section 2.4.3, is crucial if the CCGs are to be adequately informed about the needs of their local membership. Notwithstanding, the current study has predominantly shown a lack in that regard, a pattern also observed in previous studies (Robertson et al. 2016). Some of the CCGs in the current study were criticised for not valuing the local GPs at GP Practice level. The wishes of member practices were identified by one of the respondents as being not always known (Respondent 54). This intimation was corroborated by the general statistical analysis results in which it was discovered that more than 40% of the respondents neither agreed nor disagreed if decisions made by their CCGs reflected the wishes of their member practices. Could this be a symptom for a decline in the perception that GP Practices generally have about their influence on CCGs? For example, to this end, Bostock (2016) reported a 15% drop, from 35% to 20%, of the GPs at GP Practice level who felt that they were able to influence decisions in the CCGs in the period spanning a survey in 2014 to the then-recent studies? Could such a landscape account for sentiments such as, “We have become disconnected to GP practices” (Responded 17)? Like Storey et al. (2018, p.35), “One might expect that

at least GPs on the CCG board would be the prime intermediaries and communicators with other primary care clinicians”.

In certain instances, the current study also discovered that some CCGs were characterised as being aloof and slow at responding to GP Practices’ problems. The CCGs were also accused of being politically motivated, which could be one of the reasons why they ignored their core responsibilities to their member practices. The other side of the picture concerns the GPs in the member practices at issue. While these individuals should, ideally, take their concerns and suggestions to the forums like locality boards, which are the conduits through which communication is escalated to the CCGs, the study discovered that they are typically overwhelmed with commitments in their practices. As such, they do not have time to attend the meetings in question which consequently hampers member practice clinical concerns and wishes from being escalated to the CCGs, thereby handicapping effective decisions from being made. This is consistent with what McDermott et al. (2015, p.96) observed, where concerns were raised “that GPs and other clinicians were too busy with their own practices and work to become engaged with the CCG”. Conversely, could it be that the meetings in question are badly designed and should be proactively adapted to the GPs’ busy schedules? In line with the ideas of McDermott et al. (2017, p.9) regarding how CCGs struggle “to ensure that their local GPs feel ownership of the work that is done in their name”, it can be concluded that poor member practice engagement can only persist this occurrence.

To conclude, this, and other studies (Storey et al. 2018; McDermott et al. 2017; McDermott et al. 2015; Naylor et al. 2013) have discovered the question of member practice engagement as being a ‘bone of contention’. The possible reasons for this, to the best knowledge of the researcher, are (1) excessive GP practice workload, which prevents the GPs from engaging with the CCGs, and (2) financial climate. GPs are perceived as thinking that spending time with the CCGs, time that they sense could be profitably spent with their patients, is not worthwhile, and (3) communication, in which various factors like the volume of information from the CCGs and delays in passing information to the GP Practices hinder engagement. Even so, studies have shown that CCGs are keen to engage member practices (McDermott et al. 2015; Naylor et al. 2013). The most recent research has shown that some of the CCGs have even

sought outside specialist help to get this subject of member practice engagement addressed (Storey et al. 2018).

7) GPs' level of influence

In the mix of roles within the CCGs where GPs, among other professional backgrounds, are selected to represent the interests of their member practices (Naylor et al. 2013), it is reasonable to believe that they (GPs) would forcefully promote the patient care interest. Important as this may be, numerous previous and subsequent studies have indicated that the level of influence that the GPs exert in the CCGs' various committees does not equal that of the managers (Storey et al. 2018; Holder et al. 2016; Naylor et al. 2013). Even though the GPs may be keen to advance concerns about efficient service delivery in relation to patient care, this may be weakened by the fact that, once they are within the CCG context, they "are actively discouraged from being the voice of the provider as that would be a conflict of interest" (Baird et al. 2016, p.82). Instead, they should view themselves as commissioners. As such, it is unclear whether these occurrences could be part of the reason that decisions that appear unfriendly to the clinical element are relatively easier to be enforced, as a result. The interesting discovery from the current study on the question of GPs' level of influence is that the GPs thought their degree of influence was significant, even though previous studies cited above earlier in this section suggest differently. In reality, the results from inferential statistical analysis in the current study generally suggested that the GPs' level of influence was not significant on decision-making, as described next.

Three hypotheses were tested respecting the question of GP influence in which three different causal relationships were portrayed. First, the level of GP influence in the Governing Body was tested to establish if it will cause a difference in the effectiveness of the decision-making process. Next, the level of GP influence in the Governing Body was tested to detect if it will impact the scale of member practice wishes being met. Finally, the test of GP influence was done to determine if it will change the degree of GP satisfaction about decision-making. The results of the first test suggested that the level of GP influence in the Governing Body is not significant to cause a difference in the effectiveness of the decision-making process. Similarly, the results of the second test indicated that the GP influence is not significant to cause member practice wishes to be met. On the contrary, the final test, which indicated

that the GP influence in the Governing Body committee is positively associated with GP satisfaction about decision-making, was found to be significant.

5.1.3.3 General observations about the perceived effective decision-making process

Other than identifying the factors influencing the perceived effective decision-making process, the study also drilled down to discover other insights related to decision-making that could be of interest in the knowledge base. For example, regarding the question of decisions that were perceived as unfriendly to the GP interests, an effort was made to establish the professional background of the leadership of the CCGs that had experienced this. In this respect, just over a third of the participants confirmed experiencing decisions that they perceived as unfriendly. Since previous research had shown that managers were more influential than the GPs, it was of interest to learn what would happen if managers held a top leadership role: would that then lead the decisions to be less friendly, from the clinical viewpoint? The role of the Accountable Officer was the only one considered in this study to that end. In this context, more than half of the respondents who indicated that they had experienced decisions unfriendly to the GP profession in their CCGs stated that their Accountable Officer was a manager – that is, personnel from a non-clinical background. While the descriptive statistics provided certain data about the professional background of the top leadership, it was not possible to establish if this phenomenon (professional background) has any influence in the development of decisions that could be perceived as unfriendly. Besides, the same phenomenon could not be verified with inferential tests. Even so, the literature mentions how powerful the offices of the Chair and the Accountable Officer are in terms of their influence on the direction of the CCG (Storey et al. 2018). To get a complete picture of the hand that the top leadership may have in the effectuation of unfriendly decisions, it could have been ideal also to investigate the professional background of the Chair. From this standpoint, the findings of the current study regarding the top leadership professional background are, therefore, not conclusive.

Another insight worth noting that the current study revealed about the impact that the GPs can have in decision-making in the CCGs concerns the supportive atmosphere to the perceived effective decision-making process that the participants reported. Several things were discovered, to this end. First, over two-thirds of the GPs

indicated that they sat on the Governing Body, of which 98% of those stated that they were voting members in that board. Over two thirds (65%) of the respondents had 3 or more positive things to say about their Governing Bodies. Also, the respondents rejected the suggestions which implied inefficiency of their Governing Bodies. For example, the suggestion that a few strong personalities influenced their Governing Bodies was overwhelmingly rejected as evidenced in the descriptive statistics over this factor demonstrated in Figure 4.15. A similar response was also seen in the case that hinted that their Governing Bodies were prone to negative groupthink. Groupthink is a phenomenon whereby members fall into the trap of “group decision biases” (Janis 1982, cited in Langfred 2004, p.386), with some yielding their held opinions to others in the spirit of what they may perceive as solidarity, to maintain cohesion and unity in the group.

Even though there may be an arguably good presence of the GPs in the Governing Bodies, it was discovered that a large number of the Governing Bodies (58.8%) were not involved in active primary decision-making routines, with their responsibility being mainly to endorse decisions made elsewhere, as demonstrated by the results of the descriptive statistics (see Figure 4.11 in Section 4.2.1.2). It is not clear whether this occurrence is favourable or unfavourable to the perceived effective decision-making process when viewed from the standpoint of this study.

In some of the cases, the respondents mentioned the incentives to the GP Practices which were both historical and current. From the tone of the responses, it was difficult to tell if the incentives in question support the process of perceived effective decision-making or not. For example, some incentives, like “prescribing incentive scheme” (Respondent 24), were mentioned as historically fostering a good relationship between the CCGs and the GP member practices but had since been removed at the time of this study. On the other hand, incentives which were identified as new to the system at the time of this study, such as cash “for reducing referrals to an arbitrary level” (Respondent 62), were condemned as being malicious for the profession with a propensity of undermining patient trust in the GPs.

5.1.4 Concluding remarks

This study, which primarily sought to identify the factors influencing effective decision-making as perceived by the GPs in the CCGs, was prompted by the BMA (2014a) research findings which generally indicated that the GP Practices were not happy with the policies that the CCGs made. As discussed in Chapter 1 (Section 1.1.1) and Chapter 2 (Section 2.3.6.1), and many other places in this thesis, CCGs were intended to be autonomous so as to improve patient care by aligning health care commissioning decisions with local needs. However, this study has discovered that structure alone appears not enough to deliver effectiveness. Other factors that seem to come to the fore are GP proportion in the Governing Body, workplace culture, conflicts of interest, bureaucracy, financial considerations, member practice engagement, and GPs' level of influence. Also, while factors like conflicts of interest, financial constraints, and bureaucracy have been identified in the same vein, these have, to a large extent, been dealt with in previous studies with comparable findings. A detailed discussion of these can be seen in Section 5.3.2. A specific aspect worth stressing is about GP proportion in the Governing Body, which seems to be a bigger influence of decision effectiveness, as confirmed by statistical hypotheses testing (Section 4.2.2.4).

There is another aspect worth highlighting, which is, while this study determined to investigate only GPs with formal roles in the CCGs, the current findings were in many respects consistent with what previous studies have established. Leading in this is the observation that, whereas the BMA surveyed all their members, the findings of this study identify many similar perceptions among GPs who have been closely associated with the CCGs. On the question of the secondary aim, which sought to establish the roles occupied by the GPs, comparative similarities with previous studies were also found, especially on complexity and diversity of the roles occupied by GPs across different CCGs.

Overall, the results demonstrated a healthy atmosphere in decision-making. This was revealed from several standpoints which include: (1) Governing Body members expressing satisfaction with the way their CCGs made decisions, (2) not being influenced by a few in decision-making routines, (3) an endorsement that their CCGs were functional, (4) high level of contentment expressed by the GPs about their level of influence in the Governing Body, (5) a suggestion that the respondents' CCGs' senior

authorities did not veto the decisions that the Governing Bodies made, as indicated by descriptive statistical results, and (6) about two thirds of the respondents expressing the view that their CCGs have never made decisions that they perceived as unfriendly to their profession in patient care.

In contrast, there were unfavourable results too in almost all instances identified above but which were at a lesser proportion. Of all the unfavourable results, two are worth mentioning as they are crucial to this study. One involved the question regarding whether the CCGs represented the wishes of member practices, where no clear-cut position was obtained. The other pertained to the question whether the respective local CCGs were GP led as defined in the Health and Social Care Act 2012, to which half of the participants concurred while the other half either disagreed or were undecided. It remains to be established from CCGs if this finding is a cause for concern given that just over 50% of the GPs who represented their practices in this study seemed unsure if their CCGs were GP led or not.

Another noteworthy thing is that, the findings of the study indicated that the GPs were more positive on the questions as to whether the CCGs were working effectively than they were on questions about 'unfriendly decisions' to GP interests being made. The effect of this could be that there may be 'unfriendly decisions' even if the CCGs' operations are optimal, because of the hard choices that have to be made in the NHS. As such, there will always be a need for compromise on the GPs' side.

When considered from the grand scheme of things, the findings from this and other related studies suggest that the current system in the CCGs is a functioning part of the NHS. This study suggests that there are aspects of the philosophy behind the CCGs which have been realised, in terms of local decision-making. However, this progress is threatened by the signs of creeping reversion back to centralisation.

5.2 Theoretical contributions

This study makes two contributions to theory. The first pertains to decentralisation under the theory of organisational structure, which underpinned the development of this study. I viewed decentralisation through Mintzberg (1979, p.181), where this concept is considered "exclusively in terms of power over the decisions made in the

organization". In this premise, I reviewed the literature centred on the decision-making structures in the CCGs within the English NHS. At inception, CCGs were intended to be autonomous entities led by GPs in commissioning services in the English NHS (The King's Fund 2018; Checkland et al. 2016; Robertson et al. 2016). At the same time, NHS England was to give strategic direction along with the allocation of financial resources at macro-level (Department of Health 2012; NHS Commissioning Board 2012b). When considered from Mintzberg's framework of organisational structuring (Mintzberg 1979), this arrangement characterised the professional model. However, the current study findings suggest that the CCGs, in general, seem to be moving back towards the bureaucratic structure (Mintzberg 1979), which PCTs operated under. The supposed autonomy appears to be eroded due to various lines of reporting and accountability discussed in Chapter 2 (Section 2.3.6.2) and confirmed in this study. To this end, one of the respondents in the current study even commented that their CCG was "returning to being a PCT" (Respondent 13). In summary, the theoretical contribution of the current study is an observation of the shift of the CCGs from the professional model back towards bureaucratic model in Mintzberg's models of organisational structuring (Mintzberg 1979).

The second theoretical contribution pertains to negative groupthink, discussed in Section 2.3.6.1, a phenomenon where the team can fall into the trap of sub-optimal decision-making due to group biases (Wang & Wagner 2018; Pautz & Forrer 2013; Langfred 2004). In this context, some members who may hold different views to their colleagues' choices may yield their views even if they do not agree with what has been tabled to avoid being perceived as violating trust. The current study suggested that this factor did not dominate the decentralised setting of the CCGs.

5.3 Implications for practice

Several findings that the current study produced have supported the findings of the previous studies. For example, the question of the conflicts of interest, time factor – from the sense that it is always limited when contrasted with what ought to be done in decision-making routines, bureaucracy, and member practice engagement. However, to the best knowledge of the researcher, no dedicated study has focused on investigating the factors influencing the effective decision-making process as perceived by the GPs in the CCGs. The current study aimed to cover this gap. As expected, the

leading contribution in this area is the empirical data on the actual process of decision-making, its weaknesses, its strengths, its place and role in the health care system, as well as how the internal and external factors influence it. Description of the factors influencing the perceived effective decision-making process could support not only the decision-makers in the CCGs but also policy-makers at macro and micro-levels, by informing them about some of the factors to consider in order to formulate decisions conducive to supporting the GP Practices in caring for patients.

5.3.1 Confirmatory implications

A striking confirmatory implication to practice pertains to the question of whether decisions made by CCGs reflect the wishes of member practices. The results of the study on a 5-point Likert scale revealed that less than one-third of the respondents agreed that the decisions made by their CCGs reflected the wishes of their member practices. It is possible that this could be due to the reality of constrained decision-making environment. To establish likely reasons for this uncertainty, further research is necessary.

5.3.2 Conflicts of interest

This implication concerns policy-makers who develop guidance on the question of conflicts of interest. The results of this study, which substantiate the findings of other studies (Storey et al. 2018; Moran et al. 2017a; Holder et al. 2016), suggest that the GPs are disconcerted by the way the conflicts of interest policy operates as it limits the GPs' influence on decision-making in the CCGs. A striking example of that is the inability of the GPs to vote, cited earlier as one of the factors influencing the perceived effective decision-making process. A review of the guidelines, designed in close consultation with the GPs, to come up with an amicable policy, could be favourable to them.

5.3.3 Time factor

The results demonstrated that time is a factor that the CCGs need to consider from various angles. First, by giving the GPs ample time to prepare for the meetings than pressing them to present at meetings with superficial knowledge. Also, either agenda items are to be condensed or time allocated for the meetings is increased to avoid rushed meetings. In the same vein, the attendees in various committee meetings

should either be trained on how to make their presentations concise but yet effective, or more time should be allocated to them, given some of the concerns raised about the time wasted in long presentations.

5.3.4 Bureaucracy

Bureaucracy, a persistent challenge yet widely accepted in contemporary societies (Kumar & Kant 2005), is another implication cutting across the macro and micro administration divide. The findings suggest that at macro-level, the central government still has a strong influence on the way decisions are shaped at micro-level, an occurrence which contradicts the fundamental principles underpinning the tenets for establishing the CCGs. As a result, the researcher believes that the CCG leadership is left without a choice but to exert the same tone of impersonal measures at the local level. For example, it is possible that the Sheffield CCG Accountable Officer reported as generating a “toxic” environment at work (Section 2.3.7) was constrained by bureaucratic clutches to behave thus (Collins 2019). Such activities flout the primary purpose of the CCGs organisations, broadly speaking. Results demonstrate that significant consequences such as decisions unfriendly to the GP interests are, thus made. What this means is that decisions that negatively impact efficient patient care are devised. This situation is aggravated by financial constraints, which the results from this study revealed that such were attributable to unfriendly decisions being made by the CCGs. It would appear like when resources are tight, local autonomy is constrained, or maybe local autonomy is maintained, but difficult choices are pushed down to that level because budgets are imposed. An unintended consequence of this may be a shift of the CCGs towards the Bureaucratic structure of the Mintzberg’s models of organisational structuring (Mintzberg 1979).

5.3.5 Knowledge vacuum

There is a likelihood of knowledge vacuum when the GPs who currently occupy formal positions in CCGs leave the system. It is essential though, to note that this implication is not directly demonstrated in this study as the suggestion of the risk of knowledge vacuum is a deduced statement. This suggestion stems from the fact that the current study discovered a significant imbalance between the GPs who were relatively new in

the CCGs (about 34%) when contrasted with those who had served their CCGs for more than 3 years (about 66%).

5.4 Research limitations

This section describes the limitations that were not foreseen beforehand when the study started and were only discovered as the research progressed. As a result, those characteristics impacted the interpretation of the results and possible additional value that this study could otherwise have produced.

5.4.1 Response rate

To start with, while at the inception of this research I highlighted that access to the target population would pose a significant limitation that would beset my study (see Section 1.4.3), I did not envisage the response rate to be as low as 6.9%. The reason that I gave then for possible low response was that GPs are ‘notoriously’ known to be busy people, an occurrence that was even frequently reported in the news media (BBC News 2015). This phenomenon was confirmed in the field by some of the respondents. For example, when I sent out emails to the pilot study participants asking them why they did not respond to my request to complete that pilot study, almost all the reasons that I received were characterised by the message of “busyness”. Some of the excerpts are,

“I did receive the invite for the questionnaire but due to a huge workload I didn’t get around to responding...”

“To confirm I did receive your email ... Time constraints and prioritising work are the main issues”

“Time constraints...”

The full emails can be seen in Appendix 2.5.

I believe, and I have worked under the assumption that the above sentiments are an accurate reflection of the circumstances besetting most of the GPs across the board, which could be part of the reason that contributed to a low survey response rate of 6.9%. Besides, it is likely that the response rate was worsened by a cyber-attack called WannaCrypt Ransomware which hit many organisations across the globe days just

before my online survey went live. This is because my survey was web-based, hence the potential respondents might have been cautious about opening web links, as substantiated by one of the respondents who mentioned that their IT department advised them not to open any web links (see Appendix 2.13 for the email in question).

5.4.2 Scope of leadership roles

The research also suffers from the limited scope of the CCG leadership roles that were assessed to ascertain the professional background of the roles in question. That is, since other studies have shown that the offices of the Chair and the Accountable Officer have the power to steer the strategic direction of the local CCG (Storey et al. 2018), it would have been ideal to establish the professional background, not only of the Accountable Officer, but also of the Chair. In doing so, the study could have fully established the question of decisions perceived as unfriendly to the GPs as to whether the kind of professional background of the leadership has any input in that. As shown earlier, while more than half of the respondents in the current study who indicated that they had experienced decisions unfriendly to the GP profession in their CCGs stated that their Accountable Officer was a manager, this finding cannot be regarded as conclusive. Additionally, the PLS-SEM model fitness tests could not accept the inclusion of the observed variable “AccOffBG” (Accountable Officer Background) in the final model to help establish its position and significance. It is, therefore, not clear if the professional background of the CCG leadership has any influence over the development of decisions that could be perceived as unfriendly. Unfortunately, the findings cited above by Storey et al. (2018) were published after the survey for the current study was already completed and, therefore, too late to inform the survey questions.

5.4.3 CCGs’ geographical locations information

Also, it became evident in data analysis that the lack of information about geographical locations of the respondents could be a limitation. While the study was designed to be anonymous (not to pinpoint the exact location or district where the respondents’ CCGs were, as that was thought would threaten anonymity), it was going to be useful to get a rough idea of the region where the respondents’ local CCGs were located. This was going to be achieved through the use of England’s statistical regions. England has nine

regions, namely North East, North West, Yorkshire and The Humber, East Midlands, West Midlands, East of England (East Anglia), London, South East, and South West (Office for National Statistics [Open Government Licence v3.0]). Such information was going to assist in estimating how representative the study was across England.

Closely tied to the question of the benefits of disclosure of anonymity is the dilemma of getting a disproportionately high number of responses from the participants in the same CCG, an occurrence likely to skew statistical insights. While there was no obvious suggestion of duplication in the responses received, I recognise this as a potential issue as such an occurrence may affect the weighting of variables in the PLS-SEM model. However, for respondents' confidentiality, I could not ask the name of the CCGs that they belonged to as this could have prejudiced the response rate.

5.4.4 Use of questionnaire in a phenomenological method

Another limitation concerned the use of questionnaires as part of a phenomenological method. While the current study managed to collect rich qualitative data, the use of a questionnaire restricts flexibility. That is, questionnaire surveys are not the most obvious way of capturing deep insights of lived experience, with face-to-face interviews being the widely utilised approach that allows for unstructured interviews which can adapt and change in line with the respondent's answers (Rose 1994). Semi-structured questionnaire surveys are not as flexible. Two studies that exemplify phenomenological data collection are Davidsen 2013 and Groenewald 2004.

5.4.5 Quantitative data analysis

While I feel content and confident about opting for Partial Least Squares Structural Equation Modelling (PLS-SEM) for the quantitative strand, which I found very useful for the reasons explained in Section 3.6.1.1, the results from the quantitative strand were, nonetheless, not as useful in shaping the conclusions as the rich qualitative strand data was. As mentioned in the introduction to Chapter 5, Section 5.1, originally, I set this study to be quantitatively driven, but it turned out that the conclusions became qualitatively driven. Even so, I found out that using PLS-SEM was not only appropriate for the reasons explained in Section 3.6.1.1, but this technique also functioned as a compass to me in instilling confidence about my research model. PLS-SEM delivered

more reliability in my study “than other techniques ... especially [with a view] of small sample size” (Carrascal et al. 2009, p.681). Nonetheless, there is a phenomenon that appeared logically inconsistent about PLS-SEM. It concerns the model fitness tests as described next.

First, in the early phase path model (see Figure 4.32) I linked the observed variable **GPPropInGB** (The proportion of GPs In CCG Governing Body Membership) to the latent variable *GP Proportion*, a relationship which logically looked correct. However, that relationship did not meet the model fitness tests. The technically acceptable relationships meeting the model fitness tests determined that observed variable **GPPropInGB** should be linked to the latent variable *GP Influence* (see Figure 4.34). Secondly, in the early phase path model, latent variable *GP Proportion* was logically considered as having the capacity to cause a difference in the level of GP influence, hence was linked to latent variable *GP Influence*, which in turn was deemed to have the capacity to cause a difference in the effectiveness of the decision-making process. However, this presumed chain of causality was broken by model fitness tests which resulted in latent variables *GP Proportion* and *GP Influence* considered separately to cause a difference in the effectiveness of the decision-making process. While logically, these two scenarios do not look right, technically, they are correct as authenticated by model fitness tests. To realise the predictive capacity that PLS-SEM affords, the outer model of the path model should be valid and reliable (Lowry & Gaskin 2014; Henseler et al. 2009), which the case was for this study.

5.5 Recommendations for future research

The current study has raised numerous opportunities for future research. First, this study offers the opportunity to refine and validate the latent variables in the conceptual model that were identified with weaknesses in the PLS-SEM model fitness analysis phase. Of specific interest was the R^2 test of the inner model fitness designed to ensure the model’s ability to predict the latent variables. The tests indicated a weak R^2 result on latent variable *Member Practice Wishes Met*. As discussed in Chapter 3, while a weak R^2 result may be suggestive of doubtful “theoretical underpinnings” (Henseler et al. 2009, p.303), such less favourable readings may, nonetheless, be used as a benchmark for future research, thereby affording subsequent researchers to treat their readings “relative to the field”, as suggested by Garson (2016). Therefore, one

could devise an explorative study with a model addressing whether, and to what extent, the member practice wishes can be met.

The second research opportunity relates to the results of hypothesis testing, from which positive correlation was discovered between variables *GP Proportion* and *Decision-making Process Effectiveness*. While on paper, in a given situation, the indication may be that indeed the GPs constitute a higher proportion in the Governing Body, it is, however, not clear what impact the question of the conflicts of interest could have on the perceived effective decision-making process, especially on components relating to GP interests.

The next implication for future study relates to the professional background of the persons occupying the offices of Accountable Officer and the Chair, CCG top leadership offices. While the current study established that about two-thirds of the participants indicated that a manager in their respective CCGs occupied the role of Accountable Officer, it will be useful for a similar question to be established for the Chair. The interesting finding in the current study drawn from the descriptive statistics is that more than half of the respondents who indicated that they had experienced decisions unfriendly to the GP profession in their CCGs stated that their Accountable Officer was a manager. Considering this, the degree of correlation between decisions unfriendly to the GP profession and the professional backgrounds of the leadership (Accountable Officer and the Chair) remains to be established, if considered in a single study. Relatedly, though slightly different, further research would be useful to establish if there is any correlation between the leadership style of CCGs' top leadership (Accountable Officer and the Chair) and the perceived effective decision-making process in general, given the influence that these key positions have in steering the direction of the CCG (Storey et al. 2018).

Another interesting factor relates to the point at which primary decisions are made in the CCGs. The current study, along with other previous studies (Checkland et al. 2016; McDermott et al. 2015), discovered that primary decisions are not necessarily made at Governing Body level as demonstrated in Figure 4.11, page 150. While interest in the current study was centred more on the way the Governing Body functions concerning decision-making, it would be interesting to explore in future

research the level of impact, if any, on the effective decision-making, as perceived by GPs, that primary decisions made outside the Governing Body – that is, decisions delegated to the sub-committees, have in achieving GPs' needs. Such delegation of decision-making responsibilities could be viewed as decentralisation within the CCG. Inversely, the same consideration could be made regarding primary decisions made by the Governing Body.

There is another intriguing observation uncovered by the analysis of results of this study which would be useful to explore in a future study. The case in point is, why do the GPs have a generally favourable view on the question of the dysfunctionality of the CCGs but a negative view on the question of decisions made by CCGs reflecting members' wishes? Could it be that the GPs have come to understand and accept the reality that the NHS will always be top down even under the dispensation of the purported autonomy designed to be led by the GPs? It is difficult to explain such results within the context of the current study.

CCGs were allegedly created to rid the primary health care system of the central blueprint (Checkland et al. 2016), liberating the ““professionals and providers from top-down control”” (The King's Fund 2018). However, the inferential statistical results demonstrated the attributes of bureaucratic control through the reflective latent variable *Decision-making Process Effectiveness*, as described earlier in this chapter, Section 5.1.3.2. It will be useful to run a dedicated study to establish the extent of bureaucracy on the CCGs at macro and micro-levels, and its impact on the perceived effective decision-making process.

The last suggestion for future research pertains to the demographic profile of the GPs' length of service in their local CCGs. The current study discovered a significant imbalance between the GPs who were relatively new in their CCGs – that is, served their CCGs for up to 3 years, and those who had served for more than 3 years. The former presented with a minuscule proportion when compared with the latter. Two possible reasons for that come from the findings of previous studies, namely, (1) lack of enthusiasm in GPs to take up roles in the CCGs (Checkland et al. 2014), and (2) a general decline in GP representation within the CCGs with the roles that the GPs should play more and more being occupied by managers (Rosser 2018; Checkland et al.

2016; Drake 2016). The other possible reason worth investigating is the researcher's speculation, which is – all the available roles in the CCGs were filled up until such a time that new ones are created, or the existing GPs retire or leave the profession. Whatever the case, a definitive study to establish the reason for fewer GPs joining the CCGs would be useful.

REFERENCES

AHMADY, G. A., MEHRPOUR, M., and NIKOORAVESH, A. (2016). Organizational Structure. *Procedia - social and behavioral sciences*, **230** (2016), 455-462.

AJJAWI, R. and HIGGS, J. (2007). Using Hermeneutic Phenomenology to Investigate How Experienced Practitioners Learn to Communicate Clinical Reasoning. *The Qualitative Report*, **12** (4), 612-638

ALLEN, I. E. and SEAMAN, C. A. (2007). Likert scales and data analyses. *Quality Progress*, **40** (7), 64-65.

AMERICAN ASSOCIATION FOR PUBLIC OPINION RESEARCH (2013). *Non-Probability Sampling: REPORT OF THE AAPOR TASK FORCE ON NON-PROBABILITY SAMPLING*. [online]. Last accessed 26 June 2019 at <https://www.aapor.org/Education-Resources/Reports/Non-Probability-Sampling.aspx>.

ANHEIER, H. K. (2005). *Nonprofit Organizations: Theory, Management, Policy*. [online]. Taylor and Francis e-Library. Last accessed 10 April 2018 at <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.452.6420&rep=rep1&type=pdf>.

ARSLAN, P. L. and YILDIRIM, S. (2015). Theoretical Frameworks, Methods, and Procedures for Conducting Phenomenological Studies in Educational Settings. *Turkish Online Journal of Qualitative Inquiry*, **6** (1), DOI: 10.17569/tojq.59813.

AVOLIO, B. J., ZHU, W., KOH, W. and BHATIA, P. (2004). Transformational leadership and organizational commitment: mediating role of psychological empowerment and moderating role of structural distance. *Journal of Organizational Behavior*, **25**, 951–968.

BAIRD, B., CHARLES, A., HONEYMAN, M., MAGUIRE, D. and DAS, P. (2016). Understanding pressures in general practice. *The King's Fund*. [online]. Last accessed

18 May 2016 at <https://www.kingsfund.org.uk/publications/pressures-in-general-practice>.

BBC NEWS (2013a). *Q&A: The NHS shake-up*. [online]. Last accessed 06 February 2019 at <https://www.bbc.co.uk/news/health-12177084>

BBC NEWS (2013b). *The changing NHS*. [online]. Last accessed 27 September 2015 at <http://www.bbc.co.uk/news/health-19674838>

BBC NEWS (2015). *GP shortages put pressure on doctors and patients*. [online]. Last accessed 10 November 2017 at <http://www.bbc.co.uk/news/health-31550423>

BELASSI, W., KONDRA, A. Z. and TUKEL, O. I. (2007). New product development projects: The effects of organizational culture. *Project management journal*, **38** (4), 12-24.

BELL, J. (1999). *Doing your research project: a guide for first-time researchers in education and social science*. 3rd ed. Buckingham; Philadelphia: Open University Press.

BENNER, P. (1994). Hermeneutic phenomenology: A methodology for family health and health promotion study in nursing. In BENNER, P. (ed.), *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness* (71-72). Thousand Oaks, CA: Sage.

BERGMAN, M. & PAAVOLA, S. (eds.) (2018a). 'Qualitative Induction'. *Term in The Commens Dictionary: Peirce's Terms in His Own Words. New Edition*. [online] Last accessed 13 January 2018 at <http://www.commens.org/dictionary/term/qualitative-induction>.

BERGMAN, M. & PAAVOLA, S. (Eds.) (2018b). 'Retroduction'. *Term in The Commens Dictionary: Peirce's Terms in His Own Words. New Edition*. [online] Last accessed 13 January 2018 at <http://www.commens.org/dictionary/term/retroduction>.

BHARATI, P. and CHAUDHURY, A. (2004). An empirical investigation of decision-making satisfaction in web-based decision support systems. *Decision support systems*, **37** (2), 187-197.

BIRD, K. D. (2004). *Analysis of variance via confidence intervals*. London: SAGE.

BODEN, Z. V. R., GIBSON, S., OWEN, G. J. and BENSON, O. (2016). Feelings and Intersubjectivity in Qualitative Suicide Research. *Qualitative health research*, **26** (8), 1078-1090.

BODENA, M. T. and BERENBAUM, H. (2011). What You are Feeling and Why: Two Distinct Types of Emotional Clarity. *Personality and Individual Differences*, **51** (5), 652–656.

BOSTOCK, N. (2016). *GP role in CCGs is being eroded, survey suggests*. [online]. Last accessed 10 September 2018 at <https://www.gponline.com/gp-role-ccgs-eroded-survey-suggests/article/1389759>

BOTS, P. W. G. and LOOTSMA, F. A. (2000). Decision support in the public sector. *Journal of Multi-Criteria decision analysis*, **9** (1), 1-6.

BOZIONELOS, N. (2003). Causal Path Modeling: What It Does and What It Does Not Tell Us. *Career development international*, **8** (1), 5-11.

BRANNICK, T. and COGHLAN, D. (2007). In Defense of Being “Native”: The Case for Insider Academic Research. *Organizational research methods*, **10** (1), 59-74.

BREWER, E. W. and STOCKTON, S. (2010). Directional Hypothesis. In: SALKIND, N. J. (ed.). *Encyclopedia of Research Design*. Thousand Oaks, SAGE Publications, 366-367.

BRITISH MEDICAL ASSOCIATION (2014a). *Clinical Commissioning Groups are failing to involve GPs and deliver improvements to care, warns new BMA survey*. [online]. Last accessed 04 April 2017 at

<http://web2.bma.org.uk/pressrel.nsf/wall/DF0B0AD33416572980257D0000597E72?OpenDocument>

BRITISH MEDICAL ASSOCIATION (2014b). *General Practitioners Committee*. [online]. Last accessed 04 April 2017 at <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/surveys/ccgs-one-year-on>

BRITISH MEDICAL ASSOCIATION (2017). *About us*. [online]. Last accessed 04 December 2017 at <https://www.bma.org.uk/about-us>

BRYMAN, A. (2007). Barriers to Integrating Quantitative and Qualitative Research. *Journal of Mixed Methods Research*, **1** (8), 8-22.

BUCKINGHAMSHIRE CLINICAL COMMISSIONING GROUP ([No Date]). *Committees of the CCG and of the Governing Body*. [online]. Last accessed 11 September 2018 at <https://www.buckinghamshireccg.nhs.uk/public/about-us/who-we-are/committees-of-the-ccg/>

BUSINESS CASE STUDIES (2015). *Developing responsiveness through organisational structure: The structure of an organisation*. [online]. Last accessed 26 September 2015 at <http://businesscasestudies.co.uk/unison/developing-responsiveness-through-organisational-structure/the-structure-of-an-organisation.html#ixzz3F5xaLdwh>.

BUSINESS DICTIONARY (2018). *Bureaucracy*. [online]. Last accessed 14 April 2018 at <http://www.businessdictionary.com/definition/bureaucracy.html>

BUSINESS DICTIONARY (2018c). *Quality*. [online]. Last accessed 19 April 2018 at <http://www.businessdictionary.com/definition/quality.html>

CAL, A. and TEHMARN, A. (2016). *Phenomenological Epistemology Approaches and Implications for HRD Research and Practice*. [online]. Last accessed 02 May 2018 at https://www.ufhrd.co.uk/wordpress/wp-content/uploads/2016/10/paper_128.pdf.

CALLEGARO, M., MANFREDA, K. L. and VEHOVAR, V. (2015). *Web Survey Methodology*. SAGE: London.

CARRASCAL, L. M., GALVÁN, I. and GORDO, O. (2009). *Partial least squares regression as an alternative to current regression methods used in ecology*. *Oikos*, **118** (5), 681-690.

CASSIDY, E., REYNOLDS, F., NAYLOR, S. and DE SOUZA, L. (2011). Using interpretative phenomenological analysis to inform physiotherapy practice: An introduction with reference to the lived experience of cerebellar ataxia. *Physiotherapy theory and practice*, **27** (4), 263-277.

CHARLICK, S., PINCOMBE, J., MCKELLAR, L. and FIELDER, A. (2016). Making sense of participant experiences: Interpretative phenomenological analysis in midwifery research. *International Journal of Doctoral Studies*, **11**, 205-216.

CHECKLAND, K., COLEMAN, A., PERKINS, N., MCDERMOTT, I., PETSOULAS, C., WRIGHT, M., GADSBY, E. and PECKHAM, S. (2014). Exploring the ongoing development and impact of Clinical Commissioning Groups. Policy Research Unit in Commissioning and the Healthcare System. (Interim).

CHECKLAND, K., DAM, R., HAMMOND, J., COLEMAN, A., SEGAR, J., MAYS, N. and ALLEN, P. (2018). Being Autonomous and Having Space in which to Act: Commissioning in the 'New NHS' in England. *Journal of Social Policy*, **47** (2), 377-395.

CHECKLAND, K., MCDERMOTT, I., COLEMAN, A. and PERKINS, N. (2016). Complexity in the new NHS: longitudinal case studies of CCGs in England. *British Medical Journal Publishing Group*, **6** (1), 1-8.

CLARKE, J. (2012). What is a CI? *Evidence-Based Nursing*, **15** (66), 1.

CLOVER, B. (2019). Whistleblower was 'bullied to protect CCG chair'. *Health Service Journal (HSJ)*. [online]. Last accessed 10 June 2019 at

<https://www.hsj.co.uk/governance/whistleblower-was-bullied-to-protect-ccg-chair/7025252.article?>

COLMAN, A. M. (2015). *Pearson's correlation coefficient*. Oxford University Press.

COLLINS, A. (2019). Revealed: Crisis at top CCG amid claims of bullying and 'toxic' culture. *Health Service Journal (HSJ)* [online]. Last accessed 01 April 2019 at <https://www.hsj.co.uk/quality-and-performance/revealed-crisis-at-top-ccg-amid-claims-of-bullying-and-toxic-culture/7024480.article>.

CONGER, J. A. (1990). The dark side of leadership. *Organizational Dynamics*, **19**, 44 – 55.

COOK, J. (2019). *Number of CCGs could be cut by 75% by April 2020*. [online]. Last accessed 16 June 2019 at <https://www.gponline.com/number-ccgs-cut-75-april-2020/article/1582119>.

COONEY, J. (1997). Requisite organization. *Business quarterly*, **61** (3), 79.

COTTONE, R. R. and CLAUS, R. E. (2000). Ethical Decision-Making Models: A Review of the Literature. *Journal of counseling & development*, **78** (3), 275-275.

CREAMER, E. G. (2011). *Workshop - Quantifying qualitative data in mixed methods research in engineering education*. IEEE. W2A-W2A-2; 1.

CRESWELL, J. W. and PLANO CLARK, V. L. (2011). *Designing and conducting mixed methods research*. 2nd Ed. Thousand Oaks, CA: SAGE Publications, Inc.

CRESWELL, J. W. (2013a). *Qualitative, Quantitative, and Mixed Methods Approaches*. 4th ed. London: SAGE Publications.

CRESWELL, J. W. (2013b). *What is Mixed Methods Research*. [online]. From YouTube last accessed 11 December 2015 at <https://www.youtube.com/watch?v=1OaNiIpyX8>.

CRESWELL, J. W., SHOPE, R., PLANO CLARK, V. L. and GREEN, D. O. (2006). How Interpretive Qualitative Research Extends Mixed Methods Research. *Research in the schools*, **13** (1), 1-11.

CRONIN, P., RYAN, F. and COUGHLAN, M. (2008). Undertaking a literature review: a step-by-step approach. *British journal of nursing*, **17** (1), 38-43.

CRUMLEY, C. L. (1995). Heterarchy and the Analysis of Complex Societies. *Archaeological papers of the American Anthropological Association*, **6** (1), 1-5.

CUMMINS, R. A. and GULLONE, E. (2000). Why we should not use 5-point Likert scales: The case for subjective quality of life measurement. In: *Proceedings, second international conference on quality of life in cities*, Singapore, National University of Singapore, 74-93.

DAVIDSEN, A. S. (2013). Phenomenological Approaches in Psychology and Health Sciences. *Qualitative Research in Psychology*, **10** (3), 318–339.

DAWSON, R. (2009). Heterarchy: Technology, Trust and Culture. *People & strategy*, **32** (1), 13-13.

DE LEEUW, E. D. (2005). To Mix or Not to Mix Data Collection Modes in Surveys. *Journal of official statistics*, **21** (2), 233-255.

DEPARTMENT OF HEALTH (2011). *Resource Allocation: Weighted Capitation Formula - Seventh Edition*. [online]. Last accessed 10 June 2018 at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216320/dh_124947.pdf.

DEPARTMENT OF HEALTH (2012). *The Functions of Clinical Commissioning Groups*. [online]. Last accessed 01 October 2015 at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216555/dh_134569.pdf

- DIVE, B. (2003). When is an organization too FLAT? *Across the board*, **40** (4), 20.
- DOUVEN, I. (2011a). Abduction. In E. N. Zalta (Principal Ed.), *Stanford encyclopedia of philosophy*. Last accessed 02 January 2018 at <http://plato.stanford.edu/entries/abduction/>
- DOUVEN, I. (2011b). Peirce on abduction. In E. N. Zalta (Principal Ed.), *Stanford encyclopedia of philosophy*. Last accessed 02 January 2018 at <http://plato.stanford.edu/entries/abduction/>
- DOYLE, L., BRADY, A-M. and BYRNE, G. (2016). An overview of mixed methods research – revisited. *Journal of research in nursing*, **21** (8), 623-635.
- DRAFT, R. L. And ARMSTRONG, A. (2012). *Organization Theory & Design*. [online]. 2nd Ed. Canada: Nelson Education Ltd. Last accessed 26 September 2015 at <http://www.nelsonbrain.com/content/9780176634728.pdf>
- DRAKE, J. (2016). *Commissioning and GPs: to commit[tee] or not?* *Public Money & Management*, **36** (2), 121-128.
- EDDIE, S. (2018). *Updated: CCG mergers and shared leadership map*. [online]. Last accessed 16 June 2019 at <https://www.hsj.co.uk/commissioning/updated-ccg-mergers-and-shared-leadership-map/7016646.article?adredir=1>.
- EDWARDS, J. (2011). The Fallacy of Formative Measurement. *Organizational research methods*, **14** (2), 370-388.
- EINARSEN, S., AASLAND, M. S. and SKOGSTAD, A. (2007). Destructive leadership behaviour: A definition and conceptual model. *The leadership quarterly*, **18** (3), 207-216.
- FAIRTLOUGH, G. (2006). *The three ways of getting things done: hierarchy, heterarchy and responsible autonomy*. [online]. Axminster: Triarchy. Book Executive Summary

from idenk.com last accessed 18 October 2015 at
<http://www.idenk.com/ra/3waysofgettingthingsdonesummary.pdf>

FARRELL, A. M. (2010). Insufficient discriminant validity: A comment on Bove, Pervan, Beatty, and Shiu (2009). [online]. *Journal of Business Research*, **63** (3), 324-327.

FINLAY, L. (2009). Debating Phenomenological Research Methods. *Phenomenology & Practice*, **3** (1), 6-25.

FOUKA, G. and MANTZOROU, M. (2011). What are the Major Ethical Issues in Conducting Research? Is there a Conflict between the Research Ethics and the Nature of Nursing? *Health Science Journal*, **5** (1), 3-14

FRANKFURT, H. G. (1958). Peirce's Notion of Abduction. *The journal of philosophy*, **55** (14), 593-597.

FRIEDMAN, A. (1977). Responsible Autonomy Versus Direct Control Over the Labour Process. *Capital & class*, **1** (1), 43-57.

GABBAY, D. and WOODS, J. (2005). *The Reach of Abduction: Insight and Trial, A Practical Logic of Cognitive Systems, vol. 2*. Elsevier: Amsterdam.

GACHET, A. and BRÉZILLON, P. (2005). Organizational Structures and Decision Making Processes: A Multi-Level Model. *Journal of decision systems*, **14** (1-2), 9-37.

GARLAND, R. (1991). The mid-point on a rating scale: Is it desirable? *Marketing bulletin*, **2**, 66-70.

GARSON, G. D. (2016). *Partial Least Squares: Regression & Structural Equation Models*. [online]. 2016 ed. Asheboro, NC: Statistical Publishing Associates. Last accessed 03 April 2018 at https://www.smartpls.com/resources/ebook_on_pls-sem.pdf

GEMIGNANI, M. (2011). Between Researcher and Researched. *Qualitative inquiry*, **17** (8), 701-708.

GHISELLI, E. E. and SIEGEL, J. P. (1972). Leadership and managerial success in tall and flat organization structures. *Personnel psychology*, **25** (4), 617-624.

GILL, J. and JOHNSON, P. (2010). *Research Methods for Managers*. 4th ed. London: SAGE Publications.

GILL, M. J. (2014). The Possibilities of Phenomenology for Organizational Research. *Organizational research methods*, **17** (2), 118-137.

GIORGI, A. (1997). The Theory, Practice, and Evaluation of the Phenomenological Method as a Qualitative Research Procedure. *Journal of phenomenological psychology*, **28** (2), 235-260.

GLOUCESTER CLINICAL COMMISSIONING GROUP (2014). *Engagement and Experience Strategy*. [online]. Last accessed 16 April 2019 at <https://www.gloucestershireccg.nhs.uk/wp-content/uploads/2014/08/Engagement-and-Experience-Strategy-October-2014.pdf>.

GREAT BRITAIN: OFFICE OF GOVERNMENT COMMERCE (2009). *Managing Successful Projects with PRINCE2 2009*. London: Stationery Office Books.

GREENE, J. C. and CARACELLI, V. J. (2003). Making paradigmatic sense of mixed methods practice. In TASHAKKORI, A. and TEDDLIE, C. (eds.), *Handbook of mixed methods in social and behavioral research* (91–110). Thousand Oaks, CA: Sage.

GROENEWALD, T. (2004). A Phenomenological Research Design Illustrated. *International journal of qualitative methods*, **3** (1), 42-55.

GRONN, P. (2002). Distributed leadership as a unit of analysis. *The leadership quarterly*, **13** (4), 423-451.

GROTH, L. (2012). *Approaches to Organization Theory*. University of Oslo. [online]. Last Accessed 14 April 2018 at

<http://www.uio.no/studier/emner/matnat/ifi/INF5890/v13/material-to-download/other-material/approaches-to-organization-theory.pdf>

GROVES, R. M. (2006). Nonresponse Rates and Nonresponse Bias in Household Surveys. *The public opinion quarterly*, **70** (5), 646-675.

GROVES, R. M., FOWLER, F. J., COUPER, M. P., LEPKOWSKI, J. M., SINGER, E. and TOURANGEAU, R. (2004). *Survey Methodology*. Hoboken, NJ: John Wiley & Sons.

HAIR, J. F., RISHER, J. J., SARSTEDT, M. and RINGLE, C.M. (2019). When to use and how to report the results of PLS-SEM. *European business review*, **31** (1), 2-24.

HAIR, J., SARSTEDT, M., RINGLE, C. M. and MENA. J. A. (2012). An assessment of the use of partial least squares structural equation modeling in marketing research. *Journal of the academy of marketing science*, **40** (3), 414-433.

HAMID, M. R. A., SAMI, W. and MOHMAND SIDEK, M. H. (2017). Discriminant Validity Assessment: Use of Fornell & Larcker criterion versus HTMT Criterion. IOP Conference Series: *Journal of Physics*, **890** (2017) 012163.

HARMAN, G. H. (1965). The inference to the best explanation. *Philosophical Review*, **74** (1), 88-95.

HATCH, M. J. and CUNLIFFE, A. L. (2006). *Organization Theory: Modern, Symbolic, and Postmodern Perspectives*. 2nd ed. New York: Oxford University Press.

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION (HFMA) (2017). *NHS financial temperature check: Finance directors' views on financial challenges facing the NHS in England*. [online]. Last accessed 10 June 2018 at <https://www.hfma.org.uk>.

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION (HFMA) (2018). *About us*. [online]. Last accessed 10 June 2018 at <https://www.hfma.org.uk>.

HEJASE, H. J., HAMDAR, B., NOUREDDIN, M., HEJASE, A. J. and NSOULI, F. (2017). Assessment of the Relationship between Managers' Emotional Intelligence and

Employees' Motivation. *The Journal of Middle East and North Africa Sciences*, **3** (4), 27-47.

HENSELER, J., DIJKSTRA, T. K., SARSTEDT, M., RINGLE, C. M., DIAMANTOPOULOS, A., STRAUB, D. W., KETCHEN, D. J., HAIR, J. F., HULT, G. T. M. and CALANTONE, R. J. (2014). Common Beliefs and Reality About PLS. *Organizational research methods*, **17** (2), 182-209.

HENSELER, J., HUBONA, G. and RAY, P. A. (2016). Using PLS path modeling in new technology research: updated guidelines. *Industrial management & data systems*, **116** (1), 2-20.

HENSELER, J., RINGLE, C. and SARSTEDT, M. (2015). A new criterion for assessing discriminant validity in variance-based structural equation modeling. *Journal of the academy of marketing science*, **43** (1), 115-135.

HENSELER, J., RINGLE, C. M. and SINKOVICS, R. R. (2009). The use of partial least squares path modeling in international marketing. *Advances in international marketing*, **20**, 277-319.

HICKS, C. (2004). *Research Methods for Clinical Therapists*. 4th ed., Edinburgh, Churchill Livingstone.

HINKLE, D. E., WIERSMA, W. and JURIS, S. G. (2003). *Applied statistics for the behavioral sciences*. 5th ed. Boston: Houghton Mifflin.

HOLDER, H., ROBERTSON, R., NAYLOR, C., ROSS, S. and MACHAQUEIRO, S. (2016). *Has clinical commissioning found its voice? GP perspectives on their CCGs*. Survey. Nuffield Trust and King's Fund. [online]. Last accessed 10 September 2018 at <https://www.nuffieldtrust.org.uk/files/2017-01/ccg-survey-2016-web-final.pdf>.

HOSSAIN, E., BABAR, M. A. and PAIK, H-Y (2009). Using scrum in global software development: A systematic literature review. *Global Software Engineering, 2009. ICGSE 2009. Fourth IEEE International Conference*, 175-184.

HOX, J. J. and BECHGER, T. M. (1998). An introduction to structural equation modeling. *Family Science Review*, 11, 354-373.

HUBER, G. P. and McDANIEL, R. R. (1986). The decision-making paradigm of organizational design. *Management Science*, **32** (5), 572-589.

HUMMON, N. P. (1970). Criticism of "effects of flat and tall organization structure". *Administrative science quarterly*, **15** (2), 230-234.

HYMAN, M. and SIERRA, J. J. (2010). *Marketing Research Kit for Dummies*. Hoboken: Wiley Publishing.

IMISON, C., ASHTON, B., STEWARD, K., and WILLIS, A. (2011). *Good Governance for Clinical Commissioning Groups: An Introductory Guide*. NAPC/KPMG Commissioning Foundation Series, The Kings Fund. [online]. Last access 13 September 2018 at <https://www.kingsfund.org.uk/sites/default/files/Good-governance-for-Clinical-Commissioning-Groups-Introductory-Guide-December2011.pdf>.

INDEPENDENT (2012). *Bureaucrats return to lead doctors' groups*. [online]. Last accessed 26 September 2015 at <http://www.independent.co.uk/life-style/health-and-families/health-news/bureaucrats-return-to-lead-doctors-groups-7606225.html>

INFORMATION COMMISSIONER'S OFFICE (Open Government Licence v3.0a). *What is the Freedom of Information Act?* [online]. Last accessed 14 January 2018 at <https://ico.org.uk/for-organisations/guide-to-freedom-of-information/what-is-the-foi-act/>.

INFORMATION COMMISSIONER'S OFFICE (Open Government Licence v3.0b). *Data Protection Act*. [online]. Last accessed 15 January 2018 at <https://ico.org.uk/about-the-ico/what-we-do/legislation-we-cover/data-protection-act/>.

JACOBIDES, M. G. (2007). The Inherent Limits of Organizational Structure and the Unfulfilled Role of Hierarchy: Lessons from a Near-War. *Organization science*, **18** (3), 455-477.

JAMROZIK, K. (2004). Research ethics paperwork: what is the plot we seem to have lost? *BMJ: British Medical Journal*, **329** (7460), 286–287.

JANICIJEVIC, N. (2017). Organizational models as configurations of structure, culture, leadership, control, and change strategy. *Economic annals*, **LXII** (213), 67-91.

JANSEN, H. (2010). The Logic of Qualitative Survey Research and its Position in the Field of Social Research Methods. *Forum qualitative sozialforschung / forum: Qualitative social research*, **11** (2).

JENSEN, M. C. (1983). Organization theory and methodology. *The accounting review*, **58** (2), 319-339.

JOHNSON, P., BUEHRING, A., CASSELL, C. and SYMON, G. (2006). Evaluating qualitative management research: Towards a contingent criteriology. *International journal of management reviews*, **8** (3), 131-156.

JOHNSON, R. B. and ONWUEGBUZIE, A. J. (2004). *Mixed Methods Research: A Research Paradigm Whose Time Has Come*. Washington, D.C.: Educational researcher, **33** (7), 14-26.

JONES, G. R. (2013). *Organizational Theory, Design, and Change*. 7th ed. Boston MA: Pearson/Prentice Hall Company.

JONES, T. (1991). Ethical Decision Making by Individuals in Organizations: An. *Academy of management. The academy of management review*, **16** (2), 366.

KARIMIMALAYER, A. M. and ANUAR, M. K. (2012). Structural equation modeling VS multiple regression. *Engineering science and technology: An international journal*, **2** (2), 326-329.

KIM, Y. H., STING, F. J. and LOCH, C. H. (2014). Top- down, bottom-up, or both? Toward an integrative perspective on operations strategy formation. *Journal of operations management*, **32** (7-8), 462-474.

- KLEIN, D. (2005). *Beyond Significance Testing: Reforming Data Analysis Methods in Behavioral Research*. Washington, American Psychiatric Association. *Am.J. Psychiatry*, **162** (3), 643-644.
- KUMAR, S. and KANT, S. (2005). Bureaucracy and new management paradigms: Modeling foresters' perceptions regarding community-based forest management in India. *Forest policy and economics*, **7** (4), 651-669.
- LAEGAARD, J. (2013). *Organizational Theory*. Jorgen Laegaard, Mille Bindslev & Ventus Publishing ApS.
- LANGFRED, C. W. (2004). Too much of a good thing? Negative effects of high trust and individual autonomy in self-managing teams. *Academy of management journal*, **47** (3), 385-399.
- LANGFRED, C. W. (2007). The Downside of Self-Management: A Longitudinal Study of the Effects of Conflict on Trust, Autonomy, and Task Interdependence in Self-Managing Teams. *The academy of management journal*, **50** (4), 885-900.
- LANSLEY, A. (2012). *Letter to CCG clinical and managerial leads*. Department of Health. [online]. Last accessed 22 February 2016 at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215072/dh_133423.pdf
- LAVERTY, S. M. (2003). Hermeneutic Phenomenology and Phenomenology: A Comparison of Historical and Methodological Considerations. *International journal of qualitative methods*, **2** (3), 21-35.
- LINCOLN, Y. S., GUBA, E. G. and GUBA, E. G. (1989). *Fourth Generation Evaluation*. Newbury Park, CA: SAGE Publications.
- LJUNGHOLM, D. (2014). Decision Making in Public Sector Organizations. *Geopolitics, history and international relations*, **6** (1), 40-45.

LONG-CROWELL, E. (2014). Max Weber: *Verstehen and the Rationalization of Society* [Online video]. Last accessed 26 September 2015 at <https://education-portal.com/academy/lesson/bureaucracy-definition-characteristics-meaning.html>

LOWRY, P. B. and GASKIN, J. (2014). Partial Least Squares (PLS) Structural Equation Modeling (SEM) for Building and Testing Behavioral Causal Theory: When to Choose It and How to Use It. *IEEE Transactions on professional communication*, **57** (2), 123-146.

LUNENBURG, F. C. (2012). Organizational structure: Mintzberg's Framework. *International Journal of Scholarly, Academic, Intellectual Diversity*, **14** (1), 1–8.

MAGNANI, L. and BERTOLOTTI, T. (eds.) (2017). *Springer Handbook of Model-Based Science*. [online]. Illustrated Edition. Springer. Last accessed 07 January 2018 at https://books.google.co.uk/books?id=mtQkDwAAQBAJ&dq=difference+between+explanatory+and+non+explanatory+abduction&source=gbs_navlinks_s

MANAGEMENT MANIA (2017). *Organizational Architecture*. [online]. Last accessed 29 January 2019 at <https://managementmania.com/en/organizational-architecture>.

MASON, J. (2006). Mixing methods in a qualitatively driven way. *Qualitative research*, **6** (1), 9-25.

MATELL, M. S. and JACOBY, J. (1971). Is There an Optimal Number of Alternatives for Likert Scale Items? Study I: Reliability and Validity. *Educational and psychological measurement*, **31** (3), 657-674.

MATELL, M. S. and JACOBY, J. (1972). Is there an optimal number of alternatives for likert-scale items? effects of testing time and scale properties. *Journal of Applied Psychology*, **56** (6), 506-509.

MAUGHAN, A. (2010). *Six reasons why the NHS National Programme for IT failed*. *Computer Weekly*. [online]. Last Accessed 25 October 2015 at <http://www.computerweekly.com/opinion/Six-reasons-why-the-NHS-National-Programme-for-IT-failed>

MCABEE, S. T., LANDIS, R. S. and BURKE, M. I. (2017). Inductive reasoning: The promise of big data. *Human resource management review*, **27** (2), 277-290.

MCAULEY, J., DUBERLY, J. and JOHNSON, P. (2014). *Organization Theory: Challenges and Perspectives*. 2nd ed. Harlow: Pearson.

MCDERMOTT, I., CHECKLAND, K., COLEMAN, A., OSIPOVIC, D., PETSOULAS, C. and PERKINS, N. (2017). Engaging GPs in commissioning: realist evaluation of the early experiences of Clinical Commissioning Groups in the English NHS. *Journal of Health Services Research & Policy*, **22** (1), 4-11.

MCDERMOTT, I., COLEMAN, A., PERKINS, N., OSIPOVIC, D., PETSOULAS, C. and CHECKLAND, K. (2015). Exploring the GP 'added value' in commissioning: What works, in what circumstances, and how? Final Report. *Policy Research Unit in Commissioning and the Healthcare System*, (10).

MCGRAW, J. J. (2012). What is Intersubjectivity? *THERE: Journal of Design*, **8**, 72-77.

MCMANUS HOLROYD, A. E. (2007) Interpretive Hermeneutic Phenomenology: Clarifying Understanding. *Indo-Pacific Journal of Phenomenology*, **7** (2), 1-12.

MEISEL, S. I. and FEARON, D. S. (1999). The new leadership construct: What happens when a flat organization builds a tall tower? *Journal of management education*, **23** (2), 180-189.

MERTENS, D. M (2009). *Research and Evaluation in Education and Psychology: Integrating Diversity with Quantitative, Qualitative, and Mixed Methods*. 3rd Ed. Thousand Oaks, CA: SAGE Publications.

MINTZBERG, H. (1979). *The Structuring of organizations: a synthesis of the research*. Prentice-Hall.

MINTZBERG, H. and WESTLEY, F. (2001). Decision Making: It's Not What You Think. *MIT sloan management review*, **42** (3), 89-93.

MIRROR (2015). *After five years of Tory rule, Jeremy Hunt admits NHS is in grip of worst financial crisis in its history*. [online]. Last accessed 04 October 2015 at <http://www.mirror.co.uk/news/uk-news/after-five-years-tory-rule-6448738>

MIRZA, N. A., AKHTAR-DANESH, N., NOESGAARD, C., MARTIN, L. and STAPLES, E. (2014). A concept analysis of abductive reasoning. *Journal of advanced nursing*, **70** (9), 1980-1994.

MORAN, V., ALLEN, P., MCDERMOTT, I., CHECKLAND, K., WARWICK-GILES, L., GORE, O., BRAMWELL, D. and COLEMAN, A. (2017a). How are clinical commissioning groups managing conflicts of interest under primary care co-commissioning in England? A qualitative analysis. *British Medical Journal Publishing Group*, **7** (11), 1-13.

MORAN, V., CHECKLAND, K., COLEMAN, A., SPOONER, S., GIBSON, J., and SUTTON, M. (2017b). General practitioners' views of clinically led commissioning: cross-sectional survey in England. *British Medical Journal Publishing Group*, **7** (6), 1-10.

MORGAN, D. L. (2007). Paradigms Lost and Pragmatism Regained: Methodological Implications of Combining Qualitative and Quantitative Methods. *Journal of mixed methods research*, **1** (1), 48-76.

MORSE, J. M. and CHEEK, J. (2014). *Making Room for Qualitatively- Driven Mixed-Method Research*. *Qual. Health Res.*, **24** (1), 3-5.

MOSLEY, D., MOSLEY, D. Jr. and PIETRI, P. (2014). *Supervisory Management*. 9th ed. Stamford, CT: Cengage Learning.

MOY, P. and MURPHY, J. (2016). Problems and Prospects in Survey Research. *Journalism & Mass Communication Quarterly*, *SAGE Publishers*, **93** (1), 16-37.

MUMFORD, M. D., MARKS, M. A., CONNELLY, M. S., ZACCARO, S. J. and REITER-PALMON, R. (2000). Development of leadership skills: Experience and timing. *The leadership quarterly*, **11** (1), 87-114.

NAYLOR, C., CURRY, N., HOLDER, H., ROSS, S., MARSHALL, L. and TAIT, E. (2013). *Clinical commissioning groups. Supporting improvement in general practice*. London: The Kings Fund and Nuffield Trust.

NAZIM, A. and AHMAD, S. (2013). Assessing the unidimensionality, reliability, validity and fitness of influential factors of 8th grades student's mathematics achievement in Malaysia. *International Journal of Advance Research*, **1** (2), 1-7.

NHS CLINICAL COMMISSIONERS ([No Date]). *About CCGs*. [online]. Last accessed 24 February 2017 at <https://www.nhscc.org/ccgs/>

NHS COMMISSIONING BOARD (2012a). *Clinical commissioning group governing body members: Roles outlines, attributes and skills*. [online]. Last accessed 01 June 2017 at <https://www.england.nhs.uk/wp-content/uploads/2016/09/ccg-members-roles.pdf>

NHS COMMISSIONING BOARD (2012b). *Commissioning fact sheet for clinical commissioning groups*. [online]. Last accessed 24 March 2016 at <https://www.england.nhs.uk/wp-content/uploads/2012/07/fs-ccg-respon.pdf>

NHS ENGLAND (2012). *CCG List: List-of-proposed-ccgs-pcts-rcas.xls*. [online]. Last accesses 22 February 2016 at <https://www.england.nhs.uk>

NHS ENGLAND (2015). *The NHS in England: The NHS structure explained*. [online]. Last accessed 01 October 2015 at <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx>

NHS ENGLAND (2016). *CCG improvement and assessment framework 2016/17*. CCG planning and assessment national team. [online]. Last accessed 12 September 2018 at <https://www.england.nhs.uk/wp-content/uploads/2017/07/ccg-iaf-mar16.pdf>.

NHS ENGLAND (Open Government Licence v3.0). *About NHS England*. [online]. Last accessed 29 May 2019 at <https://www.england.nhs.uk/about/>

NHS ENGLAND (Open Government Licence v3.0). *Conflicts of interest management*. [online]. Last accessed 27 November at <https://www.england.nhs.uk/commissioning/pc-co-comms/coi/>

NHS LEADERSHIP (2014). *Leadership Programmes*. [online]. Last accessed 18 February 2019 at <http://www.nhsleadership.org.uk/leadership-programmes/>.

NORFOLK AND SUFFOLK NHS FOUNDATION TRUST (2014). *NSFT Research Procedure: 2 – Student Approvals. V1 Jul14. Getting your NHS research project approved: A guide for students*. [online]. Last accessed 19 February 2018 at www.nsft.nhs.uk.

NORTH DURHAM CLINICAL COMMISSIONING GROUP (2013). *Understanding Your Culture Results*. [online]. Last accessed 16 April 2019 at <https://northdurhamccg.nhs.uk/wp-content/uploads/2013/07/NDCCG-Baseline-results-only.pdf>.

NOWELL, L. S., NORRIS, J. M. and WHITE, D. E. and MOULES, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International journal of qualitative methods*, **16** (1), 1609406917733847.

OFFICE FOR NATIONAL STATISTICS (Open Government Licence v3.0). *England: Detailed information on the administrative structure within England*. [online]. Last accessed 31 January 2018 at <https://www.ons.gov.uk/methodology/geography/ukgeographies/administrativegeography/england#regions-former-gors>

OXFORD UNIVERSITY PRESS (2018). *Decision-making*. [online]. Last accessed 14 April 2018 at <https://en.oxforddictionaries.com/definition/decision-making>

PADILLA, A., HOGAN, R. and KAISER, R. B. (2007). The toxic triangle: Destructive leaders, susceptible followers, and conducive environments. *The leadership quarterly*, **18** (3), 176-194.

PALAGANAS, E. C., SANCHEZ, M. C. and MOLINTAS, M. V. P. and CARICATIVO R. D. (2017). Reflexivity in Qualitative Research: A Journey of Learning. *The qualitative report*, **22** (2), 426-438.

PANIAGUA, H. (2002) Planning research: methods and ethics. *Practice Nursing*, **13** (1), 22-5.

PARK, S. H., KIM, J-N. and KRISHNA, A. (2014). Bottom-Up Building of an Innovative Organization. *Management communication quarterly*, **28** (4), 531-560.

PARK, W. (2015). On classifying abduction. *Journal of Applied Logic*, **13** (3), 215-238.

PARLIAMENTARY (2007). *Department of Health: The National Programme for IT in the NHS*. [online]. Last accessed 12 April 2016 at <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmpubacc/390/390.pdf>.

PARLIAMENTARY (2013). *Dismantled National Programme for IT in NHS: report published*. [online]. Last accessed 12 April 2016 at <http://www.publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/294/294.pdf>.

PAUTZ, Jessica and FORRER, Donald (2013). The Dynamics Of Groupthink: The Cape Coral Experience. *Journal of international energy policy*, **2** (1), 1-14.

POWELL, L. (2002). Shedding a tier: Flattening organisational structures and employee empowerment. *The international journal of educational management*, **16** (1), 54-59.

PRESTHUS, W. and MUNKVOLD, B. E. (2016). How to frame your contribution to knowledge? A guide for junior researchers in information systems. *Bibsys Open Journal Systems*, **24** (1).

PRICE, P. C., JHANGIANI, R. S. and CHIANG, I. A. (2015). *Research Methods in Psychology*. [online]. 2nd Canadian ed. Pressbooks.com. Book from BC Open Textbooks last accessed 26 June 2019 at <https://opentextbc.ca/researchmethods/>.

RASKIN, J. D. and BRDGES, S. K. (eds.) (2003). *Studies in Meaning: Exploring Constructivist Psychology*. New York: Pace University Press.

REDLAWSK, D. (2006). *Feeling Politics: Emotion in Political Information Processing*. Illustrated. Springer. Last accessed 11 February 2018 at https://books.google.co.uk/books?id=bTnIAAAAQBAJ&pg=PA43&lpg=PA43&dq=likert+scale+for+feelings+or+emotions&source=bl&ots=raS-RJaKQ9&sig=WCvw0KmPH5BZ_70N8WSNDIT1HCM&hl=en&sa=X&ved=0ahUKEwi19JvQtJ7ZAhXHESwKHeoAB8o4ChDoAQg6MAM#v=onepage&q=likert%20scale%20for%20feelings%20or%20emotions&f=false.

REICHARDT, C. and RALLIS, S. (1994) *The Qualitative-Quantitative Debate: New Perspectives*. San Francisco: Jossey-Bass.

RESNIK, D. B. (2010). What is Ethics in Research & Why is it Important? *National Institute of Environmental Health Sciences*. [online]. Last accessed 16 February 2018 at <https://www.niehs.nih.gov/research/resources/bioethics/whatis/index.cfm?links=false>

REVILLA, M. (2010). Quality in Unimode and Mixed-Mode designs: A Multitrait-Multimethod approach. *Survey research methods*, **4** (3), 151-164.

REVILLA, M. (2015). Comparison of the quality estimates in a mixed-mode and a unimode design: an experiment from the European Social Survey. *Quality & quantity*, **49** (3), 1219-1238.

REVILLA, M. A. (2012). Measurement invariance and quality of composite scores in a face-to-face and a web survey. *Survey research methods*, **7** (1), 17-28.

RICHARDS. H. M. and SCHWARTZ, L. J. (2002). Ethics of qualitative research: are there special issues for health services research? *Family practice*, **19** (2), 135-139.

RICKARDS, T. (2012). *Dilemmas of Leadership*. 2nd ed. Oxon: Routledge.

ROBERTSON, R., HOLDER, BENNETT, L., H., ROSS, S., and GOSLING, J. (2014). *CCGs one year on: member engagement and primary care development*. Research report. The King's Fund and Nuffield Trust. [online]. Last accessed 07 September 2018 at <https://www.kingsfund.org.uk/sites/default/files/media/clinical-commissioning-groups-one-year-on.pdf>.

ROBERTSON, R., HOLDER, H., ROSS, S., NAYLOR, C. and MACHAQUEIRO, S. (2016). *Clinical commissioning: GPs in charge?* Research report. The King's Fund and Nuffield Trust. [online]. Last accessed 07 September 2018 at <https://www.nuffieldtrust.org.uk/files/2017-01/clinical-commissioning-gps-in-charge-web-final.pdf>

ROBINSON, S., DICKINSON, H., WILLIAMS, I., FREEMAN, T., RUMBOLD, B. and SPENCE, K. (2011). *Setting priorities in health: The challenge of clinical commissioning*. Research report. Nuffield Trust and Health Services Management Centre, University of Birmingham. [online]. Last accessed 26 June 2019 at <https://www.nuffieldtrust.org.uk/research/setting-priorities-in-health-the-challenge-of-clinical-commissioning#partners>.

ROLFE, P. (2011). Transformational leadership theory: What every leader needs to know. *Nurse leader*, **9** (2), 54-57.

RONKKO, M. and EVERMANN, J. (2013). A Critical Examination of Common Beliefs About Partial Least Squares Path Modeling. *Organizational research methods*, **16** (3), 425-448.

ROSE, K. (1994). Unstructured and semi-structured interviewing. *Nurse researcher (through 2013)*, **1** (3), 23.

ROSSER, E. (2018). *Revealed: GP representation on CCGs being eroded*. [online]. Last accessed 23 May 2019 at

<http://www.pulsetoday.co.uk/news/commissioning/revealed-gp-representation-on-ccgs-being-eroded/20036748.article>

ROWLEY, J. (2012). Conducting research interviews. *Management research review*, **35** (3), 260-271.

ROWLEY, J. (2014). Designing and using research questionnaires. *Management research review*, **37** (3), 308-330.

ROYAL MAIL (2018). *1st Class mail*. [online]. Last accessed 24 February 2018 at <https://www.royalmail.com/personal/uk-delivery/1st-class-mail>.

RUSSO, F. (2009). Explaining Causal Modelling. Or, What a Causal Model Ought to Explain. In: *Proceedings of the SILFS conference*, Milan, 8-10 October 2007. London, College Publications.

SCHEFF, S. W. (2016). Chapter 2 - Experimental Design and Hypothesis. In: SCHEFF, S. W. (ed.). *Fundamental Statistical Principles for the Neurobiologist*. Academic Press, 15-35.

SCHEIN, E. H. and SCHEIN, P. (2017). *Organizational culture and leadership*. 5th ed., Hoboken, New Jersey, Wiley.

SCHUMACHER, J. R. (2010). *Heterarchical Organization: A new model for grassroots nonprofit organizations in an innovation society*. Master of Liberal Studies, University of Minnesota. Unpublished.

SCHURZ, G. (2008). Patterns of abduction. *Synthese*, **164** (2), 201-234.

SCHYNS, B. and SCHILLING, J. (2013). How bad are the effects of bad leaders? A meta-analysis of destructive leadership and its outcomes. *The leadership quarterly*, **24** (1), 138-158.

SCOTT, D. and MORRISON, M. (2006). *Key Ideas in Educational Research*. London: Continuum.

SHAFRITZ, J. M., OTT, J. S. and JANG Y. S. (2005). *Classics of Organization Theory*. 6th ed. Belmont, CA: Wadsworth.

SIMON, M. (2011). Assumptions, limitations and delimitations. *Dissertation and scholarly research: Recipes for success*. Seattle, WA: Dissertation Success, LLC. [online]. Last accessed 09 November 2017 at www.dissertationrecipes.com

SLOAN, A. and BOWE, B. (2014). Phenomenology and Hermeneutic Phenomenology: The Philosophy, the Methodologies and Using Hermeneutic Phenomenology to Investigate Lecturers' Experiences of Curriculum Design. *Quality & Quantity*, **48** (3), 1291-1303.

SOMERSET CLINICAL COMMISSIONING GROUP ([No Date]). *Governance Structure*. [online]. Last accessed 11 September 2018 at <https://slideplayer.com/slide/10587168/>.

STAVROULAKIS, P. J. (2013). Normative analysis and statistical treatment/validity of the Likert scale. In: FRANGOS, C. (ed.). *3rd international conference: Quantitative and quantitative methodologies in the economic & administrative sciences*, Athens, Greece, 23-24 May 2013. 380-382.

STERNBERG, R. J., ROEDIGER III, H. L. and HALPERN, D. F. (2007). *Critical Thinking in Psychology*. Cambridge: Cambridge University Press.

STOMMEL M. and WILLS, C. (2004). *Clinical research: concepts and principles for advanced practice nurses*. Philadelphia, Lippincott Williams & Wilkins.

STOREY, J., HOLTI, R., HARTLEY, J., MARSHALL, M. and MATHARU, T. (2018). Clinical leadership in service redesign using Clinical Commissioning Groups: a mixed-methods study. *National Institute for Health Research*, **6** (2), DOI: 10.3310/hsdr06020.

STREUKENS, S. and LEROI-WERELDS, S. (2016). Bootstrapping and PLS-SEM: A step-by-step guide to get more out of your bootstrap results. *European Management Journal*, **xxx** (2016), 1-15.

STRUTTON, D. and CARTER, W. (2013). Reducing Biases in Cross-Cultural Top Management Team Decision-Making Processes. *International journal of business administration*, **4** (3), 1-13.

SULLIVAN, G. M. and FEINN, R. (2012). Using Effect Size-or Why the P Value Is Not Enough. *Journal of graduate medical education*, **4** (3), 279.

SVENNEVIG, J. (2001). Abduction as a methodological approach to the study of spoken interaction. *Norskraft*, 103, 1-22.

SYMON, G. and CASSELL, C. (2012). *Qualitative Organizational Research: Core Methods and Current Challenge*. London: SAGE Publications.

TALBOT, D. (2014). *Are CCGs set to fail?* [online]. Last accessed 30 September 2015 at <http://www.political-intelligence.com/are-ccgs-set-to-fail/>

TEMME, D., DIAMANTOPOULOS, A. and PFEIGFEIDEL, V. (2014). Specifying formatively-measured constructs in endogenous positions in structural equation models: Caveats and guidelines for researchers. *International Journal of Research in Marketing*, **31** (3), 309-316.

THE FINANCIAL TIMES (2015). *The mounting challenges facing Britain's NHS*. [online]. Last accessed 26 September 2015 at <http://www.ft.com/cms/s/0/c2297076-dde1-11e4-8d14-00144feab7de.html#axzz3mqEdcz6m>

THE GUARDIAN (2015). *The NHS is on a one-way road to privatisation*. [online]. Last accessed 16 June 2019 at <https://www.theguardian.com/healthcare-network/2015/oct/02/nhs-one-way-road-privatisation>.

THE GUARDIAN (2017). *What is WannaCry ransomware and why is it attacking global computers?* [online]. Last accessed 24 February 2018 at <https://www.theguardian.com/technology/2017/may/12/nhs-ransomware-cyber-attack-what-is-wanacrypt0r-20>.

THE KING'S FUND (2018). *Autonomy, accountability and democratic legitimacy*. [online]. Last accessed 11 September 2018 at <https://www.kingsfund.org.uk/projects/nhs-white-paper/autonomy-accountability>

THE REGISTER (2017a). *74 countries hit by NSA-powered WannaCrypt ransomware backdoor: Emergency fixes emitted by Microsoft for WinXP+*. [online]. Last accessed 24 February 2018 at https://www.theregister.co.uk/2017/05/13/wannacrypt_ransomware_worm/.

THE REGISTER (2017b). *NHS WannaCrypt postmortem: Outbreak blamed on lack of accountability*. [online]. Last accessed 24 February 2018 at https://www.theregister.co.uk/2017/06/29/nhs_wannacry_report/.

THE TELEGRAPH (2015). *NHS doctors spend 10 hours a week on bureaucracy*. [online]. Last accessed 09 October 2015 at <http://www.telegraph.co.uk/news/health/news/10462858/NHS-doctors-spend-10-hours-a-week-on-bureaucracy.html>

THOMPSON, K. N. (2010). *Servant-Leadership: An Effective Model for Project Management*. PhD thesis ed. Capella University.

TUFFORD, L. and NEWMAN, P. (2012). Bracketing in Qualitative Research. *Qualitative social work*, **11** (1), 80-96.

TUFFOUR, I. (2017). A Critical Overview of Interpretative Phenomenological Analysis: A Contemporary Qualitative Research Approach. *Journal of healthcare communications*, **2** (4:52), 1-5.

TUZET, G. (2007). *Is Qualitative Induction a Kind of Induction? Seminar Study Group, Peircean University of Navarra*. [online]. Last accessed 11 January 2018 at <http://www.unav.es/gep/SeminarioTuzet2.html>.

TYSSEN, A. K., WALD, A. and SPIETH, P. (2014). The challenge of transactional and transformational leadership in projects. *International journal of project management*, **32** (3), 365-375.

UK PARLIAMENT (2013). *NHS - Backdoor Privatisation*. [online]. Last accessed 16 June 2019 at <https://edm.parliament.uk/early-day-motion/45302/nhs-backdoor-privatisation>.

UNITED KINGDOM CLINICAL RESEARCH COLLABORATION (2005). *Integrated Research Application System*. [online]. Last accessed 19 February 2018 at <http://www.ukcrc.org/regulation-governance/integrated-research-application-system/>.

UNITED KINGDOM GOVERNMENT (2012). *Health and Social Care Act 2012*. [online]. Last accessed 26 September 2015 at <http://www.legislation.gov.uk/ukpga/2012/7/schedule/2>

URQUHART, C. (2012). *Grounded Theory for Qualitative Research: A Practical Guide*. [online]. Illustrated. Last accessed 29 November 2018 at <https://books.google.co.uk>

WANG, Y. and WAGNER, S. (2018). *On groupthink in safety analysis: an industrial case study*. ACM. 266-275.

WASSERSTEIN, R. L. and LAZAR, N. A. (2016). The ASA's statement on p-values: context, process, and purpose. *The American Statistician*, DOI: 10.1080/00031305.2016.1154108.

WHITING, R., SYMON, G. and ROBY, H. and CHAMAKIOTIS, P. (2018). Who's Behind the Lens?: A Reflexive Analysis of Roles in Participatory Video Research. *Organizational research methods*, **21** (2), 316-340.

WILKIN, D., GILLAM, S., and SMITH, K. (2001). Tackling organisational change in the new NHS. *BMJ (Clinical research ed.)*, **322** (7300), 1464-7.

WILLIAMS, A. (2003). How to ... write and analyse a questionnaire. *Journal of orthodontics*, **30** (3), 245-252.

WILLIAMS, I. and BROWN, H. (2014). *Factors influencing decisions of value in health care: a review of the literature*. [online]. Last accessed 28 March 2019 at https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/DOV_HSMC_Final_report_July_2014.pdf.

WILLIAMS, I., BROWN, H. and HEALY, P. (2018). Contextual Factors Influencing Cost and Quality Decisions in Health and Care: A Structured Evidence Review and Narrative Synthesis. *International Journal of Health Policy and Management*, **7** (8), 683–695.

WILLIAMS, S. and PATERSON, M. (2009). A phenomenological study of the art of Occupational Therapy. (Essay). *The qualitative report*, **14** (4), 689.

WOJNAR, D. and SWANSON, K. (2007). Phenomenology: An Exploration/Commentary on "Phenomenology: An Exploration". *Journal of holistic nursing*, **25** (3), 172-180.

WOOD, J. and HEATH, S. (2014). *Clinical commissioning group (CCG) funding*. House of Commons Library. SN06779: Social and General Statistics and Social Policy Section. [online]. Last Access 10 June 2018 at researchbriefings.files.parliament.uk/documents/SN06779/SN06779.pdf.

APPENDICES

Appendix 1 Email Communications with BMA

Appendix 1.1 Request for BMA's advice and assistance in proposed research: 18 February 2016

Dear British Medical Association,

Re: Request for BMA's advice and assistance in proposed research

My name is Mpumelelo Sibanda, a doctoral degree student enrolled on the Doctor of Business Administration (DBA) Degree Course at the Sheffield Business School. I am writing this e-mail to ask for advice and assistance from British Medical Association (BMA) with respect to a research that I plan to conduct on Clinical Commissioning Groups (CCGs). This research will seek to gather the opinions of the general practitioners (GPs) in connection with the structure of their respective CCGs that they work for. This activity will be a follow-up study to a survey which was conducted in April 2014 by the BMA on 1,393 GPs to investigate the future of the NHS. From that study, the BMA website summarised one of their main findings in the following words ^[1]:

The survey revealed a lack of engagement between CCGs and GPs, with two thirds of respondents stating that they 'do not feel like a member and have little influence on CCG policies and strategy' or that they were simply 'told about CCG policies rather than able to contribute views'.

(British Medical Association 2014)

In view of this, the study that I am planning to carry out will be aimed at identifying and developing propositions that will streamline the current CCGs' structure with the intention of mitigating concerns such as the abovementioned. All the research questions will be electronically administered to the participants. As such, the assistance that I would like to get from the BMA to that end is,

1. **Getting GPs' contacts:** Basically, my plan is to use GPs who work for CCGs in England for my sample population. I therefore need at least 500 GPs' contact email

addresses for that purpose. My predicament is that I do not know where to get those email addresses from. I was wondering if the BMA could help me with that. I am willing to go through all the necessary vetting procedures that will enable me to reach the GPs.

2. **Advice on clearance for my research to go ahead in relation to GPs:** Given that my planned research aims to use BMA members to anonymously respond to questions about their working environments, do I need any clearance from the NHS for that purpose? Is there any need for me to complete the Integrated Research Application System (IRAS)? What clearance did the BMA go through when the BMA conducted their survey on GPs in April 2014? As mentioned earlier, my research will be a follow up of that research.

Please note that I live and work in the UK.

Thank you for your support in advance.

Kind regards,

Mpumelelo Sibanda

References:

1. BRITISH MEDICAL ASSOCIATION (2014). *General Practitioners Committee*. [Online]. Last accessed 01 November 2015 at <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/surveys/ccgs-one-year-on>

Appendix 1.2 BMA's Reply: Request for advice and assistance in proposed research: 18 February 2016

Dear Mr Sibanda,

Thank you for contacting the British Medical Association.

As you may know the BMA is a trade union and professional association for doctors. Unfortunately we do not have the resources to assist students with projects or address your questions in detail, due to the UK confidentiality laws we are unable to release any of our members details, such as email address', to you. We would be unable to pass your questionnaires on to members of the BMA.

I am sorry we have been unable to assist you in your studies.

Kind regards

BMA Public Enquiries

British Medical Association

T: 0207 387 4499 | E: info.public@bma.org.uk

Appendix 1.3 Request for BMA Press Release Email Trail

MPUMELELO SIBANDA xxxx@xxxx.shu.ac.uk 08/06/2017 to webcontent, info.public

Dear BMA Web Content Team,

I'm writing you in connection with the below email trail. I was wondering how far you were with progress about this request.

Kind regards,

Mpumelelo

On 7 June 2017 at 11:12, info.public <info.public@bma.org.uk> wrote:

Dear Mpumelelo

Your enquiry was emailed to our Web Contact team on 18th May. You may wish to contact them directly by emailing webcontent@bma.org.uk

I hope this helps

Kind regards

Public Information

British Medical Association

T: 0207 387 4499 | E: info.public@bma.org.uk

From: MPUMELELO SIBANDA [mailto:xxxx.xxxx@xxx.shu.ac.uk]

Sent: 06 June 2017 16:35

To: info.public

Subject: Re: Request for a Media Release on BMA Newsletter CRM:0097900004516

Dear Public information adviser,

Further to the last communication in this email trail that I sent to you, I was wondering

how far BMA was with progress in making a decision about my request.

Kind regards,

Mpumelelo

On 18 May 2017 at 00:08, MPUMELELO SIBANDA <xxxx@xxxx.shu.ac.uk> wrote:

Dear Public Information Adviser,

Thank you for your reply to my request. I note that in your email you have indicated that “BMA is not in a position to contact individual doctors”. My apologies to you if my request gave you the impression that I wanted BMA to contact individual doctors for me. Instead, all that I’m requesting from BMA is just to feature the survey that I’m undertaking in its Newsletter, explaining in brief the aim and rationale of that survey and how it is likely to benefit the CCGs. In that way, anyone who is subscribed with BMA will then receive the news as part of their regular feeds of the Newsletter. I notice that in the email that I sent you on Tuesday I did not give an outline of the proposed message for release on the Newsletter. Find below a draft of that message. You are free to edit this message in any way that will best suit the publication.

Message title: *Decision-making effectiveness in CCGs*

In June 2014, barely a year after the CCGs were officially launched, BMA conducted a survey on 1,393 GPs to investigate the future of the NHS. Interesting findings were made in that study which include that “almost three out of ten GPs believe their local CCG has introduced policies that have adversely affected their ability to care for patients”^[1]. Two thirds of the participants (GPs) felt that they had no influence on CCGs’ “policies and strategy”, with 50% expressing that they felt powerless “to challenge the decision made by their CCG board”^[2]. Further to this study, Mpumelelo Sibanda, a Final Year doctoral degree student at Sheffield Business School, Sheffield Hallam University, is conducting a related survey (not sponsored by BMA) aimed at identifying enablers of and barriers to effective decision-making process in the CCGs. You can participate in this survey either by responding to the invitations from Mpumelelo to the GPs with roles in their local CCGs, or by following this link <https://docs.google.com/forms/d/e/1FAIpQLSeYAxv10XKhjPd1pw5J357y1XByNvi>

[35U_CRB9pB1-NIS5XA/viewform?usp=sf link.](mailto:35U_CRB9pB1-NIS5XA/viewform?usp=sf_link)

[1] <http://web2.bma.org.uk/mediarel.nsf/wall/DF0B0AD33416572980257D0000597E72?OpenDocument>

[2] <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/surveys/ccqs-one-year-on>

*****END OF PROPOSED MESSAGE*****

Please note that I have tried to talk to BMJ as suggested in your reply. BMJ has advised me that BMA is the best platform to get my survey published as BMJ does not deal with requests of this kind.

I look forward to your favourable response. I am open to any improvements or suggestions on my proposal.

Kind regards,

Mpumelelo

On 17 May 2017 at 11:01, info.public <info.public@bma.org.uk> wrote:

Dear Mpumelelo

Thank you for contacting the BMA.

Whilst the BMA is not in a position to contact individual doctors, you wish to contact the British Medical Journal (BMJ), as they may have the facility to advertise your survey in their various editions.

I have provided their contact details below:

Address: British Medical Journal

BMA House

Tavistock Square

London

WC1H 9JR

Telephone: 0207 387 4410

I hope you find this information useful.

Kind regards

Public information adviser

British Medical Association

T: 0207 387 4499 | E: info.public@bma.org.uk

From: MPUMELELO SIBANDA [mailto:xxxx@xxxx.shu.ac.uk]

Sent: 16 May 2017 21:58

To: info.public

Subject: Request for a Media Release on BMA Newsletter

Dear Sir/Madam,

Re: Request for a Media Release on BMA Newsletter

I am writing this email to request a media release on BMA Newsletter of a survey that I am undertaking on all the CCGs across England. This survey is largely informed by a study that BMA conducted in June 2014 on CCGs, a study which influenced the choice of my research topic. In that study, BMA discovered among other things, that “almost three out of ten GPs believe their local CCG has introduced policies that have adversely affected their ability to care for patients” ^[1]. It was also discovered that two thirds of participants (GPs) felt that they had no influence on CCGs’ “policies and strategy”, with 50% expressing that they felt powerless “to challenge the decision made by their CCG board” ^[2]. Considering this, my research is designed to gather the thoughts and perspectives of GPs about decision-making processes in their local CCGs with the aim of identifying enablers of and barriers to effective decision-making process.

Given the membership base of the BMA, I believe that the BMA Newsletter is a great platform to promote my study, which I feel will not only enthuse the GPs, but will also possibly yield valuable discoveries which will be helpful to the CCGs.

Please note that I am not a BMA member and neither am I a medical doctor. Instead, I am a doctoral student at the Sheffield Business School, Sheffield Hallam University. I work for the NHS.

Looking forward to hearing a favourable response from you.

Kind regards,

Mpumelelo Sibanda

(Student: Doctor of Business Administration Degree)

[1] BRITISH MEDICAL ASSOCIATION (2014a). *Clinical Commissioning Groups are failing to involve GPs and deliver improvements to care, warns new BMA survey*. [Online]. Last accessed 15 May 2017

at <http://web2.bma.org.uk/mediarel.nsf/wall/DF0B0AD33416572980257D0000597E72?OpenDocument>

[2] BRITISH MEDICAL ASSOCIATION (2014b). *General Practitioners Committee*. [Online]. Last accessed 15 May 2017 at <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/surveys/ccgs-one-year-on>

Appendix 2 Communications with CCGs

Appendix 2.1 Freedom of Information Act 2000 – Information Request for GPs' Email Contacts

Address

City

County

POSTCODE

07***** (Mobile)

xxxx@xxxx.shu.ac.uk (University Email)

Dear NHS Bristol CCG

Re: Freedom of Information Act 2000 – Information Request

My name is Mpumelelo Sibanda and I am a student at Sheffield Hallam University studying for a Doctor of Business Administration (DBA) Degree. I am writing you under the Freedom of Information Act 2000 to ask for the following information about GPs at your local CCG, NHS Bristol CCG.

1. Name of the GP
2. Business email address of the GP

*Please note that I am not looking for information about GPs from individual GP Practices in your local district as NHS England is responsible for them. Instead, I only need information about GPs who are directly involved in **different** decision-making routines, like Governing Body for example, at your local CCG (NHS Bristol CCG).* The purpose of collecting this information is for a study that I am planning to conduct in which I will invite GPs from various CCGs across England to take part in the study in question.

I understand that under the Freedom of Information Act 2000 I am entitled to a response within 20 working days of your receipt of this request. I would prefer to receive the information electronically. If you require any clarification, I expect you to

contact me under your section 16 duty to provide advice and assistance if you find any aspect of this FOI request problematic.

Thank you in advance.

Yours faithfully,

Mpumelelo Sibanda

Appendix 2.2 FOI Request – CCG Details as in December 2016

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Ashford CCG	ashford.ccg@nhs.net	Ashford Clinical Commissioning Group Inca House Trinity Road Ashford Kent, TN25 4AB	Yes	No
NHS Shropshire CCG	ccg@shropshireccg.nhs.uk	Shropshire Clinical Commissioning Group William Farr House Mytton Oak Road Shrewsbury SY3 8XL	Yes	Yes
NHS North, East, West Devon CCG	d-ccg.corporateservices@nhs.net	NHS Northern, Eastern and Western Devon Clinical Commissioning Group Newcourt House Newcourt Drive Old Rydon Lane Exeter Devon EX2 7JQ	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Newham CCG	enquiries@newhamccg.nhs.uk	NHS Newham Clinical Commissioning Group 4th Floor, Unex Tower, 5 Station Street, London E15 1DA	Yes	No
NHS Hounslow CCG	houcgg.contacts@nhs.net	NHS Hounslow CCG, Green Zone (Pavilion CG), Ground Floor, Civic Centre Lampton Road Hounslow TW3 4DN	Yes	Yes
NHS Birmingham South and Central CCG	infobsc@nhs.net	NHS Birmingham South Central CCG Bartholomew House 142 Hagley Road Birmingham B16 9PA	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Newcastle North & East CCG	ngccg.enquiries@nhs.net	NHS Newcastle MyCity Clinical Commissioning Group Goldcrest Way Newburn Riverside (Business Park) Newcastle upon Tyne NE15 8NY.	Yes	Yes
NHS Newcastle West CCG	ngccg.enquiries@nhs.net	NHS Newcastle MyCity Clinical Commissioning Group Goldcrest Way Newburn Riverside (Business Park) Newcastle upon Tyne NE15 8NY.	Yes	No
NHS North Kirklees CCG	ask@northkirkleescg.nhs.uk	NHS North Kirklees CCG, Broad Lea House/Dyson Wood Way, Huddersfield HD2 1GZ	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Bracknell and Ascot CCG	BACCG.BACCGenquiries@nhs.net	Bracknell and Ascot Clinical Commissioning Group King Edward VII Hospital St Leonards Road Windsor Berkshire SL4 3DP	Yes	Yes
NHS Barnsley CCG	barnccg.foi@nhs.net	NHS Barnsley CCG, 49/51 Gawber Road, Barnsley S75 2PY	Yes	Yes
NHS Bassetlaw CCG	BASCCG.FOIRequests@nhs.net	NHS Bassetlaw CCG , North Rd, Retford DN22 7XF	Yes	No
NHS Basildon and Brentwood CCG	bbccg.contact@nhs.net	NHS Basildon and Brentwood CCG, Phoenix House, Christopher Martin Rd, Basildon SS14 3HG	Yes	Yes
NHS Barking and Dagenham CCG	bdccg@barkingdagenhamccg.nhs.uk	NHS Barking and Dagenham CCG, Barking Hospital, Upney Ln, Barking, IG11 9LX	Yes	No
NHS Bexley CCG	bexccg.contactus@nhs.net	NHS Bexley CCG, 2 Watling St, Bexley Heath, DA7 6AT	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Birmingham Crosscity CCG	bhamcrosscity@nhs.net	NHS Birmingham Crosscity CCG, 142 Hagley Rd, Birmingham, B16 9PA	Yes	Yes
NHS Brighton and Hove CCG	bhccg.ccg@nhs.net	NHS Brighton and Hove CCG, Hove Town Hall, Norton Rd, Hove, BN3 4AH	Yes	No
NHS Brent CCG	BRECCG.Brentenquiries@nhs.net	Brent CCG Wembley Centre for Health and Care 116 Chaplin Road Wembley HA0 4UZ	Yes	Yes
NHS Bromley CCG	broccg.contactus@nhs.net	NHS Bromley Clinical Commissioning Group 1st Floor Beckenham Beacon 379 Croydon Road Beckenham Kent BR3 3QL	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Bath and North East Somerset CCG	BSCCG.information@nhs.net	NHS Bath and North East Somerset CCG, St. Martins Hospital Clara Cross Lane Bath BA2 5RP	Yes	Yes
NHS Bury CCG	BUCCG.corporateoffice@nhs.net	NHS Bury CCG, 21 Silver St, Bury BL9 0EN	Yes	No
NHS Canterbury and Coastal CCG	c4.ccg@nhs.net	Canterbury and Coastal Clinical Commissioning Group NHS Canterbury and Coastal CCG Ground floor Council building Canterbury Kent CT1 1YW	Yes	No
NHS City and Hackney CCG	CAHCCG.cityandhackneyccg@nhs.net	NHS City & Hackney Clinical Commissioning Group 3rd Floor, Block A St Leonard's Hospital, London N1 5LZ	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Cannock Chase CCG	cannockccg.feedback@northstaffs.nhs.uk	Cannock Chase Clinical Commissioning Group Number 2, Staffordshire Place Stafford ST16 2LP	Yes	Yes
NHS Cambridgeshire and Peterborough CCG	capccg.communications@nhs.net	NHS Cambridgeshire and Peterborough CCG, Lockton House Clarendon Road Cambridge CB2 8FH	Yes	Yes
NHS Crawley CCG	CCCG.Contactus-crawleyccg@nhs.net	NHS Crawley CCG, Lower Ground Floor Crawley Hospital, West Green Drive, Crawley RH11 7DH	Yes	No
NHS Calderdale CCG	CCG.FEEDBACK@calderdaleccg.nhs.uk	NHS Calderdale CCG, F Mill, Dean Clough, Halifax HX3 5AX	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Isle of Wight CCG	ccg@iow.nhs.uk	Isle of Wight Clinical Commissioning Group (CCG) Building A The APEX St. Cross Business Park Newport Isle of Wight PO30 5XW	Yes	Yes
NHS Chiltern CCG	chilternccg@nhs.net	NHS Chiltern CCG Ground Floor Chiltern District Council Offices King George V Road Amersham Buckinghamshire HP6 5AW	Yes	Yes
NHS Central London (Westminster) CCG	clccg@nhs.net	NHS Central London (Westminster) CCG, Ferguson House, 15 Marylebone Rd, Marylebone, London NW1 5JD	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Leeds West CCG	commsleedswestccg@nhs.net	NHS Leeds West CCG, B5-B9, Wira House, Wira Business Park, Ring Rd, Leeds LS16 6EB	Yes	No
NHS St Helens CCG	Communications.ccg@sthelensccg.nhs.uk -	NHS St Helens CCG, St Helens Chamber, Salisbury St, Saint Helens WA10 1YF	Yes	Yes
NHS Wiltshire CCG	communications.wiltshireccg@nhs.net	NHS Wiltshire CCG, Southgate House, Pans Lane, Devizes SN10 5EQ	Yes	Yes
NHS Doncaster CCG	communications@doncasterccg.nhs.uk	NHS Doncaster CCG, Sovereign House/White Rose House, Heavens Walk, Doncaster DN4 5DJ	Yes	Yes
NHS Kingston CCG	communications@kingstonccg.nhs.uk	NHS Kingston CCG, Guildhall 1, High Street, Kingston upon Thames KT1 1EU	Yes	No
NHS South Sefton CCG	communications@sefton.nhs.uk	NHS South Sefton CCG, Merton House, Stanley Rd, Bootle L20 3DL	Yes	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Southport & Formby CCG	communications@sefton.nhs.uk	NHS Southport & Formby CCG, 5 Curzon Rd, Southport PR8 6PL	Yes	No
NHS West Norfolk CCG	contact.wnccg@nhs.net	NHS West Norfolk CCG, Kings Court, Chapel Street, King's Lynn PE30 1EL	Yes	Yes
NHS Dudley CCG	contact@dudleyccg.nhs.uk	NHS Dudley CCG, Brierley Hill Health And Social Care Centre, Venture Way, Brierley Hill DY5 1RU	Yes	Yes
NHS Coastal West Sussex CCG	contactus.coastal@nhs.net	NHS Coastal West Sussex CCG, The Causeway, Worthing BN12 6BT	Yes	No
NHS Surrey Downs CCG	contactus.surreydownsccg@nhs.net	NHS Surrey Downs CCG, Cedar Court, 36 Guildford Rd, Fetcham, Leatherhead KT22 9AE	Yes	No
NHS Bristol CCG	contactus@bristolccg.nhs.uk	Bristol CCG, South Plaza, Marlborough Street, Bristol, BS1 3NX - See more at: https://www.bristolccg.nhs.uk/contact/#sthash.ode1rGMf.dpuf	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Coventry and Rugby CCG	contactus@coventryrugbyccg.nhs.uk	NHS Coventry and Rugby CCG, Quinton Rd, Coventry CV1 2NJ	Yes	Yes
NHS Greater Huddersfield CCG	contactus@greaterhuddersfieldccg.nhs.uk	NHS Greater Huddersfield Clinical Commissioning Group Bradley Business Park Dyson Wood Way Bradley Huddersfield HD2 1GZ	Yes	Yes
NHS Luton CCG	contactus@lutonccg.nhs.uk		Yes	No
NHS North Tyneside CCG	contactus@northtynesideccg.nhs.uk	NHS North Tyneside Clinical Commissioning Group 12 Hedley Court Orion Business Park North Shields NE29 7ST	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS South Gloucestershire CCG	contactus@southgloucestershireccg.nhs.uk	South Gloucestershire CCG, Corum 2, Corum Office Park, Crown Way, Warmley, South Gloucestershire BS30 8FJ	Yes	Yes
NHS South Warwickshire CCG	Contactus@southwarwickshireccg.nhs.uk	NHS South Warwickshire Clinical Commissioning Group Westgate House Warwick CV34 4DE	Yes	Yes
NHS North West Surrey CCG	contactus2@nwsurreyccg.nhs.uk	North West Surrey CCG 58 Church Street Weybridge Surrey KT13 8DP	Yes	Yes
NHS Castle Point and Rochford CCG	cpr.ccg@nhs.net	NHS Castle Point and Rochford CCG, Pearl House 12 Castle Road Rayleigh Essex SS6 7QF	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Blackburn with Darwen CCG	customer.care@lancashirecsu.nhs.uk	NHS Blackburn with Darwen CCG, Fusion House, Evolution Park, Haslingden Rd, Blackburn BB1 2FD	Yes	No
NHS East Lancashire CCG	customer.care@lancashirecsu.nhs.uk	NHS East Lancashire CCG, Walshaw House, Regent St, Nelson BB9 8AS	Yes	No
NHS Darlington CCG	DARCCG.contact@nhs.net	Darlington Clinical Commissioning Group Dr Piper House King Street Darlington DL3 6JL	Yes	Yes
NHS Durham Dales, Easington & Sedgefield CCG	ddescg.enquiries@nhs.net	NHS Durham Dales, Easington & Sedgefield CCG, Sedgefield Community Hospital, Salters Lane, Sedgefield, Stockton-on-Tees TS21 3EE	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Dartford, Gravesham and Swanley CCG	dgs.ccg@nhs.net	NHS Dartford, Gravesham and Swanley Clinical Commissioning Group 2nd Floor, Gravesham Civic Centre Windmill Street Gravesend Kent DA12 1AU	Yes	Yes
NHS Eastern Cheshire CCG	ecccg.generalenquiries@nhs.net	NHS Eastern Cheshire CCG, 1st Floor, West Wing New Alderley House Victoria Road Macclesfield Cheshire SK10 3BL	Yes	No
NHS Eastbourne, Hailsham and Seaford CCG	EHSCCG.enquiries@nhs.net	NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group 36-38 Friars Walk Lewes East Sussex BN7 2PB	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Hardwick CCG	enquiries.hardwickccg@nhs.net	NHS Hardwick CCG Scarsdale Hospital Nightingale Close Off Newbold Road Chesterfield S41 7PF	Yes	Yes
NHS Herts Valleys CCG	enquiries.hvccg@nhs.net	Herts Valleys Clinical Commissioning Group Hemel One, Boundary Way, Hemel Hempstead, Herts. HP2 7YU	Yes	Yes
NHS West Cheshire CCG	enquiries.wcheshireccg@nhs.net	West Cheshire Clinical Commissioning Group 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester, Cheshire CH2 1HJ	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Bedfordshire CCG	enquiries@bedfordshireccg.nhs.uk	Bedfordshire Clinical Commissioning Group Capability House Silsoe Bedfordshire MK45 4HR	Yes	Yes
NHS Camden CCG	enquiries@camdenccg.nhs.uk	NHS Camden Clinical Commissioning Group Stephenson House 75 Hampstead Road, London NW1 2PL	Yes	Yes
NHS Chorley & South Ribble CCG	enquiries@chorleysouthribbleccg.nhs.uk	Chorley and South Ribble Clinical Commissioning Group Chorley House Lancashire Business Park Centurion Way Leyland Lancashire PR26 6TT	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Cumbria CCG	enquiries@cumbriaccg.nhs.uk	NHS Cumbria CCG, Lonsdale Unit, Penrith Hospital, Bridge Lane, Penrith CA11 8HX	Yes	Yes
NHS Erewash CCG	enquiries@erewashccg.nhs.uk	Erewash Clinical Commissioning Group Toll Bar House 1 Derby Road Ilkeston Derby DE7 5FH	Yes	Yes
NHS Fylde & Wyre CCG	enquiries@fyldeandwyreccg.nhs.uk	NHS Fylde and Wyre CCG Derby Road Wesham Lancashire PR4 3AL	Yes	Yes
NHS Greater Preston CCG	enquiries@greaterprestonccg.nhs.uk	Greater Preston Clinical Commissioning Group Chorley House Lancashire Business Park Centurion Way Leyland Lancashire PR26 6TT	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Liverpool CCG	enquiries@liverpoolccg.nhs.uk	NHS Liverpool Clinical Commissioning Group The Department 2 Renshaw Street Liverpool L1 2SA	Yes	Yes
NHS North Somerset CCG	enquiries@northsomersetccg.nhs.uk	North Somerset CCG, Post Point 11, Clevedon, North Somerset, BS21 6FW	Yes	No
NHS Portsmouth CCG	enquiries@portsmouthccg.nhs.uk	NHS Portsmouth CCG, CCG headquarters 4th Floor 1 Guildhall Square Portsmouth PO1 2GJ	Yes	Yes
NHS Somerset CCG	enquiries@somersetccg.nhs.uk	Somerset Clinical Commissioning Group Wynford House Lufton Way Yeovil Somerset BA22 8HR	Yes	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Southern Derbyshire CCG	enquiries@southernderbyshireccg.nhs.uk		Yes	No
NHS Swindon CCG	enquiries@swindonccg.nhs.uk	NHS Swindon CCG, The Pierre Simonet Building North Swindon Gateway North Latham Road Swindon Wiltshire SN25 4DL	Yes	Yes
NHS Telford and Wrekin CCG	enquiries@telfordccg.nhs.uk	Telford and Wrekin CCG NHS Telford and Wrekin Halesfield 6 Halesfield	Yes	No
NHS West Leicestershire CCG	enquiries@westleicestershireccg.nhs.uk	West Leicestershire Clinical Commissioning Group 55 Woodgate Loughborough Leicestershire LE11 2TZ	Yes	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS East Riding of Yorkshire CCG	ERYCCG.ContactUs@nhs.net	East Riding of Yorkshire Clinical Commissioning Group Health House Grange Park Lane Willerby East Yorkshire HU10 6DT	Yes	Yes
NHS East Staffordshire CCG	feedback@staffordshirecss.nhs.uk	NHS East Staffordshire CCG, Edwin House, Second Avenue, Burton-on-Trent, DE14 2WF	Yes	No
NHS Stoke on Trent CCG	feedback@staffordshirecss.nhs.uk	NHS Stoke on Trent CCG, NHS Stoke on Trent CCG	Yes	No
NHS Fareham and Gosport CCG	fgccg.enquiries@nhs.net	Fareham and Gosport CCG CommCen Building Fort Southwick James Callaghan Drive Fareham Hampshire PO17 6AR	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Walsall CCG	getinvolved@walsall.nhs.uk	Walsall Clinical Commissioning Group Jubilee House Bloxwich Lane Walsall WS2 7JL	Yes	Yes
NHS West Suffolk CCG	getinvolved@westsuffolkccg.nhs.uk	West Suffolk Clinical Commissioning Group West Suffolk House Western Way Bury St Edmunds Suffolk IP33 3YU	Yes	No
NHS Gloucestershire CCG	GLCCG.enquiries@nhs.net	Gloucestershire CCG Sanger House 5220 Valiant Court Gloucester Business Park Brockworth Gloucester GL3 4FE	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Greenwich CCG	GRECCG.NHSGreenwichCCG@nhs.net	NHS Greenwich Clinical Commissioning Group The Woolwich Centre 35, Wellington Street London SE18 6ND	Yes	No
NHS Great Yarmouth and Waveney CCG	gywccg.your-views-matter@nhs.net	NHS Great Yarmouth and Waveney CCG, HealthEast Beccles House 1 Common Lane North Beccles Suffolk NR34 9BN	Yes	Yes
NHS Harrogate & Rural District CCG	hardccg.enquiries@nhs.net	Harrogate and Rural District Clinical Commissioning Group 1 Grimbald Crag Court St James Business Park Knaresborough HG5 8QB	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Havering CCG	hccg@haveringccg.nhs.uk	Havering Clinical Commissioning Group 3rd Floor, Imperial Offices, 2-4 Eastern Road, Romford Essex RM1 3PJ	Yes	No
NHS Hammersmith and Fulham CCG	hf.ccg@inwl.nhs.uk	NHS Hammersmith and Fulham CCG, 15 Marylebone Rd, Marylebone, London NW1 5JD	Yes	Yes
NHS Hastings and Rother CCG	HRCCG.enquiries@nhs.net	NHS Hastings and Rother Clinical Commissioning Group Bexhill Hospital Holliers Hill Bexhill-on-Sea TN40 2DZ	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Hambleton, Richmondshire & Whitby CCG	HRWCCG.HRWCCGenquiries@nhs.net	NHS Hambleton, Richmondshire & Whitby CCG, Civic Centre, Stonecross, Northallerton, North Yorkshire DL6 2UU	Yes	Yes
NHS Horsham and Mid Sussex CCG	HSCCG.Contactus-horshamandmidsussexccg@nhs.net	Horsham and Mid Sussex CCG Lower Ground Floor Crawley Hospital West Green Drive Crawley West Sussex	Yes	No
NHS Hartlepool & Stockton-On-Tees CCG	hstccg.hartlepoolandstocktonccg@nhs.net	NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group Billingham Health Centre Queensway Billingham TS23 2LA	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Hull CCG	HULLCCG.contactus@nhs.net	NHS Hull Clinical Commissioning Group 2nd Floor Wilberforce Court Alfred Gelder Street Hull HU1 1UY	Yes	Yes
NHS High Weald Lewes Havens CCG	HWCCG.HWLHCCGenquiries@nhs.net	NHS High Weald Lewes Havens CCG 36-38 Friars Walk, Lewes, East Sussex BN7 2PB	Yes	No
NHS Haringey CCG	info@haringeyccg.nhs.uk	NHS Haringey CCG, Haringey CCG River Park House 225 High Road Wood Green London N22 8HQ	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Southampton CCG	info@southamptoncityccg.nhs.uk	NHS Southampton City Clinical Commissioning Group NHS Commissioning HQ Oakley Road Millbrook Southampton SO16 4GX	Yes	Yes
NHS Tower Hamlets CCG	info@towerhamletscg.nhs.uk	NHS Tower Hamlets Clinical Commissioning Group 2nd Floor Alderney Building Mile End Hospital Bancroft Road London E1 4DG	Yes	Yes
NHS West Hampshire CCG	info@westhampshireccg.nhs.uk	Omega House 112 Southampton Road Eastleigh Hampshire SO50 5PB	Yes	No
NHS West Lancashire CCG	info@westlancashireccg.nhs.uk		Yes	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Nene CCG	involvement.nene@nhs.net	NHS Nene Clinical Commissioning Group Francis Crick House Summerhouse Road Moulton Park Northampton NN3 6BF	Yes	Yes
NHS Islington CCG	islington.ccg@nhs.net	NHS Islington CCG, 338-346 Goswell Rd, London EC1V 7LQ	Yes	Yes
NHS Kernow CCG	kccg.contactus@nhs.net	NHS Kernow Clinical Commissioning Group Sedgemoor Centre, Priory Road, St Austell PL25 5AS	Yes	Yes
NHS Knowsley CCG	Knowsley.CCGCommunications@knowsley.nhs.uk	NHS Knowsley CCG, Nutgrove Villa, Westmorland Rd, Huyton, Liverpool L36 6GA	Yes	Yes
NHS Leeds North CCG	leedsnorthccg@nhs.net	NHS Leeds North CCG Leafield House 107-109 King Lane Leeds, LS17 5BP	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Leeds South & East CCG	leedssouthandeastccg@nhs.net	NHS Leeds South & East CCG 3200 Century Way Thorpe Park Leeds, LS15 8ZB	Yes	Yes
NHS Lewisham CCG	lewccg.enquiry@nhs.net	NHS Lewisham Clinical Commissioning Group Cantilever House Eltham Road London SE12 8RN	Yes	Yes
NHS Rushcliffe CCG	mail@rushcliffeccg.nhs.uk	NHS Rushcliffe CCG Easthorpe House 165 Loughborough Road Ruddington Nottingham NG11 6LQ	Yes	Yes
NHS Medway CCG	medway.ccg@nhs.net	NHS Medway CCG, Fifty Pembroke Court Chatham Maritime Chatham Kent ME4 4EL	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Merton CCG	MERCCG.SWL@NHS.net	NHS Merton Clinical Commissioning Group Fifth Floor 120 Broadway Wimbledon London SW19 1RH	Yes	Yes
NHS Milton Keynes CCG	miltonkeynes.ccg@nhs.net	NHS Milton Keynes Clinical Commissioning Group Sherwood Place Sherwood Drive Bletchley MK3 6RT	Yes	No
NHS Newbury and District CCG	NDCCG.enquiries@nhs.net		Yes	Yes
NHS North Durham CCG	nduccg.northdurhamccg@nhs.net	North Durham Clinical Commissioning Group The Rivergreen Centre Aykley Heads Durham DH1 5TS	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS North East Essex CCG	neeccg.enquiries@nhs.net	NHS North East Essex CCG, Turner Rd, Mile End, Colchester CO4 5JR	Yes	No
NHS North East Hampshire and Farnham CCG	NEHCCG.public@nhs.net	NHS North East Hampshire & Farnham CCG Aldershot Centre for Health Hospital Hill Aldershot GU11 1AY	Yes	Yes
NHS North East Lincolnshire CCG	nelccg.askus@nhs.net	NHS North East Lincolnshire CCG, Olympia House 1-2 Saxon Court, Europa Park, Grimsby DN31 2UJ	Yes	No
NHS MyCity CCG	ngccg.enquiries@nhs.net	NHS Newcastle MyCity Clinical Commissioning Group Goldcrest Way Newburn Riverside (Business Park) Newcastle upon Tyne NE15 8NY	Yes	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS North Hampshire CCG	nhccg.enquiries@nhs.net	North Hampshire Clinical Commissioning Group Central 40 Lime Tree Way Chineham Business Park Basingstoke Hampshire RG24 8GU	Yes	Yes
NHS South Cheshire CCG	nhssouthcheshire.ccg@nhs.net	NHS South Cheshire CCG Bevan House Barony Court Nantwich Cheshire CW5 5RD	Yes	Yes
NHS Vale Royal CCG	nhsvaleroyal.ccg@nhs.net	NHS Vale Royal CCG & NHS South Cheshire CCG Bevan House Barony Court Nantwich Cheshire CW5 5RD	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS North Lincolnshire CCG	NLCCG.ContactUs@nhs.net	North Lincolnshire Clinical Commissioning Group Health Place Wrawby Road Brigg North Lincolnshire DN20 8GS	Yes	No
NHS Ipswich and East Suffolk CCG	ipswichandeastsuffolk.ccg@nhs.net	Ipswich & East Suffolk Clinical Commissioning Group Rushbrook House Paper Mill Lane Bramford Ipswich IP8 4DE	No	No
NHS Bolton CCG	foi.gmcusu@nhs.net	NHS Bolton CCG, St Peters House Silverwell Street Bolton BL1 1PP	No	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Central Manchester CCG	foi.gmcusu@nhs.net	NHS Central Manchester CCG, Parkway 3, Parkway Business Centre, Princess Road, Manchester M14 7LU	No	Yes
NHS Heywood, Middleton & Rochdale CCG	None	NHS Heywood, Middleton & Rochdale CCG, 3rd Floor Number One Riverside, Smith Street, Rochdale OL16 1XU	Yes	Yes
NHS Central Manchester CCG	foi.gmcusu@nhs.net	NHS Central Manchester CCG, Parkway 3, Parkway Business Centre, Princess Road, Manchester M14 7LU	No	Yes
NHS North Manchester CCG	foi.gmcusu@nhs.net	NHS Central Manchester CCG, Parkway 3, Parkway Business Centre, Princess Road, Manchester M14 7LU	Yes	Yes
NHS South Manchester CCG	foi.gmcusu@nhs.net	NHS Central Manchester CCG, Parkway 3, Parkway Business Centre, Princess Road, Manchester M14 7LU	No	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Stockport CCG	STOCCG.CustomerServices@nhs.net	NHS Stockport Clinical Commissioning Group 7th Floor Regent House Heaton Lane Stockport SK4 1BS	No	No
NHS Wigan Borough CCG	public@wiganboroughccg.nhs.uk	NHS, Wigan Borough CCG Wigan Life Centre College Ave Wigan WN1 1NJ	No	No
NHS Blackpool CCG	ccgcomments@blackpool.nhs.uk	NHS Blackpool Clinical Commissioning Group Blackpool Stadium Seasiders Way Blackpool Lancashire FY1 6JX	No	No
NHS Lancashire North CCG	info@lancashirenorthccg.nhs.uk		No	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Sunderland CCG	SUNCCG.FOI@nhs.net	NHS Sunderland Clinical Commissioning Group Pemberton House Colima Avenue Sunderland SR5 3XB	No	No
NHS Airedale, Wharfedale & Craven CCG	None		No	No
NHS Bradford Districts CCG	None	NHS Bradford Districts CCG, Douglas Mill Bowling Old Lane Bradford BD5 7JR	Yes	No
NHS Bradford City CCG	None	NHS Bradford City CCG, Douglas Mill Bowling Old Lane Bradford BD5 7JR	Yes	No
NHS Wakefield CCG	None	NHS Wakefield CCG, White Rose House, W Parade, Wakefield WF1 1LT	Yes	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS South Devon and Torbay CCG	None	NHS South Devon and Torbay CCG, Pomona House, Oak View Close, Torquay TQ2 7FF	Yes	No
NHS East Surrey CCG	SCWCSU.FOI@nhs.net	NHS East Surrey CCG Tandridge District Council Offices 8 Station Road East Oxted RH8 0BT	No	No
NHS Aylesbury Vale CCG	avccg.foiccg@nhs.net	NHS Aylesbury Vale CCG, Second Floor, The Gateway, Gatehouse Rd, Aylesbury HP19 8FF	No	No
NHS Wokingham CCG	WOCCG.FOI@nhs.net		No	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Dorset CCG	foi-requests@dorsetccg.nhs.uk	Dorset Clinical Commissioning Group Canford House Discovery Court Business Centre 551-553 Wallisdown Road Poole Dorset BH12 5AG	No	No
NHS Herefordshire CCG	foi.herefordshireccg@lancashirecsu.nhs.uk	Herefordshire Clinical Commissioning Group St Owen's Chambers 22 St Owen street Hereford HR1 2PL	No	No
NHS Mansfield and Ashfield CCG	NSHCCG.Pet-North@nhs.net		No	Yes
NHS North Derbyshire CCG	foi.north@ardengemcsu.nhs.uk	NHS North Derbyshire CCG, CCG Headquarters Nightingale Close Off Newbold Road Chesterfield S41 7PF	No	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Nottingham City CCG	freedom.ofinformation@nottinghamcity.nhs.uk	NHS Nottingham City CCG, 1 Standard Ct, Nottingham NG1 6GN	No	No
NHS North Norfolk CCG	NNCCG.FOI@nhs.net	NHS North Norfolk CCG 1 Mill Close Aylsham NR11 6LZ	No	No
NHS South Norfolk CCG	Snccg.foi@nhs.net	NHS South Norfolk CCG, Lakeside 400 Old Chapel Way Broadland Business Park Thorpe St Andrew Norwich Norfolk NR7 0WG	No	No
NHS Mid Essex CCG	foi.meccg@nhs.net	NHS Mid Essex CCG, Wren House Hedgerows Business Park Colchester Road Chelmsford Essex CM2 5PF	No	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Corby CCG	Foi.corbyccg@nhs.net	NHS Corby Clinical Commissioning Group Corby Enterprise Centre Priors Hall Corby NN17 5EU	No	No
NHS East and North Hertfordshire CCG	FOILEAD@enhertscg.nhs.uk	NHS East and North Hertfordshire CCG, Charter House, Parkway, Welwyn Garden City, Herts. AL8 6JL	No	No
NHS Lincolnshire East CCG	optumcss.leccgfoi@nhs.net	NHS Lincolnshire East Clinical Commissioning Group Cross O'Cliff Court Bracebridge Heath Lincoln LN4 2HN	No	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS East Leicestershire and Rutland CCG	None	East Leicestershire and Rutland CCG Leicestershire County Council Room G30, Penn Lloyd Building County Hall, Glenfield Leicester LE3 8TB	Yes	No
NHS Leicester City CCG	None	NHS Leicester City CCG, St Johns House, 30 East St, Leicester LE1 6NB	Yes	No
NHS Lincolnshire West CCG	FOI.Lincs@ardengemcsu.nhs.uk	NHS Lincolnshire West Clinical Commissioning Group Cross O'Cliff Bracebridge Heath Lincoln LN4 2HN	No	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS North Staffordshire CCG	foi.northstaffordshireccg@lancashirecsu.nhs.uk	NHS North Staffordshire CCG, One Smithfield Building Leonard Coates Way Stoke-on-Trent Staffordshire ST1 4FA	No	No
NHS Barnet CCG	FOI@barnetCCG.nhs.uk	NHS Barnet CCG, 4 North London Business Park, Oakleigh Rd S, London N11 1NP	No	No
NHS Croydon CCG	secsu.foi@nhs.net	NHS Croydon Clinical Commissioning Group Bernard Weatherill House 2nd Floor Zone G 8 Mint Walk Croydon CR0 1EA	No	No
NHS Ealing CCG	ccgfoi@nw.london.nhs.uk	NHS Ealing CCG, 3rd Floor, Perceval House, 14/16 Uxbridge Road, Ealing, London, W5 2HL	No	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Harrow CCG	ccgfoi@nw.london.nhs.uk	NHS Harrow CCG, 4th Floor The Heights 59-65 Lowlands Road Harrow on the Hill HA1 3AW	No	Yes
NHS Hillingdon CCG	ccgfoi@nw.london.nhs.uk	NHS Hillingdon CCG, Boundary House, Cricket Field Rd, Uxbridge UB8 1QG	No	Yes
NHS Lambeth CCG	secsu.foi@nhs.net		No	No
NHS West London CCG	ccgfoi@nw.london.nhs.uk	NHS West London CCG 15 Marylebone Road London NW1 5JD	No	Yes
NHS Northumberland CCG	norccg.enquiries@nhs.net	NHS Northumberland Clinical Commissioning Group County Hall Morpeth Northumberland NE61 2EF	Yes	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Norwich CCG	norwich.ccg@nhs.net	NHS Norwich CCG, Room 202 City Hall St Peters Street Norwich NR2 1NH	Yes	Yes
NHS Nottingham West CCG	nottingham.west@nottinghamwestccg.nhs.uk	NHS Nottingham West CCG, Stapleford Care Centre Church Street Stapleford Nottingham NG9 8DB	Yes	Yes
NHS South Lincolnshire CCG	office@southlincolnshireCCG.nhs.uk	NHS South Lincolnshire CCG Eventus Sunderland Road Northfields Industrial Estate Market Deeping Peterborough PE6 8FD	Yes	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS South West Lincolnshire CCG	office@southwestlincolnshireccg.nhs.uk	South West Lincolnshire Clinical Commissioning Group South Kesteven District Council Offices, St Peter's Hill, Grantham, NG31 6PZ	Yes	No
NHS Oxfordshire CCG	oxon.gpc@nhs.net	Oxfordshire Clinical Commissioning Group Jubilee House, John Smith Drive, Oxford Business Park South, Oxford OX4 2LH	Yes	Yes
NHS Enfield CCG	patient.enquiries@enfieldccg.nhs.uk	NHS Enfield CCG, 116 Cockfosters Rd, Barnet EN4 0DR	Yes	Yes
NHS Oldham CCG	patientservices.gmcso@nhs.net	NHS Oldham Clinical Commissioning Group Ellen House Waddington Street Oldham OL9 6EE	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Guildford and Waverley CCG	paul.davey3@nhs.net	NHS Guildford and Waverley CCG, 3rd Floor, Dominion House, Woodbridge Road, Guildford, GU1 4PU	Yes	No
NHS Nottingham North and East CCG	pet@nottinghamnortheastccg.nhs.uk	South Nottinghamshire CCGs Civic Centre Arnot Hill Park Arnold NOTTINGHAM NG5 6LU	Yes	Yes
NHS Warrington CCG	queries.warringtonccg@nhs.net	NHS Warrington CCG, Headquarters, Arpley House, 110 Birchwood Blvd, Birchwood, Warrington WA3 7QH	Yes	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Redditch and Bromsgrove CCG	rbccg@nhs.net	NHS Redditch and Bromsgrove Clinical Commissioning Group Barnsley Court, Barnsley Hall Road, Bromsgrove Worcestershire B61 0TX	Yes	No
NHS North & West Reading CCG	RCCG.NandWReadingCCG@nhs.net	NHS North and West Reading CCG 57-59 Bath Road Reading Berkshire RG30 2BA	Yes	Yes
NHS Redbridge CCG	rccg@redbridgeccg.nhs.uk	NHS Redbridge CCG, Becketts House 2-14 Ilford Hill Ilford Essex IG1 2QX	Yes	No
NHS Richmond CCG	ricccg.richmond pals@nhs.net	Richmond CCG First Floor Civic Centre 44 York Street Twickenham TW1 3BZ	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Rotherham CCG	rotherhamccg@rotherham.nhs.uk	NHS Rotherham Clinical Commissioning Group Oak House Moorhead Way Bramley Rotherham South Yorkshire S66 1YY	Yes	No
NHS Newark & Sherwood CCG	Ruth.Lloyd@mansfieldandashfieldccg.nhs.uk	NHS Newark & Sherwood CCG, Lowfield Ln, Balderton, Newark NG24 3HJ	Yes	No
NHS Salford CCG	salccg.involve@nhs.net	Salford CCG St James's House Pendleton Way Salford M6 5FW	Yes	No
NHS Scarborough & Ryedale CCG	SCRCCG.enquiries@nhs.net	NHS Scarborough and Ryedale Clinical Commissioning Group Scarborough Town Hall - York House St Nicholas Street Scarborough YO11 2HG	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS South Eastern Hampshire CCG	sehccg.enquiries@nhs.net	South Eastern Hampshire CCG CommCen Building Fort Southwick James Callaghan Drive Fareham Hampshire PO17 6AR	Yes	No
NHS South East Staffs and Seisdon Peninsular CCG	sesp.ccg@nhs.net	South East Staffordshire Locality Office Second Floor Marmion House Lichfield Street Tamworth Staffordshire B79 7BZ	Yes	Yes
NHS Surrey Heath CCG	SHCCG.ContactUs@nhs.net	NHS Surrey Heath CCG, Surrey Heath House, Knoll Rd, Camberley GU15 3HD	Yes	No
NHS Sheffield CCG	sheCCG.sheffieldCCG@nhs.net	NHS Sheffield CCG 722 Prince of Wales Road Sheffield S9 4EU	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Slough CCG	SLOCCG.Info@nhs.net	NHS Slough CCG, King Edward VII Hospital, St Leonards Road, Windsor, Berkshire, SL4 3DP	Yes	Yes
NHS Solihull CCG	solihull.ccg@nhs.net	Solihull CCG Friars Gate 1011 Stratford Road Solihull West Midlands B90 4BN	Yes	Yes
NHS Southwark CCG	souccg.southwark-ccg@nhs.net	NHS Southwark CCG PO BOX 64529 London SE1P 5LX	Yes	Yes
NHS Southend CCG	southend.ccg@nhs.net	NHS Southend CCG, Harcourt House 5-15 Harcourt Avenue Southend on sea SS2 6HT	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS South Kent Coast CCG	southkentcoast.ccg@nhs.net	South Kent Coast Clinical Commissioning Group Council Offices White Cliffs Business Park Whitfield CT16 3PJ	Yes	Yes
NHS South Reading CCG	southreadingccg@nhs.net	NHS South Reading CCG, 57-59 Bath Rd, Reading RG30 2BA	Yes	Yes
NHS Stafford and Surrounds CCG	staffordccg.feedback@northstaffs.nhs.uk	Stafford and Surrounds Clinical Commissioning Group Number 2, Staffordshire Place Stafford, ST16 2LP	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS South Tees CCG	STCCG.enquiries@nhs.net	NHS South Tees Clinical Commissioning Group North Ormesby Health Village First Floor 14 Trinity Mews North Ormesby Middlesbrough TS3 6AL	Yes	Yes
NHS South Tyneside CCG	stynccg.enquiries@nhs.net	NHS South Tyneside CCG, Monkton Hall, Monkton Lane, Monkton Village, Jarrow NE32 5NN	Yes	Yes
NHS Sutton CCG	sutccg.complaints@nhs.net		Yes	Yes
NHS Swale CCG	swale.ccg@nhs.net	NHS Swale CCG, Bramblefield Clinic, Grovehurst Road, Kemsley, Sittingbourne ME10 2ST	Yes	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Sandwell and West Birmingham CCG	swbccg.time2talk@nhs.net	Sandwell and West Birmingham CCG Kingston House 438-450 High Street West Bromwich B70 9LD	Yes	Yes
NHS South Worcestershire CCG	swccg@worcestershire.nhs.uk	NHS South Worcestershire CCG, The Coach House, John Comyn Dr, Perdiswell, Worcester WR3 7NS	Yes	No
NHS Halton CCG	talk2us@haltonccg.nhs.uk	NHS Halton CCG, First Floor Town Hall, Heath Road, Runcorn WA7 5TD	Yes	Yes
NHS Tameside & Glossop CCG	TGCCG.Communications@nhs.net		Yes	No
NHS Thanet CCG	thn@thanetccg.info	Thanet Clinical Commissioning Group Thanet District Council Cecil Street Margate Kent, CT9 1XZ	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Thurrock CCG	thurrock.ccg@nhs.net	NHS Thurrock CCG, Civic Offices 2nd Floor New Road Grays, RM17 6SL	Yes	Yes
NHS Trafford CCG	TRCCG.Mail@nhs.net	NHS Trafford CCG, Crossgate House, Cross St, Sale M33 7FT	Yes	Yes
NHS Vale of York CCG	valeofyork.contactus@nhs.net	NHS Vale of York Clinical Commissioning Group West Offices Station Rise York Y01 6GA	Yes	Yes
NHS Windsor, Ascot and Maidenhead CCG	WAMCCG.Info@nhs.net	NHS Windsor, Ascot and Maidenhead CCG, King Edward VII Hospital, St Leonard's Road, Windsor, Berkshire SL4 3DP	Yes	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Wandsworth CCG	wandsworth.ccg@wandsworthccg.nhs.uk -	Wandsworth CCG are based at: 73 Upper Richmond Rd East Putney London SW15 2SR	Yes	Yes
NHS Warwickshire North CCG	warwick.ccg@ardengemcsu.nhs.uk	NHS Warwickshire North CCG Second Floor Heron House Newdegate Street Nuneaton CV11 4EL	Yes	Yes
NHS West Essex CCG	weccg.comms@nhs.net	NHS West Essex CCG, Building 4, Spencer Close, St Margaret's Hospital, The Plain, Epping, Essex, CM16 6TN	Yes	Yes

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS West Kent CCG	westkent.ccg@nhs.net	NHS West Kent Clinical Commissioning Group Wharf House Medway Wharf Road Tonbridge Kent TN9 1RE	Yes	No
NHS Waltham Forest CCG	wfccg.enquiries@nhs.net	NHS Waltham Forest Clinical Commissioning Group Kirkdale House 7 Kirkdale Road E11 1HP	Yes	Yes
NHS Wirral CCG	WICCG.InTouch@nhs.net	NHS Wirral CCG, 13 Hamilton St, Birkenhead CH41 5AL	Yes	No

CCG Name	Practice Email Address	CCG Address	FOI Email Sent Status	FOI Responded Status
NHS Wolverhampton CCG	wolccg.wccg@nhs.net	Wolverhampton Clinical Commissioning Group Technology Centre Wolverhampton Science Park Glaisher Drive Wolverhampton WV10 9RU	Yes	No
NHS Wyre Forest CCG	WYRECCG.wfccg@nhs.net	NHS Wyre Forest CCG, Kidderminster Health Centre, Bromsgrove Street, Kidderminster, DY10 1PG	Yes	Yes

Appendix 2.3 Invitation to take part in pilot study: 10 & 14 April 2017

Dear Dr FirstName Surname,

Re: Invitation to participate in a pilot study on decision-making practices in CCGs

The Clinical Commissioning Groups (CCGs) were intended to “devolve power to the clinicians such as GPs, consultants, and nurses, so that they could directly run healthcare services at the local level, thereby enabling them to improve patient care and increase accountability”. In June 2014, barely a year after the official launch of CCGs, a study conducted by the BMA found that “almost three out of ten GPs believe their local CCG has introduced policies that have adversely affected their ability to care for patients” [1]. Two thirds of GPs who participated in the survey felt that they had no influence on CCGs’ “policies and strategy” [2]. What is more, 50% of the participants “felt that they were not able to challenge the decision made by their CCG board” [2]. Further studies published in the British Medical Journal [3] discovered that CCGs’ internal structures are too complex to understand, a phenomenon which stifles the ability to prudently judge “the factors affecting the success and impact of CCGs” [3].

I am using a doctoral research project to try and understand the CCGs on their structure and decision-making. This will be realised through a survey of the clinicians involved with CCGs. Before sending out the survey to the entire population targeted for the study, I have decided to first conduct a pilot test to ascertain the validity of the survey. I am therefore asking if you can kindly review my survey questionnaire which is on Google Forms and can be accessed through this link, <https://goo.gl/forms/djJnmpBAOLSwkCko1>.

How will this survey benefit the CCGs?

It is projected that this survey will facilitate in identifying, amongst other things, the enablers of and barriers to effective decision-making process within the CCGs. The findings of this study will be communicated to all the CCGs when the study concludes.

What is the next step?

Please complete the pilot questionnaire on the link given above and then kindly provide the following feedback to me in reply to this email.

1. How long did it take you to go through the questions?
2. Were all the instructions and questions clear?
3. Are there any questions which were inappropriate?
4. Are there any critical issues about the subject under investigation that you feel should have been asked?
5. What do you think about the layout of the questionnaire?

Once I have received comments from the clinicians nominated for the pilot study (which you are part of), I will implement the feedback accordingly. After that, I will send the survey out to all the CCGs across England.

I am acutely aware of the time constraints that you may be under. I would really appreciate your input in making this pilot study a success by responding to my request at your earliest convenient time, possibly within the next two weeks.

If you have any questions please do not hesitate to contact me.

Kind regards,

Mpumelelo Sibanda

(Student: Doctor of Business Administration Degree – Sheffield Hallam University)

[1] BRITISH MEDICAL ASSOCIATION (2014a). *Clinical Commissioning Groups are failing to involve GPs and deliver improvements to care, warns new BMA survey*. [Online]. Last accessed 04 April 2017

at <http://web2.bma.org.uk/pressrel.nsf/wall/DF0B0AD33416572980257D0000597E72?OpenDocument>

[2] BRITISH MEDICAL ASSOCIATION (2014b). *General Practitioners Committee*. [Online]. Last accessed 04 April 2017 at <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/surveys/ccgs-one-year-on>

[3] CHECKLAND, K., COLEMAN, A., PERKINS, N. and MCDERMOTT, I. (2016). *Complexity in the new NHS: longitudinal case studies of CCGs in England*. *BMJ open*, **6** (1)

Appendix 2.4 Invitation to pilot study reminder: 24 April 2017

Dear Dr FirstName Surname,

Just over a week ago you may have received an email requesting you to participate in a pilot study of a survey designed to investigate the Clinical Commissioning Groups' decision-making practices. In that email, I mentioned about how previous research has revealed the frustration that GP Practices have about the policies that CCGs make. I also mentioned about how previous research has discovered the complexity entailed within the structures of CCGs. Due to these reasons, I have decided to use a doctoral research project to try and understand the CCGs on their structure and decision-making. The research is targeted on all CCGs across England. Before sending it out, I have decided to conduct a pilot study to ascertain its validity, hence the invitation that I made to you. I have noticed that you have not yet responded. I'm asking if you can spare just a few minutes filling out the survey. I appreciate the level of busyness and competing priorities that you may be faced with as a clinician.

The survey questionnaire is on Google Forms, a trusted and secure platform, and can be accessed through this secure link:

https://docs.google.com/forms/d/e/1FAIpQLSekVTBhhRo6Qz4m_Y1KEKI3UqookHxSOfsSlqT_oZqx1jyoA/viewform?usp=sf_link.

At the end of the questionnaire there is a feedback section. Could you please kindly fill it out as well.

If you have any questions please do not hesitate to contact me.

I look forward to your goodwill in participating in this pilot study. Please send your response by the end of April.

Kind regards,

Mpumelelo

(Student: Doctor of Business Administration Degree – Sheffield Hallam University)

Appendix 2.5 Replies collection to pilot study 'entreaty' email

EMAIL 1:

On 3 May 2017 at 23:07, XXXX, xxxx (NHS SUNDERLAND CCG) <xxxx@nhs.net> wrote:

Hi so sorry for the late reply-

I did receive the invite for the questionnaire but due to a huge workload I didn't get around to responding - I work a day a week for the CCG only and am a practising GP for 3 days a week as a GP partner. I hold some strategic responsibility for urgent and ambulatory care for Sunderland so a large remit and limited time. If you wanted to resend the questionnaire I could try to find some time to look at it. Sorry again for the late reply to your request.

Best wishes Tracey

Dr xxxx xxxx

Deerness Park Medical Group

Sunderland CCG.

EMAIL 2:

On 3 May 2017 at 22:43, XXXX, xxxx (TUDOR PRACTICE) <xxxx@nhs.net> wrote:

Dear Mpumelelo,

To confirm I did receive your email. I do receive many unsolicited emails in my CCG role. I am terribly sorry but I just do not have the time to answer all. Time constraints and prioritising work are the main issues.

Best wishes

xxxx

Dr xxxx xxxx

Tudor Practice

Ashfurlong Medical Centre

233 Tamworth Road

Sutton Coldfield

West Midlands

B75 6DX

[0121 323 3235](tel:01213233235)

[07767 641460](tel:07767641460)

EMAIL 3:

On 3 May 2017 at 23:54, XXXX, xxxx (NHS NORTH TYNESIDE CCG) <xxxx.xxxx@nhs.net> wrote:

I have completed this survey

John

EMAIL 4:

On 4 May 2017 at 07:17, XXXX, xxxx (HANDSWORTH WOOD MED.CTR.) <xxxx.xxxx@nhs.net> wrote:

Thanks for your email

1. Yes

2. Time constraints

And the email link you sent doesn't work

Best wishes,

Prof xxxx xxxx XXXX

FRCGP FRCP HonMFPH DRCOG DOccMed PGDIP(Cardiology)

Chair Sandwell and West Birmingham CCG

EMAIL 5:

On 4 May 2017 at 08:09, XXXX, xxxx (OAKHAM SURGERY) <xxxx.xxxx@nhs.net> wrote:

I am unable to remember if I received the original e-mail.

I try to respond-however if I did not, it would be pressure of time, and I get a lot of outside requests for completing questionnaires

xxxx xxxx

EMAIL 6:

On 5 May 2017 at 13:11, XXXX, xxxx (MINCHINHAMPTON SURGERY) <xxxx.xxxx@nhs.net> wrote:

Thanks for this, sorry I get many emails a day and only work 1.5 days per week.

BW

xxxx

EMAIL 7:

On 6 May 2017 at 12:48, XXXX, xxxx (NHS GLOUCESTERSHIRE CCG) <xxxx.xxxx@nhs.net> wrote:

Hi - I have now responded! I would not have done due to pressure of work - over 100 emails every day to manage!

Dr xxxx xxxx

Clinical Chair

Gloucestershire CCG

Appendix 2.6 Hard copy letter announcing forthcoming electronic based survey: 22 May 2017

Dear Dr FirstName Surname,

I'm writing this letter to inform you about a survey that I will be conducting from the beginning of June 2017 across all CCGs in England. My name is Mpumelelo Sibanda, a Final Year doctoral student in Business Administration at Sheffield Business School, Sheffield Hallam University (SHU).

The reason for contacting you using the traditional hard copy letter is because of the recent developments in cyber space in which there has been a widespread WannaCrypt Ransomware attack on IT systems across the world. My survey is electronic based, and therefore you will shortly receive an email invitation to participate in that survey. To allay uncertainty because of unexpected email communication from me, I have decided to send this letter beforehand as a precautionary measure so that when you receive my email you will be already aware of its legitimacy. The email that I will send will clearly show the sender's name as "Mpumelelo Sibanda", and it will be from a Sheffield Hallam University (SHU) email domain. That email will introduce the study and give a Sheffield Hallam University recognised weblink to the survey questionnaire.

Regarding the survey, I think for now it suffices to say this survey is designed to gather the thoughts and perspectives of clinicians about decision-making processes in their local CCGs with the aim of identifying enablers of and barriers to effective decision-making process.

Thank you for taking time to read this letter. If you have any questions please do not hesitate to contact me through my Director of Studies, Dr Richard Breese on the following address.

Mpumelelo Sibanda
C/O Dr Richard Breese (Senior Lecturer)
Stoddart Building

City Campus
Sheffield Business School
Sheffield Hallam University
Sheffield
S1 1WB

XXXX@xxxx.shu.ac.uk (my email address)

XXXX@shu.ac.uk (Supervisor's email address)

I am looking forward to your full support in this study which I believe will yield fascinating results to support CCGs.

Kind regards,

Mpumelelo Sibanda

(Student: Doctor of Business Administration Degree)

Appendix 2.7 Stockton CCG complaint email: 23 May 2017

On 23 May 2017 at 14:44, XXXX, xxxx (NHS STOCKPORT CCG) <xxxx.xxxx@nhs.net> wrote:

Dear Mpumelelo,

We have today received a large number of letters from you to us here at the NHS Stockport Clinical Commissioning Group at Regent House, Stockport.

The letters are all individually named for Doctors who do not reside at this address. We are trying to help by re-directing the mail to the individual GP addresses but would appreciate in future that correspondence like this is not sent in bulk to us at the NHS Stockport CCG.

Kind Regards,

xxxx

xxxx xxxx

Receptionist / Customer Services

NHS Stockport Clinical Commissioning Group

Tel: 0161 426 5046

Email : xxxx.xxxx@nhs.net

Website: www.stockportccg.nhs.uk

Appendix 2.8 Email seeking confirmation from DoS if my study is legitimate: 24 May 2017

From: XXXX, xxxx (NHS NORTHUMBERLAND CCG) [xxxx.xxxx@nhs.net]

Sent: 24 May 2017 08:57

To: xxxx@shu.ac.uk

Subject: Mpumelelo Sibanda

Hi,

We have received a letter from Mpumelelo Sibanda asking my clinical directors to participate in a survey on decision making in the NHS. I have to say it is full credit to Mpumelelo that he has recognised the recent cyber-attack and is warning the directors to expect an email from him with the title etc. I am just checking that the excellent letter is legitimate and then I can encourage the clinicians to participate in the questionnaire and knowing by pressing the link they are not risking the NHS' IT security.

Kind regards.

xxxx

xxxx xxxx

Head of Commissioning (Planned Care)
NHS Northumberland Clinical Commissioning Group
County Hall, Morpeth. NE61 2EF
Tel: 01670 335162
Email: xxxx.xxxx@nhs.net
Website: www.northumberlandccg.nhs.uk

Appendix 2.9 Good idea to introduce yourself: 27 June 2017

On 27 June 2017 at 19:02, XXXX, xxxx (NHS SHEFFIELD
CCG) <xxxx.xxxx@nhs.net> wrote:

Thank you Mpumelelo

This was a good idea to introduce yourself prior to sending the survey request.

I have just completed the survey and wish you well with your research.

Dr xxxx xxxx

Clinical Director – Children, Young People and Maternity Portfolio
NHS Sheffield CCG
722 Prince of Wales Road
Darnall
Sheffield
S9 4EU

Email: xxxx.xxxx@nhs.net

SHECCG.ChildrensCommissioning@nhs.net

Ext: xxxx

Tel: 0114 30 51071

Appendix 2.10
2017

Happy to take part in the survey: 25 May

On 25 May 2017 at 12:29, XXXX, xxxx (UNIVERSITY HEALTH SERVICE HEALTH CENTRE) <xxxx.xxxx@nhs.net> wrote:

Dear Mpumelelo

I received your letter today - happy to take the survey whenever you want to send it to me.

Kind regards

xxxx

Dr xxxx xxxx

Cambridgeshire & Peterborough CCG

GP Clinical Lead (Planned Care & Demand Management)

GP Board Member of Clinical Executive, Governing Body and Cambridge Health & Wellbeing Board.

(NIHR EoE CLARHC Fellow 2016)

Appendix 2.11

CCG refusal to take part in survey

On 23 May 2017 at 10:52, XXXX, xxxx (NHS HIGH WEALD LEWES HAVENS CCG) <xxxx.xxxx@nhs.net> wrote:

Dear Mpumelelo

Thank you for your letter which we received this morning addressed to various members of our Governing Body regarding your forthcoming survey. I have however been asked to advise that we as a CCG do not wish to take part on this occasion.

We would therefore request that you do not email your survey to those you addressed the letter to.

We wish you well with your research.

Kind regards

xxxx

xxxx xxxx

PA to Chair, Chief Officer & Chief Finance Officer
High Weald Lewes Havens Clinical Commissioning Group
36-38 Friars Walk, Lewes, East Sussex, BN7 2PB
Direct Line: 01273 403645
Email: xxxx.xxxx@nhs.net

Appendix 2.12 2017

Invitation to take part in survey: 04 June

Dear Dr xxxx xxxx,

Re: A survey of decision making in CCGs

I am writing you this email further to a hard copy letter that I sent to you on the week commencing 21/05/2017, which I believe you have received by now. In that letter, I

mentioned that I was going to contact you by email regarding a survey that I am conducting on CCGs designed to identify enablers of and barriers to effective decision-making. As such, I am kindly inviting you to participate in this survey which will take about 10minutes of your time to complete.

Find below is a brief background to this study along with a link to the questionnaire.

CCGs were designed to be at the heart of world class standards for healthcare delivery, as per Government's propositions drawn in 2012 ^[1]. However, the question is – how have the CCGs fared to date?

A study that BMA conducted in June 2014 discovered among other things that “almost three out of ten GPs believe their local CCG has introduced policies that have adversely affected their ability to care for patients” ^[2]. Two thirds of GPs who participated in that study felt that they had no influence on CCGs’ “policies and strategy”, with 50% of the participants expressing that they felt powerless “to challenge the decision made by their CCG board” ^[3]. Further studies published in the British Medical Journal ^[4] discovered that CCGs’ internal structures are too complex to understand, a phenomenon which stifles the ability to judiciously judge “the factors affecting the success and impact of CCGs” ^[4].

I am using a doctoral research project to try to better understand the CCGs’ current structure and decision making. The survey questionnaire which has been tested with GPs can be accessed through this secure

link: https://docs.google.com/forms/d/e/1FAIpQLScGW7SiSFivG-4tOaFsd0P6VgCqEfY2RAf302DQOw35AxPE_Q/viewform?usp=sf_link.

Your responses will be completely anonymous and analysed in combination with responses from other CCGs’ representatives across England.

If you have any questions please do not hesitate to contact me.

Would you please be so kind as to acknowledge receipt of this mail.

Thank you for your support.

Kind regards,

Mpumelelo Sibanda

(Student: Doctor of Business Administration Degree)

[1] NHS COMMISSIONING BOARD (2012). *Clinical commissioning group governing body members: Roles outlines, attributes and skills*. [Online]. Last accessed 01 June 2017 at <https://www.england.nhs.uk/wp-content/uploads/2016/09/ccg-members-roles.pdf>

[2] BRITISH MEDICAL ASSOCIATION (2014a). *Clinical Commissioning Groups are failing to involve GPs and deliver improvements to care, warns new BMA survey*. [online]. Last accessed 15 May 2017 at

<http://web2.bma.org.uk/pressrel.nsf/wall/DF0B0AD33416572980257D0000597E72?OpenDocument>

[3] BRITISH MEDICAL ASSOCIATION (2014b). *General Practitioners Committee*. [online]. Last accessed 15 May 2017 at <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/surveys/ccgs-one-year-on>

[4] CHECKLAND, K., COLEMAN, A., PERKINS, N. and MCDERMOTT, I. (2016). *Complexity in the new NHS: longitudinal case studies of CCGs in England*. *BMJ open*, **6** (1).

Appendix 2.13 June 2017

Instructed not to open weblinks by IT: 05

On 5 June 2017 at 15:38, XXXX, xxxx (OMNIA PRACTICE) <xxxx@nhs.net> wrote:

Thanks.

I have received your email and I appreciate you have proper credentials.

Unfortunately, however in light of recent cyber-attacks – our IT lead has requested us not to respond to links though google docs and other links.

Sorry

X

Appendix 2.14 Response from unconventional email address category: 05 June 2017

On 5 June 2017 at 16:32, xxxx xxxx <xxxx.xxxx@beh-mht.nhs.uk> wrote:

Hi Sibanda

I cannot forward these E-Mails not on directory its Ok to send one to Patients Experience but rest would need to go directly to them.

We have enormous amounts of units in the 3 Boroughs and some staff not listed on the system.

Thanks

xxxx

xxxx. xxxx

Patients Experience Team Advisor

Barnet, Enfield and Haringey Mental Health Trust

Chase Farm EN2 8JL

Mobile -0208-702-6705

Appendix 2.15 Reminder invitation email: 20 June 2017

Dear Dr FirstName Surname,

REMINDER: A Survey of Decision-Making in CCGs – Sheffield Hallam University

You may have received an email that I sent to you just over two weeks ago inviting you to participate in a survey relating to decision-making in the CCGs. If you have already completed the survey, please accept my sincere thanks for your participation. If you have not yet completed the survey, may I kindly ask you to support this study by sparing about 10minutes of your time filling out the questionnaire. I appreciate the level of busyness and competing priorities that you may be faced with as a clinician. However, I believe that this study has a potential for injecting ideas to the CCGs' decision-making framework. The study results will be shared with all the participants.

The survey is anonymous, and for that reason it is not possible to identify if you have completed the questionnaire unless you choose to waive your anonymity at the end of the survey by supplying your email contact for follow up questions. The survey questionnaire which has been tested with GPs can be accessed through this secure link: [https://docs.google.com/forms/d/e/1FAIpQLScGW7SiSFivG-4tOaFsd0P6VgCqEfY2RAf302DQOw35AxPE_Q/viewform?usp=sf link](https://docs.google.com/forms/d/e/1FAIpQLScGW7SiSFivG-4tOaFsd0P6VgCqEfY2RAf302DQOw35AxPE_Q/viewform?usp=sf_link).

If the link appears as if it does not work, please try one of the following as the link has been tested and proved to work.

1. Use a different web browser. One of the respondents has advised that they could not access the questionnaire on Internet Explorer but when they tried it on Google Chrome it worked.
2. Try accessing the questionnaire from a different network environment. It could be that security settings on your work network are blocking the link from launching; especially in the wake of the recent WannaCry ransomware cyber-attack, some organisations have intensified their security settings.

The survey will close at 12am on Sunday 02 July 2017.

If you have any questions please do not hesitate to contact me.

Thank you for your support.

Kind regards,

Mpumelelo Sibanda

(Student: Doctor of Business Administration Degree)

Appendix 3 Ethical considerations

Appendix 3.1 Research Ethics Committee approval email

On 15 September 2016 at 09:55, xxx, xxx <xxxx@exchange.shu.ac.uk> wrote:

Dear Mpumelelo

Please find below the feedback from your application to the SBS Research Ethics Committee

RESEARCH ETHICS REVIEWER'S FEEDBACK FORM (SHUREC3)

Principal investigator: Mpumelelo Sibanda

Reference number: SBS-105

Other investigators: xxxx xxxx

Title of project: Organizational Structure Impact on Decision-Making: A Mixed methods Study of Clinical Commissioning Groups

The Committee agreed the application should be (tick one box):

	Approved
X	Approved with attention to the items listed below (1). Please email the details of how the issues have been addressed to the FREC and provide confirmation from the supervisor that the issues have been addressed for student projects.
	Referred back to the applicant for a full resubmission to address all the conditions listed below (1).
	Not approved for the reasons listed below (2).
	Does not require approval by Faculty Research Ethics Committee.

1. The following issues need to be addressed:

Section B: Question 8: Debriefing refers to providing details of the information participants will receive after the study/their participation is complete. Please amend this box.

Question 9 & 12: the University has recently developed a central storage system for data (the Q:drive). It is recommended that all data is now stored on this. Can you please explore using this, see link: <http://research.shu.ac.uk/library/rdm/research-store.html>

There is also guidance available on how to preserve and store your data. <https://www.shu.ac.uk/research/ethics-integrity-and-practice/research-data-management-policy> This is especially important if you are planning to publish your results.

Please provide a copy of the quantitative questionnaire that you intend to use for your online survey

It is recommended that you use an informed consent form to obtain consent from the GPs you intend to interview face-to-face. Please attach a form to your application (an example template is available on the central ethics webpages <https://www.shu.ac.uk/research/ethics-integrity-and-practice/research-ethics-approval-procedures>)

Section C: Question 7: you indicate that the project requires a health and safety risk assessment. Please ensure this is in place before you visit any GPs. If you needs assistance with this, xxxx xxxx is the Head of Health and Safety in the Faculty

We confirm that we do not have a conflict of interest with the project application.

Signature: Dr xxxx xxxx Date : 15/9/16

On behalf of SBS Research Ethics Committee

Appendix 3.2 Head of Research Ethics email about IRAS

Dear Mpumelelo

The good news is that you do not need to complete the IRAS form. As you are undertaking your study with NHS staff you simply need University Research ethics approval which you now have. In your communication with the doctors you simply need to tell that that favourable research ethics review for the study was provided by Sheffield Hallam University Research Ethics Committee. Keep a copy of your approval letter in case they want a copy of it. The research is automatically sponsored by the University too so you do not need to chase that up either.

Good luck with your research.

Kindest regards,

xxxx

Professor xxxx xxxx MA PHD C Psychol PFHEA AFBPS.

Head of Research Ethics/Professor of Health Psychology, Sheffield Hallam University,

Development and Society, Room U0803, Unit 8 Science Park, Sheffield S1 2 WB

Appendix 4 PLS-SEM Path Model Assessment

Appendix 4.1 Outer Model Assessment

Reflective measurement models

Reflective measurement models are assessed for both reliability and validity (Lowry & Gaskin 2014; Hair et al. 2012; Henseler et al. 2009). Since I used SmartPLS 3, reliability and validity measurements were performed at the same time in a single run. Reliability was measured to establish the model's internal consistency. The term reliability denotes the ability to yield consistent results "when the assumption is being made that the object being measured has not changed" (Scott & Morrison 2006, p.208). I considered the routinely employed methods for reliability measurement, which are Cronbach's alpha and the composite reliability score (Lowry & Gaskin 2014; Henseler et al. 2009), where measurement of reliability is based on the interrelationship of indicators. Cronbach's alpha test has a limitation though in that it assumes "that all indicators are equally reliable" (Henseler et al. 2009, p.299), thereby compromising the internal consistency reliability of the model's latent variables. In contrast, the composite reliability embraces the understanding that "indicators have different loadings" but then can be interpreted in a similar way as Cronbach's alpha. Reflective indicators "are expected to correlate positively, given that they are designed as alternative indicators of the same underlying construct" (Edwards 2011). Measurement values range from 0 to 1. The general recommended reliability threshold is 0.7 (Lowry & Gaskin 2014; Henseler et al. 2009), while in exploratory studies, such as the current study, a threshold of 0.6 is acceptable (Hamid et al. 2017). Anything less than those values is considered as indicating lack of reliability which could be suggestive "of poorly designed reflective measures" (Edwards 2011, p.375). The higher the value, the more the reliability level. Considering the shortfalls in Cronbach's alpha, I resolved to use composite reliability score only.

Validity pertains to the degree to which the indicators represent the latent variables that they relate to (Edwards 2011). In other words, indicators embody the definition of the latent variable, a phenomenon that is empirically "manifested by the magnitudes of the loadings relating the measures to the construct" (Edwards 2011, p.378). The magnitudes of the loadings are assessed through two subtypes of validity, namely, convergent validity and discriminant validity. Convergent validity tests the

degree of correlation of a set of indicators linked to the same latent variable to determine if the indicators in question are really related. This is established by assessing the average variance extracted (AVE) from across the represented indicators in which a value of at least 0.5 should be obtained (Henseler et al. 2009). Measurement values range from 0 to 1. A reading of at least 0.5 denotes that convergence being assessed is valid, thereby indicating that the associated “latent variable is able to explain more than half of the variance of its indicators on average” (Henseler et al. 2009, p.299).

Discriminant validity, on the other hand, complements convergent validity by determining if the indicators that are not meant to be related are indeed not related. Evaluation of discriminant validity helps to ensure that latent variables are truly distinct from each other, thus preventing multicollinearity issues (Hamid et al. 2017). As such, the likelihood of the latent variables measuring the same thing would be eliminated. In other words, discriminant validity helps researchers to ascertain “whether results confirming hypothesized structural paths are real or whether they are a result of statistical discrepancies” (Farrell 2010, p.324). Without the discriminant validity test, researchers are likely to draw incorrect conclusions about their models’ relationships. The literature discusses about various ways of evaluating discriminant validity which include Cross-loadings, Paired latent variables test, Fornell-Larcker Criterion and Heterotrait-monotrait (HTMT) ratio of correlation, and Multitrait-multimethod matrix (MTMM) (Hamid et al. 2017; Henseler et al. 2015; Lowry & Gaskin 2014; Farrell 2010; Henseler et al. 2009). For this study, I used Cross-loadings, Fornell-Larcker Criterion, and HTMT. Unlike convergent validity, discriminant validity does not have a standard value to signify the test (Lowry & Gaskin 2014). Instead, valuation is dependent on the assessment method used, as explained below. Just like other measurements, Cross-loadings, Fornell-Larcker Criterion, and HTMT are computed simultaneously in a single run in SmartPLS 3.

Cross-loadings assesses the correlation of an indicator to its assigned latent variable in which it should be higher than its correlation with any other latent variables in the model (Hamid et al. 2017; Farrell 2010; Henseler et al. 2009). Any results different to this would necessitate a revision of the model for its correctness and removal of the redundant indicator (Farrell 2010). With Fornell-Larcker Criterion, the

square root of each latent variable's AVE is compared with the correlations of other latent variables. In this, the reflective latent variable should be able to account for "more variance with its assigned indicators than with any other latent variable" (Henseler et al. 2009, p.299). Cross-loadings and the Fornell-Larcker Criterion "do not reliably detect the lack of discriminant validity" (Henseler et al. 2015, p.115). Besides, studies have shown that Cross-loadings tends to be more liberal in indicating discriminant validity, whereby it "supports discriminant validity when the Fornell-Larcker criterion fails to do so" (Henseler et al. 2015, p.116). Because of these possible inconsistencies, HTMT ratio of correlation, which Henseler et al. (2015, p.116) refer to "as a new approach to assess discriminant validity in variance-based SEM", had to be considered. HTMT is more stringent in detecting possible indiscriminant occurrence among the latent variables unlike Cross-loadings and Fornell-Larcker Criterion which are deficient in establishing uniqueness amongst the latent variables (Hamid et al. 2017; Henseler et al. 2015). A Monte Carlo simulation is used in HTMT to achieve higher rates of sensitivity. Since SmartPLS 3 performed the calculations for this test, this thesis will keep the related technicalities to a minimum. It is worth mentioning though that the values from this test are compared with a predefined threshold of 0.85, which Henseler et al. (2015) argue that the value is debatable and therefore suggests 0.9 too. This study adopted the widely used threshold of 0.85. If the HTMT value is higher than 0.85, then "there is a lack of discriminant validity" (Henseler et al. 2015, p.121).

Formative measurement models

The formative measurement models can be assessed at latent variable level and indicator level. The concepts of reliability and latent variable validity do not exist in formative measurement models (Lowry & Gaskin 2014; Hair et al. 2012; Edwards 2011; Henseler et al. 2009). One of the reasons for this is a theoretical assertion that formative indicators may "co-vary with other constructs" (Lowry & Gaskin 2014, p.137). Besides, since the formative indicators represent different aspects, "there is no necessary reason to expect the facets represented ... to correlate with one another" (Edwards 2011, p.374-375). This is different in reflective measurement models where the correlation of indicators is an expected occurrence for reliability measurement, as seen earlier. Unlike in reflective measurement models, assessment of latent variable

validity in formative measurement models does not have widely recognised statistical approaches (Lowry & Gaskin 2014; Henseler et al. 2009). Different methods, not described in this thesis, are discussed in the literature depending on what different researchers have used to test the formative outer models. Given the ambiguity surrounding formative measurement validity, I resolved that I would not assess it at latent variable level. Instead, I focused my assessment on indicators where there are significant implications to the credibility of the overall model assessment outcomes (Henseler et al. 2009).

Formative measurement indicators should be assessed at individual level to determine “whether each indicator indeed delivers a contribution to the formative index by carrying the intended meaning” (Henseler et al. 2009, p.301). Two things should be checked to that end. First, if the indicator is relevant for the structure of the formative measurement model, and secondly if the model does not suffer from indicator multicollinearity. Assessment of indicator relevance contributes primary statistics in formative indicators (Hair et al. 2012). This is achieved by determining estimated indicator weights in which they should be “roughly equal and all have significant t-values” (Lowry & Gaskin 2014, p.137).

One of the problems, which is comparably bigger in formative measurement models than reflective measurement models, concerns collinearity of indicators (Lowry & Gaskin 2014; Edwards 2011; Henseler et al. 2009). High correlations impact on the indicator loadings to the latent variables by making them unstable and tending “to exhibit large standard errors, which create difficulties for estimation and interpretation” (Edwards 2011, p.375). What is more, multicollinearity renders affected indicators’ information redundant (Henseler et al. 2009). Correlations in formative measurement model indicators should be ideally low, thus indicating distinctiveness of the aspects that the indicators represent. Correlations can be tested through regression in SPSS in which a variance inflation factor (VIF) of the indicators should not be more than 10, as “VIFs greater than 10 reveal a critical level of multicollinearity” (Henseler et al. 2009, p.302). Even so, Henseler et al. (2009, p.302) caution that VIF values that are considerably higher than 1 “should alert researchers to the typical problems of multicollinearity”. In SmartPLS 3, the “VIF coefficients should

not be higher than 4.0 (some use the more lenient criterion of 5.0)" (Garson 2016, p.72).

Insignificant formative indicators or those affected by high collinearity – that is, a VIF of more than 10 in SPSS or more than 5 in SmartPLS 3, should be eliminated from the model (Henseler et al. 2009).

Appendix 4.2 Inner Model Assessment

R² of endogenous latent variables: This test is a primary criterion of inner model evaluation which is based on individually explained amount of variance of all endogenous latent variables denoted by the coefficient of determination (R^2). Three rankings to indicate the quality of R^2 are discussed in the literature, namely 0.67, 0.33, and 0.19, interpreted "as substantial, moderate, and weak, respectively" (Henseler et al. 2009, p.303). Tests with "weak" R^2 results are suggestive of doubtful "theoretical underpinnings" of the model, meaning that the model is not capable of explaining the endogenous latent variable(s). On the other hand, "moderate" R^2 may be acceptable in situations where an endogenous latent variable has only one or two inner paths joining to the exogenous latent variable(s). In all other cases where the latent endogenous variable has multiple inner paths joining to exogenous latent variables, R^2 should be "substantial". However, Garson (2016) argues that what may be considered as high R^2 values is relative depending on previous studies. For example, "a value of .25 might be considered "high" if the state of the art in the given subject and field had previously led to values even lower" (Garson 2016, p.80).

As demonstrated earlier in The PLS-SEM path model for the current study, shown above in Figure 3.10, had all its latent variables modelled in the first-order. This means that all the latent variables, regardless of their mode, had direct relationships with the associated indicators (Lowry & Gaskin 2014). In contrast, latent variables that have relationships with other latent variables are known as higher order latent variables. As shown in Figure 3.10, the current study path model was comprised of

both formative and reflective indicators. This path model is complemented by Table 3.5, which outlines the items that were measured along with the associated indicators and latent variables, presented in a format derived from Bharati and Chaudhury (2004). The names of the shortened indicators outlined in Table 3.5, as well as those outlined in Table 3.6, were derived from the items that were measured, which are described in the same tables.

Table 3.5, the model developed for this study had five latent variables, of which two were exogenous and three endogenous. The maximum number of inner paths joining to any given endogenous latent variables from exogenous latent variables was two, meaning that a test result of at least “moderate” R^2 had to be attained on the current research’s model. In SmartPLS 3, the R^2 “values are shown inside the blue ellipses for endogenous latent variables (factors)” (Garson 2016).

Significance of path coefficients: Path coefficients indicate the strength of relationships between latent variables in inner model paths. Path coefficients are standardised weighted factors with algebraic values ranging from -1 to +1 (Garson 2016). The closer the weight to absolute 1, the stronger the path, with the weights closest to 0 reflecting weakest paths.

Effect size f^2 : Effect size measures the magnitude of effect between two variables; for example, the relative effect that an exogenous latent variable has on an endogenous latent variable (Garson 2016; Hair et al. 2012). Unlike statistical significance which tells the researcher how likely his or her results are, due to chance, effect size demonstrates the degree of importance of the results (Sullivan & Feinn 2012). Effect size is empirically calculated using means of Cohen’s (1988) f^2 where “values of 0.02, 0.15, and 0.35 signify small, medium, and large effects, respectively” (Henseler et al. 2009, p.304) while a reading below 0.02 indicates no effect. In SmartPLS 3, f^2 values are automatically generated for the researcher (Garson 2016).

Prediction relevance Q^2 : Prediction relevance is a measure which assesses the inner model’s capability to predict, and this is achieved using Stone-Geisser’s Q^2 empirical test criterion where the measurement is done by blindfolding (Henseler et al. 2009). This procedure (blindfolding) only applies “to endogenous latent variables that

have a reflective measurement model operationalization” (Henseler et al. 2009, p.305).

SmartPLS refers to blindfolding as ““predictive accuracy” criteria” (Garson 2016, p.115), and is calculated by running the blindfolding module on the tool. Stone-Geisser’s Q^2 in SmartPLS is outputted as ““1 – SSE/SSO” in the “Total” table of the “Construct Crossvalidated Redundancy”” (Garson 2016, p.118). Cohen (1988) suggested that “.02 represents a “small” effect size, .15 represents a “medium” effect size, and .35 represents a “high” effect size” (cited in Garson 2016, p.118). The Q^2 value should be above 0 for the model to be relevant to predict that latent variable (Garson 2016; Henseler et al. 2009). Q^2 estimation is “for each reflectively-modeled endogenous factor in the model” (Garson 2016, p.115).

Appendix 5 Data Analysis Concepts

Appendix 5.1 Qualitative Data Analysis: Hermeneutic phenomenology concepts

Like the broader field of phenomenology, hermeneutic phenomenology is about lived experience of the individuals being investigated (Tuffour 2017; Gill 2014; Finlay 2009; Wojnar & Swanson 2007; Lavery 2003). Due to methodological focus consistent with pragmatic approach, a handful of hermeneutic phenomenology concepts that were relevant to the generation of knowledge in the current study will be considered. These include the fore-structure of understanding, the context of the phenomenon, and bracketing.

Fore-structure of understanding: In the quest to understand the lived experience, hermeneutic phenomenology believes that the researcher and the participants, both have what Heidegger called the fore-structure of understanding, which is relevant to sense-making of the phenomenon of study. The fore-structure “is an innate capacity that exists in all individuals to intuit the meaning of being” (McManus Holroyd 2007, p.3). McManus Holroyd (2007, p.3) further argues that “there can never be a presuppositionless stance in any act of interpretation”, thus inferring that the presuppositions that a researcher may have are embraced in hermeneutic phenomenology. Instead of detaching the researcher from the phenomenon of study, hermeneutic phenomenology incorporates the researcher to be part of the study. As the researched uses his or her own fore-structure of understanding to interpret his or her lived experience, the researcher in turn endeavours to make sense of those interpretations through the lens of his or her fore-structure of understanding, the two thereby cogenerating a meaningful “understanding of the phenomenon being studied” (Wojnar & Swanson 2007, p.175). The fore-structure of understanding in any individual is predicated on the context of the phenomenon, which is described next.

Context of the phenomenon: The context of the phenomenon is a key tenet of hermeneutic approach, about which Heidegger stated that, “the understanding of individuals cannot occur in isolation of their culture, social context, or historical period in which they live” (Wojnar & Swanson 2007, p.174). In other words, lived experience can be precisely understood when the participants are viewed from a holistic standpoint in which individuals’ fore-structure of understanding is embraced “in

relation to the broader social, political, and cultural contexts” (Campbell 2001, cited in Wojnar & Swanson 2007, p.174).

Bracketing: Although the general understanding of the hermeneutic approach embraces the researcher’s fore-structure of understanding, IPA prescribes that researchers should bracket their preconceptions beforehand (Tuffour 2017). Bracketing, as explained earlier in the text, is “a method used ... to mitigate the potential deleterious effects of unacknowledged preconceptions related to the research and thereby to increase the rigor of the project” (Tufford & Newman 2012, p.81). Along the same lines, Lavery (2003, p.31) states that bracketing “is one factor that is central to the rigor of the study”. Unlike descriptive phenomenology where bracketing is applied through the whole process, in IPA bracketing is stated beforehand to bring into awareness the researcher’s preconceptions. Otherwise in IPA, “analysis always involves interpretation” (McManus Holroyd 2007, p.208). It is worth noting that in IPA awareness of the preconceptions that a researcher may have is likely to increase as the researcher reads or listens to the participants’ lived experiences. As a result, “a cyclical approach to bracketing” (McManus Holroyd 2007, p.208) should be assumed. The researcher should guard against his or her own biases to allow the text to “assert its own truth against one’s own fore-meaning” (Smith et al. 2009, cited in McManus Holroyd 2007, p.208). Striking a balance between bracketing of preconceptions while at the same time using them as a source of insight is a challenge that is tackled by approaching interpretative descriptions reflexively (Palaganas et al. 2017; Tuffour 2017; Gill 2014; Brannick & Coghlan 2007; Lavery 2003). Reflexivity and its import to the current study will be discussed next.

Appendix 5.2 Qualitative Data Analysis: Reflexivity

Reflexivity “is both a concept and a process” (Dowling 2006, cited in Palaganas et al. 2017). As a concept, reflexivity is about self-awareness which, in research, recognises that “we are part of the social world that we study” (Palaganas et al. 2017, p.427) and thus are likely to have presuppositions about the phenomenon of study.

Such presuppositions may risk contaminating the study as the researcher may lack “the distance and objectivity deemed to be necessary for valid research” (Brannick & Coghlan 2007, p.60). Notwithstanding, reflexivity allows the researcher to take advantage of his or her presuppositions, and thus “articulate tacit knowledge ... and reframe it as theoretical knowledge” (Brannick & Coghlan 2007, p.60). To this end, the researcher undertakes a process of continuous and intentional introspection, “challenging perspectives and assumptions both about the social world and of the researcher him/herself” (Palaganas et al. 2017, p.427). Put differently, the researcher shifts “back and forth, focusing on personal assumptions and then returning to looking at participants’ experiences in a fresh way” (Finlay 2009, p.13). However, caution is made that the researcher should not be overly absorbed in the reflexivity process as the study may risk being “pulled in unfortunate directions which privilege the researcher over the participant” (Finlay 2009, p.13). When rightly implemented, reflexivity can richly benefit the research process and its results (Whiting et al. 2018; Palaganas et al. 2017).

Appendix 6 Data Dictionary

Appendix 6.1 Data Dictionary: Format 1 Analysis Assigned Categories and Codes

Question Number	Assigned Category – Format 1 Analysis	Assigned Code
Question 3	N/A	N/A
Question 3	Board Member	BM
Question 3	Chair	CHR
Question 3	Director	DIR
Question 3	Executive	EXEC
Question 3	Lead	LEAD
Question 3	Other	OTHER
Question 4a.	N/A	N/A
Question 4a.	clinical cabinet	CC
Question 4a.	Clinical Management Group	CMG
Question 4a.	Diabetes clinical forum	DCF
Question 4a.	Executive Team	EXEC
Question 4a.	Formulary Development	FD
Question 4a.	Locality Development	LD
Question 4a.	Mental health transformation board	MHTB
Question 4a.	Multi-professional group	MPG
Question 4a.	N/A	N/A
Question 4a.	Procurement Decisions	PD
Question 4a.	Quality Assurance	QA
Question 4a.	Statutory role	SR
Question 4a.	Workstream update	WU
Question 4b.	Audit	AUDIT
Question 4b.	Commissioning Committee	CC
Question 4b.	Clinical Cabinet	CCBT
Question 4b.	Delivery	DELIVERY
Question 4b.	Executive	EXEC
Question 4b.	Finance	FINANCE
Question 4b.	Governance	GOVERNANCE
Question 4b.	Health and Well Being	HWB
Question 4b.	Locality	LOCALITY

Question Number	Assigned Category – Format 1 Analysis	Assigned Code
Question 4b.	Membership council	MC
Question 4b.	Medicine Management	MedMGT
Question 4b.	Ophthalmology	OPHTHALMOLOGY
Question 4b.	Other	OTHER
Question 4b.	Primary Care Committee	PCC
Question 4b.	Prescribing	PRESCR
Question 4b.	Quality	QUALITY
Question 4b.	Reference Group	REFGRP
Question 4b.	Remuneration committee	REM
Question 4b.	Steering Group	SG
Question 4b.	Sustainability and transformation partnerships (STPs)	STP
Question 4b.	Strategy	STRATEGY
Question 4b.	Transformation	TRANSFORMATION
Question 4b.	Workforce	WORKFORCE
Question 7	N/A	N/A
Question 7	Both A and B	BOTH_A&B
Question 7	Other	OTHER
Question 13	Jeopardy to doctors	DOCJPD
Question 13	Other	OTHER
Question 13	Political pressure	PP
Question 13	Detrimental to patient care	PTNTCARE
Question 14	Financial reasons	FINANCIAL
Question 14	Lack of clinical understanding	LCU
Question 14	Misbalanced authority	MA
Question 14	N/A	N/A
Question 14	Other	OTHER
Question 14	Political control	POLCNTRL
Question 15	N/A	N/A
Question 15	Conflict of interest management	CIM
Question 15	Clinically perceptive	CP
Question 15	Decision making	DM
Question 15	Effective Leadership	EL
Question 15	Good governance	GG

Question Number	Assigned Category – Format 1 Analysis	Assigned Code
Question 15	Membership balance	MB
Question 15	Membership practice engagement	MPE
Question 15	Mutual Respect	MR
Question 15	Other	OTHER
Question 15	Clinically perceptive	PP
Question 15	Patient/Public Inclusivity	PPI
Question 15	Quality Emphasis	QE
Question 15	Stakeholder Inclusivity	SI
Question 15	Shared vision	SV
Question 15	Thorough review of issues	TRI
Question 15	Trust between members	TRUST
Question 16	N/A	N/A
Question 16	Distracted	Dd
Question 16	Lack of ownership	LOO
Question 16	Inconsistency	Incy
Question 16	Bureaucracy – NHS England	BEU_NHSE
Question 16	Constrained Compromise – NHS England	CC_NHSE
Question 16	Imbalanced decision-making	IDM
Question 16	Inconsiderate	Incdte
Question 16	Indifferent	Indiff
Question 16	Ineffectual	Ineff
Question 16	Intransegence	Intra
Question 16	Lack of expertise	LOE
Question 16	Lack of information	LOI
Question 16	Lack of Synergy	LOS
Question 16	Lack of Synergy	LS
Question 16	Other	OTHER
Question 16	Poor communication	PC
Question 16	Poor member practice engagement	PPME
Question 16	Time factor	TF
Question 17	N/A	N/A
Question 17	Balanced Committee Structure	BCS
Question 17	Conflict of interest management	CIM

Question Number	Assigned Category – Format 1 Analysis	Assigned Code
Question 17	Good Governance	GG
Question 17	Gate Keeping	GK
Question 17	More needs to be done	MNTD
Question 17	Mutual Respect	MR
Question 17	None	NONE
Question 17	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	OBL
Question 17	Open Culture	OC
Question 17	Other	OTHER
Question 17	Procurement Support	PS
Question 17	Tiered Approach	TA
Question 20	Themes	Assigned Code
Question 20	N/A	N/A
Question 20	Collaborative Decision-making Approach	CDA
Question 20	Commissioning responsibility not clear between NHSE and CCGs	CR
Question 20	CCG role poorly understood	CRPU
Question 20	Decision-making based on financial constraints	DMBFC
Question 20	Decision-making influenced by government policy	DMIGP
Question 20	Decision-making politically driven	DMPD
Question 20	Decision-making rushed or poor due to time constraints	DMR
Question 20	Good approval ratings	GAR
Question 20	Imbalanced approach to decision-making	IARM
Question 20	Lack of transparency in decision-making	LOTDM
Question 20	Other	OTHER
Question 20	Partially informed decision-making	PIDM
Question 20	Member practice expectations not met	PMENM
Question 20	Member practice GPs disregarded or poorly engaged	PMGDPE
Question 22	N/A	N/A

Question Number	Assigned Category – Format 1 Analysis	Assigned Code
Question 22	Cluster Groups Meetings	CGM
Question 22	Council of Members Meetings	CMM
Question 22	Engagement events	EV
Question 22	GP representation in key committees	GRKC
Question 22	Learning events	LE
Question 22	Locality meeting	LM
Question 22	Mass media	MM
Question 22	Other networks	ON
Question 22	Other	OTHER
Question 22	Plenary meetings	PM
Question 22	Practice managers' meetings	PMM
Question 22	Practice visits by key senior members	PVKSM
Question 22	Practice visits by key senior members	PVKSM
Question 23	N/A	N/A
Question 23	Clinician	CLINICIAN
Question 23	Other	OTHER
Question 23	Post currently unfilled	PCU
Question 23	Unknown	UNKNOWN

Appendix 6.2 Data Dictionary: Format 2 Analysis Assigned Categories and Codes

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
Question 4a.	Executive Team	ET
Question 4a.	Clinical Cabinet Workstream Update	CC_WU
Question 4a.	Clinical Management Group	CG
Question 4a.	Diabetes clinical forum Multi-professional group	DF_MG
Question 4a.	Formulary Development Locality Development Procurement Decisions Quality Assurance Statutory Role	FD_LD_PD_QA_SR
Question 4a.	Mental health transformation board Statutory role	MH_SR
Question 4b.	OTHER	OT
Question 4b.	CC	CC
Question 4b.	AUDIT Commissioning Committee Health and Well Being LOCALITY OTHER Steering Group	AU_CC_HW_LO_OT_SG
Question 4b.	AUDIT Commissioning Committee Prescribing	AU_CC_PR
Question 4b.	AUDIT Medicine Management OTHER QUALITY	AU_MM_OT_QU
Question 4b.	AUDIT Primary Care Committee QUALITY	AU_PC_QU
Question 4b.	Clinical Cabinet	CB
Question 4b.	Commissioning Committee DELIVERY Executive OTHER QUALITY	CC_DE_EX_OT_QU

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
Question 4b.	Commissioning Committee Executive Health and Well Being OTHER TRANSFORMATION	CC_EX_HW_OT_TR
Question 4b.	Commissioning Committee FINANCE Membership Council OTHER Remuneration committee	CC_FI_MC_OT_RC
Question 4b.	Commissioning Committee FINANCE OTHER QUALITY	CC_FI_OT_QU
Question 4b.	Commissioning Committee Health and Well Being LOCALITY QUALITY	CC_HW_LO_QU
Question 4b.	Commissioning Committee Health and Well Being LOCALITY Remuneration committee	CC_HW_LO_RC
Question 4b.	Commissioning Committee Health and Well Being OTHER QUALITY TRANSFORMATION	CC_HW_OT_QU_TR
Question 4b.	Commissioning Committee Membership Council OTHER WORKFORCE	CC_MC_OT_WF
Question 4b.	Commissioning Committee Medicine Management QUALITY	CC_MM_QU
Question 4b.	Commissioning Committee OTHER	CC_OT
Question 4b.	Commissioning Committee OTHERQUALITY Sustainability and transformation partnership	CC_OT_QU_ST
Question 4b.	DELIVERY FINANCE GOVERNANCE OTHER QUALITY	DE_FI_GO_OT_QU

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
Question 4b.	DELIVERY FINANCE Primary Care Committee Reference Group	DE_FI_PC_RG
Question 4b.	Executive	EX
Question 4b.	Executive GOVERNANCE Health and Well Being LOCALITY Sustainability and transformation partnership	EX_GO_HW_LO_ST
Question 4b.	Executive LOCALITY	EX_LO
Question 4b.	Executive LOCALITY OTHER	EX_LO_OT
Question 4b.	FINANCE	FI
Question 4b.	FINANCE GOVERNANCE Primary Care Committee	FI_GO_PC
Question 4b.	FINANCE QUALITY TRANSFORMATION	FI_QU_TR
Question 4b.	GOVERNANCE Medicine Management OTHER QUALITY Sustainability and transformation partnership	GO_MM_OT_QU_ST
Question 4b.	LOCALITY	LO
Question 4b.	LOCALITY OTHER Prescribing	LO_OT_PR
Question 4b.	Medicine Management	MM
Question 4b.	OPHTHALMOLOGY OTHER Steering Group	OP_OT_SG
Question 4b.	OTHER Prescribing QUALITY	OT_PR_QU
Question 4b.	OTHER QUALITY Reference Group STRATEGYWORKFORCE	OT_QU_RG_ST_WF

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
Question 4b.	OTHER STRATEGY	OT_ST
Question 4b.	PCC	PCC
Question 4b.	Prescribing	PR
Question 4b.	Reference Group	RG
Question 4b.	Steering Group	SG
Question 13	N/A	N/A
Question 13	Jeopardy to doctors Detrimental to patient care	DJ_PC
Question 13	Financial reasons	FI
Question 13	Financial reasons Self-interest	FI_SI
Question 13	OTHER	OT
Question 13	Detrimental to patient care	PC
Question 13	Political box ticking	PP
Question 13	Political box ticking Detrimental to patient care	PP_PC
Question 14	Financial reasons	FI
Question 14	Financial reasons Other	FR_OT
Question 14	Financial reasons Other Political control	FR_OT_PC
Question 14	Financial reasons Political control	FR_PC
Question 14	Lack of clinical understanding	LU
Question 14	MA	MA
Question 14	N/A	N/A
Question 14	OTHER	OT
Question 14	Political control	PC
Question 15	N/A	N/A
Question 15	Conflict of interest management Decision making Good governance Mutual Respect Stakeholder Inclusivity	CM_DM_GG_MR_SI
Question 15	Conflict of interest management Mutual Respect Thorough review of issues	CM_MR_TR

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
Question 15	Conflict of interest management Thorough review of issues	CM_TR
Question 15	Clinically perceptive Decision making Membership practice engagement Other	CP_DM_ME_OT
Question 15	Clinically perceptive Effective Leadership Shared vision	CP_EL_SV
Question 15	Clinically perceptive Good governance Mutual Respect Shared vision	CP_GG_MR_SV
Question 15	Clinically perceptive Good governance Other Thorough review of issues	CP_GG_OT_TR
Question 15	Clinically perceptive Membership balance Other Stakeholder Inclusivity	CP_MB_OT_SI
Question 15	Clinically perceptive Other Shared vision	CP_OT_SV
Question 15	Clinically perceptive Patient/Public Inclusivity	CP_PI
Question 15	Clinically perceptive Quality Emphasis Stakeholder Inclusivity	CP_QE_SI
Question 15	Clinically perceptive Stakeholder Inclusivity	CP_SI
Question 15	Decision making	DM
Question 15	Decision making Effective Leadership Other	DM_EL_OT
Question 15	Decision making Mutual Respect Other Stakeholder Inclusivity Thorough review of issues	DM_MR_OT_SI_TR
Question 15	Decision making Other	DM_OT

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
Question 15	Decision making Patient/Public Inclusivity Thorough review of issues	DM_PI_TR
Question 15	Effective Leadership Good governance Mutual Respect Stakeholder Inclusivity Shared vision	EL_GG_MR_SI_SV
Question 15	Good governance Patient/Public Inclusivity Stakeholder Inclusivity	GG_PI_SI
Question 15	Membership balance Mutual Respect Shared vision	MB_MR_SV
Question 15	Membership practice engagement N/A Other	ME_N/A_OT
Question 15	Membership practice engagement Patient/Public Inclusivity	ME_PI
Question 15	Membership practice engagement Patient/Public Inclusivity Quality Emphasis	ME_PI_QE
Question 15	Membership practice engagement Stakeholder Inclusivity	ME_SI
Question 15	Mutual Respect Other Quality Emphasis Thorough review of issues	MR_OT_QE_TR
Question 15	Mutual Respect Other Stakeholder Inclusivity	MR_OT_SI
Question 15	Mutual Respect Other Thorough review of issues	MR_OT_TR
Question 15	Mutual Respect Clinically perceptive Shared vision	MR_PP_SV
Question 15	Mutual Respect Stakeholder Inclusivity Trust between members	MR_SI_TB
Question 15	Mutual Respect Trust between members	MR_TB
Question 15	OTHER	OT

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
Question 15	Other Clinically perceptive Quality Emphasis	OT_PP_QE
Question 15	Other Stakeholder Inclusivity	OT_SI
Question 15	Other Shared vision Trust between members	OT_SV_TB
Question 15	Other Thorough review of issues	OT_TR
Question 15	Patient/Public Inclusivity Thorough review of issues	PI_TR
Question 15	Clinically perceptive	PP
Question 15	Quality Emphasis Thorough review of issues	QE_TR
Question 15	Stakeholder Inclusivity	SI
Question 15	Thorough review of issues	TRI
Question 15	TRUST	TT
Question 16	N/A	N/A
Question 16	Bureaucracy – NHS England	BN
Question 16	Bureaucracy – NHS England Constrained Compromise – NHS England Imbalanced decision-making Time factor	BN_CC_ID_TF
Question 16	Bureaucracy – NHS England Imbalanced decision-making	BN_ID
Question 16	Constrained Compromise – NHS England	CC
Question 16	Dd	Dd
Question 16	Distracted Imbalanced decision-making Ineffectual Lack of expertise Lack of ownership OTHER	Dd_ID_IE_LE_LO_OT
Question 16	Distracted Imbalanced decision-making Lack of Synergy OTHER	Dd_ID_LS_OT
Question 16	Distracted	Dd_LO

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
	Lack of ownership	
Question 16	Distracted Poor member practice engagement	Dd_PE
Question 16	Inconsistency	IC
Question 16	Imbalanced decision-making Ineffectual	ID_IE
Question 16	Imbalanced decision-making Indifferent	ID_IN
Question 16	Imbalanced decision-making Lack of expertise Lack of information Poor member practice engagement Time factor	ID_LE_LI_PE_TF
Question 16	Imbalanced decision-making Lack of expertise OTHER	ID_LE_OT
Question 16	Imbalanced decision-making OTHER Poor communication	ID_OT_PC
Question 16	Ineffectual	IE
Question 16	Ineffectual Lack of Synergy Poor member practice engagement	IE_LS_PE
Question 16	Ineffectual Poor communication Time factor	IE_PC_TF
Question 16	Ineffectual Time factor	IE_TF
Question 16	Inconsiderate	IN
Question 16	Indifferent	IN
Question 16	Indifferent Ineffectual	IN_IE
Question 16	Intransegence	IR
Question 16	Lack of Synergy Time factor	LS_TF
Question 16	PC	PC
Question 16	Poor communication Time factor	PC_TF
Question 16	Poor member practice engagement	PE
Question 16	TF	TF

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
Question 17	N/A	N/A
Question 17	Balanced Committee Structure	BC
Question 17	Balanced Committee Structure Good governance Gate Keeping Tiered Approach	BC_GG_GK_TA
Question 17	Balanced Committee Structure Gate Keeping	BC_GK
Question 17	Balanced Committee Structure Mutual Respect Overseen By Leadership OTHER	BC_MR_OL_OT
Question 17	Balanced Committee Structure Open Culture	BC_OC
Question 17	Balanced Committee Structure OTHER	BC_OT
Question 17	Conflict of interest management Good governance Overseen By Leadership OTHER Procurement support	CM_GG_OL_OT_PS
Question 17	Conflict of interest management Mutual Respect	CM_MR
Question 17	Conflict of interest management Mutual Respect Open Culture	CM_MR_OC
Question 17	Conflict of interest management Mutual Respect Open Culture Procurement support	CM_MR_OC_PS
Question 17	Conflict of interest management Mutual Respect Overseen By Leadership	CM_MR_OL
Question 17	Conflict of interest management Overseen By Leadership Open Culture	CM_OL_OC
Question 17	Conflict of interest management OTHER	CM_OT
Question 17	Good governance Mutual Respect Open Culture	GG_MR_OC
Question 17	Good governance Tiered Approach	GG_TA

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
Question 17	Gate Keeping Overseen By Leadership	GK_OL
Question 17	More needs to be done Overseen By Leadership	MD_OL
Question 17	More needs to be done Tiered Approach	MD_TA
Question 17	MR	MR
Question 17	Mutual Respect Overseen By Leadership	MR_OL
Question 17	Mutual Respect Overseen By Leadership Open Culture OTHER	MR_OL_OC_OT
Question 17	NONE	NN
Question 17	OC	OC
Question 17	Overseen By Leadership	OL
Question 17	OTHER	OT
Question 17	TA	TA
Question 20	N/A	N/A
Question 20	Collaborative Decision-making Approach	CA
Question 20	Collaborative Decision-making Approach Imbalanced approach to decision- making	CA_IA
Question 20	Collaborative Decision-making Approach Member practice GPs disregarded or poorly engaged	CA_PD
Question 22	Council of Members Meetings	CM
Question 22	Council of Members Meetings GP representation in key committees Learning events Practice visits by key senior members	CM_GR_LE_PV
Question 22	Council of Members Meetings GP representation in key committees Mass media Other networks Practice visits by key senior members	CM_GR_MM_ON_PV
Question 22	Council of Members Meetings GP representation in key committees	CM_GR_PV

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
	Practice visits by key senior members	
Question 22	Council of Members Meetings Mass media	CM_MM
Question 22	Council of Members Meetings Mass media Practice visits by key senior members	CM_MM_PV
Question 22	Council of Members Meetings Other networks Practice visits by key senior members	CM_ON_PV
Question 22	Council of Members Meetings Practice visits by key senior members	CM_PV
Question 20	CR	CR
Question 20	CCG role poorly understood	CU
Question 20	Decision-making based on financial constraints	DF
Question 20	Decision-making influenced by government policy	DP
Question 20	Decision-making politically driven Imbalanced approach to decision-making	DP_IA
Question 20	Decision-making politically driven Member practice GPs disregarded or poorly engaged	DP_PD
Question 20	Decision-making rushed or poor due to time constraints Imbalanced approach to decision-making	DR_IA
Question 20	Decision-making rushed or poor due to time constraints Imbalanced approach to decision-making Partially informed decision-making	DR_IA_PI
Question 20	Decision-making rushed or poor due to time constraints OTHER	DR_OT
Question 22	EV	EV
Question 22	Engagement events GP representation in key committees	EV_GR
Question 22	Engagement events Mass media_Other networks	EV_MM_ON

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
Question 22	Engagement events Other networks	EV_ON
Question 20	Member practice GPs disregarded or poorly engaged	GD
Question 22	Cluster Groups Meetings	GM
Question 22	Cluster Groups Meetings GP representation in key committees	GM_GR
Question 22	Cluster Groups Meetings Other networks Practice visits by key senior members	GM_ON_PV
Question 20	Good approval ratings	GR
Question 22	GP representation in key committees	GR
Question 22	GP representation in key committees Learning events	GR_LE
Question 22	GP representation in key committees Learning events_Mass media	GR_LE_MM
Question 22	GP representation in key committees Learning events Mass media	GR_LE_MM
Question 22	GP representation in key committees Learning events Mass media Other networks	GR_LE_MM_ON
Question 22	GP representation in key committees Learning events Mass media Other networks Practice managers' meetings Practice visits by key senior members	GR_LE_MM_ON_PM_PV
Question 22	GP representation in key committees Learning events Mass media Practice visits by key senior members	GR_LE_MM_PV
Question 22	GP representation in key committees Locality meeting Other networks	GR_LM_ON
Question 22	GP representation in key committees Locality meeting OTHER	GR_LM_OT
Question 22	GP representation in key committees Mass media	GR_MM
Question 22	GP representation in key committees	GR_MM_ON

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
	Mass media Other networks	
Question 22	GP representation in key committees Mass media Other networks Practice managers' meetings	GR_MM_ON_PM
Question 22	GP representation in key committees Mass media Other networks Practice visits by key senior members	GR_MM_ON_PV
Question 22	GP representation in key committees Mass media Practice visits by key senior members	GR_MM_PV
Question 22	GP representation in key committees Other networks	GR_ON
Question 22	GP representation in key committees Other networks Practice managers' meetings	GR_ON_PM
Question 22	GP representation in key committees Plenary meetings	GR_PM
Question 22	GP representation in key committees Practice managers' meetings	GR_PM
Question 22	GP representation in key committees Plenary meetings Practice visits by key senior members	GR_PM_PV
Question 22	GP representation in key committees Practice visits by key senior members	GR_PV
Question 20	Imbalanced approach to decision-making Member practice GPs disregarded or poorly engaged	IA_PD
Question 22	Learning events Locality meeting Other networks Practice visits by key senior members	LE_LM_ON_PV
Question 20	Lack of transparency in decision-making	LT
Question 22	Mass media Other networks	MM_ON
Question 22	N/A	N/A
Question 22	ON	ON
Question 20	OTHER	OT

Question Number	Assigned Category – Format 2 Analysis	Assigned Code
Question 22	OTHER	OT
Question 20	Member practice expectations not met	PE
Question 22	PM	PM
Question 22	Practice visits by key senior members	PV

Appendix 7 Statistics Tables

Appendix 7.1 Question 3 CCG Roles Distribution

Question 3 Respondent ID	Assigned Code	Code Description	Sub-Code	Code Frequency Count
1	N/A	N/A		1
2	BM	Board Member		1
2	LEAD	Lead	Clinical Lead, Children's	1
2	LEAD	Lead	Clinical Lead, Prescribing	1
3	CHR	Chair		1
4	CHR	Chair	Clinical chair	1
5	BM	Board Member		1
5	LEAD	Lead	Clinical Lead, Planned care	1
6	OTHER	Other	GP principal single handed	1
7	EXEC	Executive	Locality member	1
8	LEAD	Lead	Clinical Lead, Unplanned clinical care	1
9	BM	Board Member		1
9	LEAD	Lead	Clinical Lead, Prescribing	1
10	CHR	Chair	Clinical chair	1
11	N/A	N/A		1
12	CHR	Chair	Locality chair	1
12	OTHER	Other	Member of medicines committee	1
13	BM	Board Member		1
13	LEAD	Lead	Clinical Lead	1
14	DIR	Director	Clinical director mental health	1
15	BM	Board Member		1
15	CHR	Chair	Vice chair	1
16	LEAD	Lead	Clinical Lead, Prescribing	1
17	EXEC	Executive	Executive member	1
17	LEAD	Lead	Clinical lead in mental health	1

Question 3 Respondent ID	Assigned Code	Code Description	Sub-Code	Code Frequency Count
18	BM	Board Member		1
18	CHR	Chair	Locality chair	1
19	CHR	Chair	Clinical chair	1
19	LEAD	Lead	Clinical Lead, various areas	1
20	CHR	Chair	Clinical chair	1
20	LEAD	Lead	Clinical Lead	1
21	LEAD	Lead	Clinical Lead, care homes	1
22	CHR	Chair	Clinical chair	1
22	LEAD	Lead	Integration lead	1
23	LEAD	Lead	Clinical Lead, diabetes	1
24	CHR	Chair	Vice Chair of our locality group	1
25	OTHER	Other	GP advisor to the CCG	1
25	OTHER	Other	GP representative for the GP practices that make up the CCG	1
26	LEAD	Lead	Clinical Lead, Planned care	1
27	DIR	Director	Unplanned (urgent and emergency) care	1
28	BM	Board Member		1
29	BM	Board Member		1
29	LEAD	Lead	Clinical Lead, quality	1
29	LEAD	Lead	Safety Lead	1
30	CHR	Chair		1
31	LEAD	Lead	Clinical Lead, innovation	1
31	LEAD	Lead	Clinical Lead, medicines optimisation	1
32	BM	Board Member		1
32	LEAD	Lead	Clinical Lead, Prescribing Lead	1
32	OTHER	Other	never event panel	1
33	CHR	Chair	Vice chair	1
33	LEAD	Lead	Clinical lead on cardiovascular	1

Question 3 Respondent ID	Assigned Code	Code Description	Sub-Code	Code Frequency Count
33	LEAD	Lead	Clinical lead on governance	1
33	LEAD	Lead	Clinical lead on mental health	1
33	LEAD	Lead	Clinical lead on primary care	1
33	LEAD	Lead	Clinical lead on training & education	1
34	BM	Board Member		1
35	LEAD	Lead	Clinical Lead, cancer	1
36	BM	Board Member		1
36	LEAD	Lead	Clinical Lead	1
37	LEAD	Lead	Clinical Lead, Mental health and equality	1
38	EXEC	Executive	Joint Locality Executive Board	1
39	CHR	Chair	Locality chair	1
40	BM	Board Member		1
40	CHR	Chair	chair finance risk and governance	1
40	LEAD	Lead	clinical lead for CCG in Rightcare commissioning for value	1
40	LEAD	Lead	clinical lead for elective care	1
40	LEAD	Lead	clinical lead for out of hospital (community care)	1
41	BM	Board Member		1
41	FINANCE	Finance		1
41	OTHER	Other	attend and contribute to monthly clinical focus group	1
41	OTHER	Other	Most importantly I am involved in scrutinising Serious Untoward Incidents incurred by our providers.	1
41	QUALITY	Quality Assurance		1
42	CHR	Chair	Vice chair	1
43	CHR	Chair		1

Question 3 Respondent ID	Assigned Code	Code Description	Sub-Code	Code Frequency Count
44	LEAD	Lead	Clinical Lead	1
45	BM	Board Member		1
46	LEAD	Lead	Clinical Lead, Planned care - particularly MSK and diabetes	1
47	BM	Board Member		1
47	OTHER	Other	Governor, Children's Hospital	1
47	OTHER	Other	Other, Health and Wellbeing Board	1
47	OTHER	Other	partner governor for Sheffield Children's Hospital	1
48	CHR	Chair		1
49	BM	Board Member		1
50	EXEC	Executive	Clinical	1
51	OTHER	Other	attend CMG meeting	1
51	OTHER	Other	PTE meetings to discuss different issues	1
52	BM	Board Member		1
52	CHR	Chair	chair various committees and groups	1
52	OTHER	Other	sit as a member of several other committees and groups	1
53	BM	Board Member		1
53	LEAD	Lead	Clinical lead, Locality	1
53	OTHER	Other	Other, representative of part of the city's GP practices	1
54	LEAD	Lead	Clinical lead, Locality	1
55	DIR	Director	Clinical director mental health	1
56	EXEC	Executive	Executive GP	1
56	OTHER	Other	Caldecott guardian	1
56	OTHER	Other	MSK	1
57	N/A	N/A		1
58	LEAD	Lead	Locality	1

Question 3 Respondent ID	Assigned Code	Code Description	Sub-Code	Code Frequency Count
59	OTHER	Other	Partner	1
60	BM	Board Member		1
60	EXEC	Executive	GP and Clinical Lead	1
60	LEAD	Lead	Clinical Lead	1
61	LEAD	Lead	Clinical Lead, cancer	1
61	LEAD	Lead	Clinical Lead, ENT	1
61	LEAD	Lead	Clinical Lead, eyes	1
62	BM	Board Member		1
63	LEAD	Lead	Clinical lead, numerous areas of service re-design	1
64	BM	Board Member		1
64	CHR	Chair	Vice chair	1
64	LEAD	Lead	Clinical lead for primary care	1
64	LEAD	Lead	Clinical lead for urgent care	1
64	LEAD	Lead	Lead for finance	1
65	CHR	Chair	Chair	1
65	DIR	Director	Urgent and unscheduled care	1
66	CHR	Chair	GP cluster chair	1
66	OTHER	Other	contribute to design of GP practice visit programme and issues relating to deprivation	1
66	OTHER	Other	sit on ophthalmology, cross CCG and secondary care group	1
67	BM	Board Member		1
67	LEAD	Lead	Clinical lead for community contract	1
67	LEAD	Lead	Clinical lead for medicines management	1
68	AUDIT	Audit		1
68	LEAD	Lead	Clinical Lead	1
68	LOCALITY	Locality Development	Attend locality meetings linking with local GPs and their practices.	1

Question 3 Respondent ID	Assigned Code	Code Description	Sub-Code	Code Frequency Count
68	OTHER	Other	Violence against women and girls	1
68	OTHER	Other	Prevention champion and linking with the voluntary sector working on community resilience	1
69	BM	Board Member		1
69	OTHER	Other	Other, various other committees	1
70	BM	Board Member		1
70	CHR	Chair	CCC chair	1
71	CHR	Chair		1
72	CHR	Chair	Chair	1
73	DIR	Director	Primary Care	1
74	DIR	Director	Children, young people and maternity	1
Grand Total				135

Appendix 7.2 Question 4b Various CCGs Committees

Question 4b: Assigned Code	Code Description	Sub-Code	Response ID	Frequenc y Count
AUDIT	Audit		2	1
AUDIT	Audit		29	1
AUDIT	Audit		31	1
AUDIT	Audit		68	1
CC	Commissioning Committee	Commissioning Committee, Clinical	2	1
CC	Commissioning Committee		3	1
CC	Commissioning Committee	Commissioning Committee, Primary Care	5	1
CC	Commissioning Committee	Commissioning Committee, (Sub-category not specified)	5	1
CC	Commissioning Committee		14	1
CC	Commissioning Committee	Commissioning Committee, Joint commissioning committee (for Primary Care)	20	1
CC	Commissioning Committee	Commissioning Committee, Service redesign and commissioning	20	1
CC	Commissioning Committee	Commissioning Committee, Primary Care	22	1
CC	Commissioning Committee	Commissioning Committee, Primary Care	28	1
CC	Commissioning Committee	Commissioning Committee, Mental Health Commissioning	28	1
CC	Commissioning Committee	Commissioning Committee, Primary Care	47	1
CC	Commissioning Committee		48	1
CC	Commissioning Committee	Commissioning Committee, Commissioning operations group	53	1
CC	Commissioning Committee	Commissioning Committee, Primary Care	53	1
CC	Commissioning Committee		55	1

Question 4b: Assigned Code	Code Description	Sub-Code	Response ID	Frequenc y Count
CC	Commissioning Committee	Commissioning Committee, Primary Care	67	1
CC	Commissioning Committee	commissioning Committee, Adults Group	68	1
CC	Commissioning Committee	Commissioning Committee, Primary Care	69	1
CC	Commissioning Committee	Commissioning Committee, Clinical	70	1
CC	Commissioning Committee	Commissioning Committee, Primary Care	72	1
CC	Commissioning Committee	Commissioning Committee, Clinical Commissioning Group	74	1
CC	Commissioning Committee	Commissioning Committee, Children's Joint Commissioning Group	74	1
CCBT	clinical cabinet		39	1
CCBT	clinical cabinet		43	1
DELIVERY	Delivery		33	1
DELIVERY	Delivery		55	1
DELIVERY	Delivery	Delivery, A+E delivery board	64	1
EXEC	Executive	Executive, Exec Team Committee	14	1
EXEC	Executive	Executive, Locality executive	17	1
EXEC	Executive	Executive, Clinical executive	19	1
EXEC	Executive	Executive, Executive board	27	1
EXEC	Executive	Executive, Executive board	37	1
EXEC	Executive	Executive, Clinical executive	42	1
EXEC	Executive	Executive, CCG executive committee	54	1
EXEC	Executive		55	1
FINANCE	Finance	Finance, Finance and Performance	8	1
FINANCE	Finance	Finance, Finance and activity	15	1
FINANCE	Finance	Finance, Quality Performance and Finance	20	1
FINANCE	Finance		33	1
FINANCE	Finance	Finance, Finance and Performance	34	1

Question 4b: Assigned Code	Code Description	Sub-Code	Response ID	Frequenc y Count
FINANCE	Finance		40	1
FINANCE	Finance		64	1
FINANCE	Finance	Finance, Finance and Performance	72	1
GOVERNANCE	Governance	Governance, Integrated Governance	19	1
GOVERNANCE	Governance	Governance, Integrated Governance	33	1
GOVERNANCE	Governance	Governance, risk and governance	40	1
GOVERNANCE	Governance	Governance, Integrated Governance	52	1
HWB	Health and Well Being		14	1
HWB	Health and Well Being		19	1
HWB	Health and Well Being		47	1
HWB	Health and Well Being		53	1
HWB	Health and Well Being		68	1
HWB	Health and Well Being	Health and Well Being, Children's Health and Wellbeing Transformation Board	74	1
LOCALITY	Locality		7	1
LOCALITY	Locality		17	1
LOCALITY	Locality	Locality, Joint Committees with Local Authority	19	1
LOCALITY	Locality	Locality, Local A&E Delivery Board	27	1
LOCALITY	Locality	Locality, Local cluster	32	1
LOCALITY	Locality	Locality, Citywide Localities Group	47	1
LOCALITY	Locality	Locality, Locality Commissioned Services Group	53	1
LOCALITY	Locality		68	1
MC	Membership		69	1

Question 4b: Assigned Code	Code Description	Sub-Code	Response ID	Frequenc y Count
	council			
MC	Membership council		72	1
MedMGT	Medicine Management	Medicine Management, Medicines approval and Stamp	12	1
MedMGT	Medicine Management	Medicine Management, Strategic medicines optimisation	31	1
MedMGT	Medicine Management		51	1
MedMGT	Medicine Management	Medicine Management, STP Medicines Optimisation Group	52	1
MedMGT	Medicine Management	Medicine Management, medicines management community contract	67	1
OPHTHALMOLOG Y	Ophthalmology		66	1
OTHER	Other	Other, Clinical Senate Council	3	1
OTHER	Other	Other, House of care programme board	5	1
OTHER	Other	Other, MSK	10	1
OTHER	Other	Other, Community Support Services (CMG) - clinical membership group	11	1
OTHER	Other	Other, Dementia Strategy Board	14	1
OTHER	Other	Other, Medicines Safety Committee	16	1
OTHER	Other	Other, Service Development	16	1
OTHER	Other	Other, Mental Health Board	17	1
OTHER	Other	Other, Service redesign	20	1
OTHER	Other	Other, Primary Care development Group	20	1
OTHER	Other	Other, Integration Board	22	1
OTHER	Other	Other, clinical pathway development	24	1
OTHER	Other	Other, GP Members Committee	25	1

Question 4b: Assigned Code	Code Description	Sub-Code	Responde nt ID	Frequenc y Count
OTHER	Other	Other, Clinical policy	31	1
OTHER	Other	Other, CCG clinicians group	32	1
OTHER	Other	Other, Never event panel	32	1
OTHER	Other	Other, Charitable Funds	33	1
OTHER	Other	Other, Community Education Providers Network (CEPN)	33	1
OTHER	Other	Other, Mortality surveillance group	45	1
OTHER	Other	Other, Cancer Clinical Programme Group	52	1
OTHER	Other	Other, about 5 more committees	52	1
OTHER	Other	Other, Clinical Effectiveness Group	52	1
OTHER	Other	Other, CVD Clinical Programme Group	52	1
OTHER	Other	Other, Assurance	55	1
OTHER	Other	Other, etc [exact words of the respondent]	55	1
OTHER	Other	Other, standardisation of care	60	1
OTHER	Other	Other, Out of hospital	60	1
OTHER	Other	Other, Committees have strange names	61	1
OTHER	Other	Other, learning disability Healthchecks working party	66	1
OTHER	Other	Other, CG	68	1
OTHER	Other	Other, CSc	68	1
OTHER	Other	Other, EPEC	68	1
OTHER	Other	Other, Estates	68	1
OTHER	Other	Other, IGP	68	1
OTHER	Other	Other, SMI	68	1
OTHER	Other	Other, Violence against women and girls	68	1
OTHER	Other	Other, IFR	69	1
OTHER	Other	Other, ACO	72	1
OTHER	Other	Other, Various Committees	73	1
OTHER	Other	Other, Contact management	74	1

Question 4b: Assigned Code	Code Description	Sub-Code	Response ID	Frequency Count
		Board		
PCC	Primary Care Committee		29	1
PCC	Primary Care Committee		40	1
PCC	Primary Care Committee		44	1
PCC	Primary Care Committee		56	1
PCC	Primary Care Committee		64	1
PRESCR	Prescribing		2	1
PRESCR	Prescribing		9	1
PRESCR	Prescribing		16	1
PRESCR	Prescribing		32	1
QUALITY	Quality		3	1
QUALITY	Quality	Quality, Quality and Performance	15	1
QUALITY	Quality	Quality, Primary Care Quality Committee	16	1
QUALITY	Quality	Quality, Performance and Finance	20	1
QUALITY	Quality	Quality, Quality and Performance	29	1
QUALITY	Quality		31	1
QUALITY	Quality	Quality, Primary Care Quality & Development	33	1
QUALITY	Quality	Quality, Quality and Safety	45	1
QUALITY	Quality	Quality, Integrated Governance and Quality Committee	52	1
QUALITY	Quality	Quality, Quality and Safety	53	1
QUALITY	Quality		55	1
QUALITY	Quality	Quality, Quality meetings	67	1
QUALITY	Quality	Quality, Quality Review Group	74	1
REFGRP	Reference Group	Reference Group, New Care Models Reference Group	45	1
REFGRP	Reference	Reference Group, Clinical	46	1

Question 4b: Assigned Code	Code Description	Sub-Code	Responde nt ID	Frequenc y Count
	Group	Reference Group		
REFGRP	Reference Group	Reference Group, Clinical Reference Group	64	1
REM	Remuneration committee	NULL	47	1
REM	Remuneration committee	NULL	72	1
SG	Steering Group		59	1
SG	Steering Group	Steering Group, practice visit steering group	66	1
SG	Steering Group	Steering Group, iris steering committee	68	1
STP	Sustainability and transformation partnerships (STPs)	STP, CPRG	3	1
STP	Sustainability and transformation partnerships (STPs)	STP, Urgent care Steering	3	1
STP	Sustainability and transformation partnerships (STPs)		19	1
STP	Sustainability and transformation partnerships (STPs)	STP, Reducing Clinical Variation Group	52	1
STRATEGY	Strategy	Strategy, Clinical Strategy group	45	1
STRATEGY	Strategy		60	1
TRANSFORMATION	Transformation		14	1
TRANSFORMATION	Transformation		15	1
TRANSFORMATION	Transformation		74	1
WORKFORCE	Workforce	Workforce, Workforce and Education committee	45	1

Question 4b: Assigned Code	Code Description	Sub-Code	Response ID	Frequency Count
WORKFORCE	Workforce		69	1

Appendix 7.3 Question 13 Unfriendly Decisions to GP Profession

Question 13 Respondent ID	Assigned Code	Code Description	Comments	Code Frequency Count
1	N/A	N/A	(blank)	1
5	DOCJPD	Jeopardy to doctors	Not allowing list closure...risk to doctors	1
5	PTNTCARE	Detrimental to patient care	Not allowing list closure. Danger to patients...	1
15	PTNTCARE	Detrimental to patient care	Forced to stop enhanced services, which has meant a reduction in service offer	1
18	PP	Political pressure	A decision to push ahead with 7-day working in spite of initially saying they would oppose politic rhetoric without evidence of need.	1
20	DOCJPD	Jeopardy to doctors	Asking GPs to do too much...at a time when General Practice was beginning to really struggle.	1
20	FINANCE	Financial reasons	Financial gain	1
20	SI	Self-interest	Asking GPs to do too much in order to win extra enhanced services and hence funding	1
24	FINANCE	Financial reasons	Financial gain	1
24	FINANCE	Financial reasons	Removal of prescribing incentive scheme after the work had been done (2011).	1
32	FINANCE	Financial reasons	Financial gain	1
40	PP	Political pressure	Local trust will not turn inappropriate referrals away for fear of	1

Question 13 Respondent ID	Assigned Code	Code Description	Comments	Code Frequency Count
			litigation	
40	PP	Political pressure	NHSE has undue influence over local decisions, chronic underfunding	1
40	PTNTCARE	Detrimental to patient care	Primary care forced to alter the way it works due to dissimilar rules between NHSE and NHSI	1
42	OTHER	Other	Deployment of resource	1
47	DOCJPD	Jeopardy to doctors	Peer reviewed referral management increases GP workload	1
47	PTNTCARE	Detrimental to patient care	Peer reviewed referral management, while it is good it may adversely affect patient care	1
48	FINANCE	Financial reasons	Financial loss	1
62	DOCJPD	Jeopardy to doctors	Cash incentives for reducing referrals to an arbitrary level - is pernicious for the profession...	1
62	PTNTCARE	Detrimental to patient care	Cash incentive to increase bowel cancer screening rate (as opposed to properly informing people about it). Morally questionable.	1
62	PTNTCARE	Detrimental to patient care	Cash incentives for reducing referrals to an arbitrary level ... may undermine patient trust.	1
63	PTNTCARE	Detrimental to patient care	Poor understanding of system design issues, epidemiology, academic literature or implementation science by most who sit on GB	1
65	DOCJPD	Jeopardy to doctors	Community work transferred to GP practices without additional resources.	1

Question 13 Respondent ID	Assigned Code	Code Description	Comments	Code Frequency Count
65	PTNTCARE	Detrimental to patient care	Community work transferred to GP practices without additional resources.	1
68	DOCJPD	Jeopardy to doctors	Population based contracts are difficult to enact.	1
68	PP	Political pressure	There is pressure from NHSE and finances.	1
68	PTNTCARE	Detrimental to patient care	Struggling with daily work; access targets QOF, etc.	1
69	PTNTCARE	Detrimental to patient care	Loss of Out-of-hours services has affected patient care.	1
70	FINANCE	Financial reasons	Cost saving	1
73	OTHER	Other	Contractual issues around Primary Care	1
Grand Total				30

Appendix 7.4 Question 14 Reasons for Unfavourable Decisions to GP Profession

Question 14 Respondent ID	Assigned Code	Code Description	Comments	Code Frequency Count
5	LCU	Lack of clinical understanding	Do not understand clinical issues and the real problems at the Coalface	1
15	FINANCIAL	Financial reasons	Finances	1
15	POLCNTRL	Political control	NHSE direction	1
18	POLCNTRL	Political control	Political agendas dictated by DoH / Whitehall	1
20	LCU	Lack of clinical understanding	The complex system we work in where there is often no one accepted way to deliver ... poor understanding of what it is really like at the clinical front line	1
24	FINANCIAL	Financial reasons	A finance director who was trying to balance the books and failed to recognise the implications of his decision.	1
29	N/A	N/A	N/A	1
32	FINANCIAL	Financial reasons	Lack of finance, desperation to make books balance	1
40	FINANCIAL	Financial reasons	Money or the lack of it	1
42	OTHER	Other	What is best for the population	1
47	FINANCIAL	Financial reasons	(blank)	1
48	LCU	Lack of clinical understanding	They were not wrong decision but they did not favour GPs	1
53	LCU	Lack of clinical	Underlying suspicion the GPs over paid and underworked.	1

Question 14 Respondent ID	Assigned Code	Code Description	Comments	Code Frequency Count
		understanding	CCG doesn't understand the commercial reality of GP.	
62	FINANCIAL	Financial reasons	(blank)	1
62	POLCNTRL	Political control	(blank)	1
63	FINANCIAL	Financial reasons	(blank)	1
63	OTHER	Other	Lack of leadership	1
65	OTHER	Other	Patient safety	1
66	LCU	Lack of clinical understanding	An attempt to be even handed with GPs as with any other provider and not to be seen to be favouring them because they have a place at the table.	1
68	FINANCIAL	Financial reasons	(blank)	1
68	OTHER	Other	Targets	1
68	POLCNTRL	Political control	Patient safety	1
69	MA	Misbalanced authority	rules applying to FTs that allowed the secondary provider to 'hold to ransom' the CCG	1
69	MA	Misbalanced authority	strong influence of senior CCG officers	1
70	FINANCIAL	Financial reasons	(blank)	1
72	OTHER	Other	NHS civil service does not always have the same understanding and sensitivities of local issues	1
73	OTHER	Other	Primary Care unduly examined compared to other providers	1
Grand Total				27

Appendix 7.5 Question 17 Mechanisms to Curb Domineering Persons

Question 17 Respondent ID	Assigned Mechanism Code	Mechanism Code Description	Comments	Code Frequency Count
1	N/A	N/A	Response not usable to the question --> "aa"	1
2	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	No formal, but this is a role of the Chair	1
3	N/A	N/A	Response not usable to the question --> "All major decisions go through governing body"	1
4	CIM	Conflict of interest management	conflicts of interest policy	1
4	OTHER	Other	various policies	1
5	NONE	None	None	1
6	NONE	None	None	1
7	NONE	None	None	1
8	NONE	None	None	1
9	NONE	None	None	1
10	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	Effective chairing of board.	1
11	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	Accountable officer of CCG	1
12	N/A	N/A	Not sure	1
13	CIM	Conflict of interest management	I am not aware of any	1

Question 17 Respondent ID	Assigned Mechanism Code	Mechanism Code Description	Comments	Code Frequency Count
13	MR	Mutual Respect	culture of being able to professionally challenge	1
13	OC	Open Culture	Open culture	1
14	OTHER	Other	Layered approach to decision-making. Executive team is decision making, Gov Body is the assurance.	1
15	BCS	Balanced Committee Structure	Good balance and review of committee structures. Lay members excellent as acting as a balance in meetings	1
16	NONE	None	None	1
17	NONE	None	None	1
18	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	An alert chair who ensures all voices are heard	1
19	CIM	Conflict of interest management	Conflict of interest committee	1
19	GG	Good governance	Integrated governance	1
19	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	Appraisal by the chair	1
19	OTHER	Other	Audit committee	1
19	OTHER	Other	Deep dives into previous decision and implementation	1
19	OTHER	Other	Regular membership consultation	1
19	PS	Procurement Support	Procurement support	1

Question 17 Respondent ID	Assigned Mechanism Code	Mechanism Code Description	Comments	Code Frequency Count
20	BCS	Balanced Committee Structure	well balanced clinical and non clinical members, 3 lay members from the start, stable membership, GP members from all localities	1
20	OTHER	Other	Code of conduct set out on laminate present at each meeting	1
21	OTHER	Other	I dont know	1
22	MR	Mutual Respect	respect each other	1
22	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	As Chair I would be able to manage any imbalance - not needed to so far	1
23	BCS	Balanced Committee Structure	Strong locality representation	1
24	MNTD	More needs to be done	There are some domineering personalities in the group and I feel that this has not been addressed systematically or consistently	1
24	TA	Tiered Approach	Tiered approach to discussions - decisions are made at clinical board or locality level first then representations made at governing body	1
25	MR	Mutual Respect	respectful meetings	1
25	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	Well run meetings and leadership	1
25	OC	Open Culture	Open meetings	1
25	OTHER	Other	Scrutiny of decisions by the GP members committee	1

Question 17 Respondent ID	Assigned Mechanism Code	Mechanism Code Description	Comments	Code Frequency Count
26	NONE	None	None	1
27	NONE	None	None	1
28	OTHER	Other	Discussions at GB meetings	1
29	NONE	None	None	1
30	CIM	Conflict of interest management	rigid adherence to COI policy	1
30	MR	Mutual Respect	Mutual respect	1
30	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	exceptional AO	1
30	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	Strong chairmanship	1
31	BCS	Balanced Committee Structure	Good committee structure	1
31	MR	Mutual Respect	Freedom and support to challenge	1
31	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	strong chairs	1
31	OTHER	Other	Freedom and support to challenge	1
32	MR	Mutual Respect	other members of Board willing to challenge	1
32	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	Strong chair	1
33	CIM	Conflict of interest management	Excellent conflict of interest management	1
33	MR	Mutual Respect	excellent relationships built over many years of	1

Question 17 Respondent ID	Assigned Mechanism Code	Mechanism Code Description	Comments	Code Frequency Count
			working in the area	
34	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	We have a good chair	1
35	TA	Tiered Approach	all decisions re policies have to go through a series of 'bodies' for discussion and decision	1
36	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	This is the chair's job, effectiveness in completing this varies between meetings	1
37	NONE	None	None	1
38	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	good chairing	1
39	CIM	Conflict of interest management	conflicts of interest policy	1
39	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	Effective chairing of discussions	1
39	OC	Open Culture	transparency of decision making	1
40	OTHER	Other	Decisions are usually thrashed out either before they get to board or at board.	1
40	OTHER	Other	PMO approach to development of ideas and processes	1
41	BCS	Balanced Committee Structure	All GP members of GB given equal opportunity to contribute and also feedback from members they represent.	1
41	OC	Open Culture	Open discussion on all issues with full	1

Question 17 Respondent ID	Assigned Mechanism Code	Mechanism Code Description	Comments	Code Frequency Count
			transparency	
42	NONE	None	None	1
43	GG	Good governance	accountability	1
43	TA	Tiered Approach	Separate GPs for delivery and for oversight	1
44	MR	Mutual Respect	Informal “being polite in meetings” rules	1
45	OC	Open Culture	Discussion in open session, informal briefings and development sessions to explore ideas and tensions	1
46	BCS	Balanced Committee Structure	Deductions are made by committee	1
46	OTHER	Other	I am not aware of ‘mechanism’ to avoid domineering	1
47	NONE	None	None	1
48	OTHER	Other	adherence to nolan principles, development sessions with external facilitation	1
49	NONE	None	None	1
50	OC	Open Culture	Open discussion at governing body	1
51	NONE	None	None	1
52	GK	Gate Keeping	thorough attention to these potential problems in organisational development sessions and our regular informal meetings	1
52	OBL	Overseen By Leadership (e.g.	Excellent chairing of meetings	1

Question 17 Respondent ID	Assigned Mechanism Code	Mechanism Code Description	Comments	Code Frequency Count
		Chairperson/Accountability Officer)		
53	NONE	None	None	1
54	N/A	N/A	I am not aware of any	1
55	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	Term of reference for each committee with an empowered chair to discharge the ToR.	1
56	NONE	None	None	1
58	OTHER	Other	I don't know if there is any formal arrangement.	1
59	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	Not sure there was any all meetings have chair	1
60	BCS	Balanced Committee Structure	All committees have balanced representation. Everyone is involved	1
60	GG	Good governance	Governance is strong with clear lines of accountability and decision making	1
60	GK	Gate Keeping	Regular non agenda meetings to air any concerns.	1
60	TA	Tiered Approach	Issues are discussed before hand in committees	1
61	OTHER	Other	There really is little apart from the odd comment about probity and conflict	1
62	NONE	None	None I think	1
63	NONE	None	None	1
64	GG	Good governance	Good governance arrangements	1
64	MR	Mutual Respect	respect for each other	1

Question 17 Respondent ID	Assigned Mechanism Code	Mechanism Code Description	Comments	Code Frequency Count
64	OC	Open Culture	open discussions	1
65	BCS	Balanced Committee Structure	Distributed leadership model	1
65	GK	Gate Keeping	board coaching; sound induction policies	1
66	MR	Mutual Respect	General consensus and team working	1
67	BCS	Balanced Committee Structure	ensuring all committees have a wide representation and that quoracy requires broad representation	1
68	NONE	None	None	1
69	MNTD	More needs to be done	The bigger problem with domineers is 'behind the scenes' in influencing what is presented to meetings in terms of content and recommendations and I don't think the mechanisms for checking that are present.	1
69	OBL	Overseen By Leadership (e.g. Chairperson/Accountability Officer)	Mainly down to discretion of the Chair during meetings but that hasn't generally been a problem	1
70	NONE	None	None	1
71	NONE	None	None	1
72	CIM	Conflict of interest management	Strict adherence to conflicts of interest guidance, particularly in PCCC and any potential procurements	1
72	MR	Mutual Respect	people feel supported to challenge	1

Question 17 Respondent ID	Assigned Mechanism Code	Mechanism Code Description	Comments	Code Frequency Count
72	OC	Open Culture	Culture of transparency and openness particularly at Governing Body	1
72	PS	Procurement Support	Expenditure of over £100, 000 must go to Governing Body for a decision. All other expenditure (<£100,000), for example operational costs, are reviewed by our SMT and reported to Finance and Performance Committee.	1
73	NONE	None	None	1
74	BCS	Balanced Committee Structure	The committee is made up of clinicians, it has wider representation - Decisions that are significant in scale and those with clinical connotations should come before the monthly Clinical Commissioning Committee which has wide representation across the CCG (not just clinicians)	1
Grand Total				113

Appendix 7.6 Question 20 GPs' Additional Views on Local CCG Decision-making Practices

Question 20 Respondent ID	Assigned View Code	View Code Description	Comments	Category Frequency Count
1	N/A	N/A	(blank)	1
2	OTHER	Other	Large CCG, many GPs with varying views.	1
6	DMPD	Decision-making politically driven	CCG has been challenged on many occasions and has its own political agenda	1
6	PMGDPE	Member practice GPs disregarded or poorly engaged	Doesn't value the local GPs	1
11	N/A	N/A	Not Applicable	1
13	DMIGP	Decision-making influenced by government policy	We are trying our best under the most difficult of circumstances. In effect we are returning to being a PCT, but ours locally was well managed and effective	1
14	DMR	Decision-making rushed or poor due to time constraints	Some decisions need to be made quickly and can happen outside Exec	1
14	IARM	Imbalanced approach to decision-making	Also it is a balance of how much detail to give to GP members who are overwhelmed with workload issues, and range in their interest with CCG decisions made; the ones that affect primary care directly tend to be the ones of most interest.	1
17	IARM	Imbalanced approach to decision-making	Decisions are made at top level with little consultation and feedback	1

Question 20 Respondent ID	Assigned View Code	View Code Description	Comments	Category Frequency Count
17	PMGDPE	Member practice GPs disregarded or poorly engaged	We have become disconnected to GP practices	1
19	CRPU	CCG role poorly understood	Whereas the general belief in decision-making is that CCGs benefit the GPs, the fact is that CCGs are led and guided by GPs for the benefit of the population.	1
22	PMENM	Member practice expectations not met	Practices often wish for unrealistic things	1
24	CRPU	CCG role poorly understood	There is a wide misunderstanding of the role of the CCG by grass-roots GPs with frequent confusion of the role of NHS England with that of the CCG.	1
25	GAR	Good approval ratings	GP practices are formally asked every year to comment on CCG. The feedback is strongly positive with high approval ratings.	1
31	LOTDM	Lack of transparency in decision-making	My satisfaction of the decisions made relies upon an understanding of the facts and also the constraining forces within which we operate this is not always easily visible to the wider membership	1
34	CRPU	CCG role poorly understood	The role of CCGs is poorly understood. Most of our commissioning is of acute and community care. Naturally there will be tension in commissioning decisions which can not be made purely to 'serve' GPs - we have to make decisions which serve our patients well too.	1
36	DMR	Decision-making rushed or poor due to time constraints	Decision making feels rushed	1
36	IARM	Imbalanced approach to	Biased by the people attending, if one person objects I do not feel that	1

Question 20 Respondent ID	Assigned View Code	View Code Description	Comments	Category Frequency Count
		decision-making	their difference in opinion is factored into the final decision that is made	
36	PIDM	Partially informed decision-making	Decisions are not based on high quality and relevant evidence.	1
37	DMPD	Decision-making politically driven	The old cultural rivalries between NHS officers and clinicians remain. It's not always easy to work with colleagues when it's clear they think GPs are lazy and greedy - an attitude that remains especially in NHS E	1
37	IARM	Imbalanced approach to decision-making	When times are hard and difficult decisions have to be made it's just another NHS body- with decisions made influenced as much by officers and their agendas as it is by clinical leadership. GPs can be excluded from decision making in view of 'conflict o	1
39	CDA	Collaborative Decision-making Approach	Our GPs are very engaged and support the CCG	1
40	DMBFC	Decision-making based on financial constraints	Member practices do not appreciate the fact that CCGs cannot deliver to the extent that they would otherwise have them to due to financial constraints --> "The difficulty with member practices is lack of understanding of the restrictions rules and regulations CCGs have to work to. In an ideal world, funding would be ample and we would have a chronic shortage of GPs in our area. Sadly the CCG has to make the books balance...."	1
45	DMIGP	Decision-making influenced by government policy	GP practices are quite heterogeneous - some have very good understanding of public health issues and the limits of CCG powers because of government policy others are less well informed	1
49	DMPD	Decision-making politically driven	Our CCG seems to disregard GP views and only politically motivated	1

Question 20 Respondent ID	Assigned View Code	View Code Description	Comments	Category Frequency Count
49	PMGDPE	Member practice GPs disregarded or poorly engaged	Our CCG seems to disregard GP views and only politically motivated-we work hard in this area and achieve a lot but get funded very poorly by the CCG and they don't listen	1
54	CDA	Collaborative Decision-making Approach	Where member practice wishes are sought, the CCG tries to abide by them.	1
54	PMGDPE	Member practice GPs disregarded or poorly engaged	The CCG makes many decisions, and it is not always known what the wishes of the members are	1
56	OTHER	Other	Not enough staff to deal with agenda	1
60	OTHER	Other	STP may change all of the above as the intention seems to be to delegate decision making to regional unconstitutional committees ie STP	1
62	DMPD	Decision-making politically driven	The CCG is viewed more as a delivery vehicle for NHS England.	1
62	PMGDPE	Member practice GPs disregarded or poorly engaged	There is no good involvement from practices.	1
64	DMR	Decision-making rushed or poor due to time constraints	GB doesn't have time to deal with all matters	1
64	OTHER	Other	Some other committees move too slowly	1
65	OTHER	Other	NHSE Primary care commissions is unresponsive	1
68	LOTDM	Lack of transparency in	It is not always clear how the final decisions are made; the local GPs	1

Question 20 Respondent ID	Assigned View Code	View Code Description	Comments	Category Frequency Count
		decision-making	certainly feel that decisions are made behind closed doors.	
69	N/A	N/A	Not Applicable	1
70	PMGDPE	Member practice GPs disregarded or poorly engaged	Very poor engagement form local GP Practices	1
72	CDA	Collaborative Decision-making Approach	We have good engagement with Member Practices through our Membership Council meetings and Member Briefing	1
72	IARM	Imbalanced approach to decision-making	As with all CCGs it is difficult to fully engage everyone on everything and we are starting to improve on how we co produce some pieces of work	1
73	N/A	N/A	Not Applicable	1
74	CR	Commissioning responsibility not clear between NHSE and CCGs	There is still a lack of clarity about the division of commissioning responsibility between NHSE and CCGs.	1
Grand Total				42

Appendix 7.7 Question 22 Member practice Engagement

Question 22 Respondent ID	Assigned Engagement Method Code	Engagement Method Code Description	Comments	Category Frequency Count
1	N/A	N/A	Not Applicable	1
2	GRKC	GP representation in key committees	GPs involved in key work areas	1
2	MM	Mass media	Website, newsletters, emails from Chair	1
2	ON	Other networks	Member networks	1
2	PVKSM	Practice visits by key senior members	Direct	1
3	GRKC	GP representation in key committees	Commissioning forum	1
3	ON	Other networks	CCG liaison	1
3	ON	Other networks	patient reference group	1
3	PMM	Practice managers' meetings	Practice managers group	1
4	EV	Engagement events	Personal engagement	1
4	ON	Other networks	Regular meetings	1
5	GRKC	GP representation in key committees	Local care teams meet bimonthly	1
5	LE	Learning events	Monthly protected learning time	1

6	OTHER	Other	Used to hold three mthly meetings and now nothing	1
7	GRKC	GP representation in key committees	Through locality working	1
8	ON	Other networks	Clinical Membership group	1
9	GRKC	GP representation in key committees	There is a locality structure with all practices represented at the locality level	1
10	GRKC	GP representation in key committees	Quarterly CCG meetings with OOH cover provided for all practices.	1
10	MM	Mass media	Email alerts	1
11	MM	Mass media	Email alerts	1
11	ON	Other networks	Two monthly CMG meeting	1
12	ON	Other networks	Meetings	1
13	ON	Other networks	Board GP members, Advisory fora	1
14	GRKC	GP representation in key committees	Locality meetings	1
14	LE	Learning events	Protected learning afternoons, education sessions provided	1
14	MM	Mass media	Bulletins and newsletters	1
14	PVKSM	Practice visits by key senior members	Practice visits	1
15	GRKC	GP representation in key committees	Monthly locality meetings (5) at which we encourage input feedback and challenge as well as informing on commissioning planning etc	1
15	PM	Plenary meetings	Regular plenaries for all practices ... at which we encourage input feedback and challenge as well as informing on commissioning planning etc	1

16	GRKC	GP representation in key committees	Many GPs are involved at the CCG from a number of local practices	1
16	LE	Learning events	Protected learning time events	1
16	MM	Mass media	Clinical Bulletins	1
16	ON	Other networks	Governing Body representatives feedback to their aligned practices and take comments from their members back to the CCG board.	1
17	GRKC	GP representation in key committees	Small group meetings and representation on the locality board, which feeds into the CCG executive committees	1
18	N/A	N/A	We used to have quarterly locality meetings, but funding for these has been withdrawn and as such there are no means to meet formally now	1
19	GRKC	GP representation in key committees	We have monthly locality meetings which covers all practices	1
19	GRKC	GP representation in key committees	We run a locality group for salaried and locum GPs.	1
19	LE	Learning events	We support and run academic halfdays with protected time	1
19	MM	Mass media	We have a weekly e- bulletin	1
19	ON	Other networks	We have about 3 full membership body meetings per year	1
19	PMM	Practice managers' meetings	We have regular practice manager meetings.	1
19	PVKSM	Practice visits by key senior members	We undertake annual practice visits to all practices	1
20	CMM	Council of Members Meetings	On average 75% member practices attend the council of members meeting which takes place 8-10/year	1

20	GRKC	GP representation in key committees	We have 6 weekly locality commissioning forums across all localities	1
20	MM	Mass media	The CEO sends out a regular briefing	1
20	ON	Other networks	We have a weekly Hot Topics communication	1
20	PVKSM	Practice visits by key senior members	We have visited practices annually except for last year and plan to reinstate this	1
21	EV	Engagement events	Hard to get every member engagement, as so big and daily life so busy.	1
21	GRKC	GP representation in key committees	All practices have a member representing them on a locality board	1
22	GRKC	GP representation in key committees	GP Forum	1
22	LE	Learning events	Regular educational/discussion meetings where CCG pays for OOH cover and most GPs can therefore attend	1
22	MM	Mass media	Lively email debates	1
23	GRKC	GP representation in key committees	Monthly locality group meetings	1
23	MM	Mass media	Regular bulletins on the web-site and newsletter	1
24	ON	Other networks	We have a resilience project running which has increased this supportive role for primary care, with some benefit to the CCG/GP relationships	1
25	GRKC	GP representation in key committees	Through the GP Members committee which represents 7 localities with Rotherham which feedback to and from the GP member practices.	1
25	LE	Learning events	Regular discussion of commissioning issues at the PLT events which directly ask for view of primary care concerning clinical and commissioning topics. these are used to inform decisions on the CCG.	1

25	MM	Mass media	Surveys and email bulletins	1
26	CMM	Council of Members Meetings	Council of members quarterly meetings with member practices	1
26	MM	Mass media	Information about CCG emailed out to practices	1
27	GRKC	GP representation in key committees	Monthly members' meetings in each of the 4 localities of Northumberland.	1
28	GRKC	GP representation in key committees	LMC involvement, weekly briefing	1
29	CMM	Council of Members Meetings	GP Members Council	1
30	EV	Engagement events	High level of locality engagement	1
31	EV	Engagement events	We are split into 5 localities with a structure that encourages engagement from GPs. There is always a range of engagement but that is a 2 way process. The future direction of our board is to further enhance the level of engagement from the governing body and throughout the organisation	1
32	CGM	Cluster Groups Meetings	Board members linked to local cluster groups	1
32	GRKC	GP representation in key committees	Quarterly general assembly	1
32	GRKC	GP representation in key committees	Quarterly open GP meetings	1
33	CMM	Council of Members Meetings	Monthly Council of Members meeting at which the GB is held accountable to the members; regular dialogue and engagement with GPs	1
34	GRKC	GP representation in key committees	We have a 'membership senate', we have an online membership 'community' forum, each practice is assigned a 'link GP' who sits on the	1

			governing body	
35	GRKC	GP representation in key committees	Local sector meetings	1
36	GRKC	GP representation in key committees	Locality meetings	1
36	MM	Mass media	By email contact	1
37	ON	Other networks	General member practices group	1
38	GRKC	GP representation in key committees	Locality meetings monthly	1
39	CMM	Council of Members Meetings	Council of members meetings for all GPs across the CCG	1
39	GRKC	GP representation in key committees	Strong locality focus, regular locality meetings	1
39	LE	Learning events	Educational meetings for all GPs ... a yearly educational meeting for all GPs across the CCG.	1
39	PVKSM	Practice visits by key senior members	Visits of locality chairs to individual practices 3 times a year	1
40	GRKC	GP representation in key committees	Commissioning forum	1
40	GRKC	GP representation in key committees	We have link GPs and are moving towards locality working	1
41	GRKC	GP representation in key committees	4 federations each represented by a GP GB member. They in turn meet monthly with GPS from the practices they represent for two way dialogue etc.	1

42	ON	Other networks	Joint meetings with membership, good working relationship with federations	1
43	CMM	Council of Members Meetings	The membership council meets 2-3 times a year, with all GPs	1
43	GRKC	GP representation in key committees	Locality chairs represent membership voice in clinical cabinet, ... hold monthly locality meetings	1
43	PVKSM	Practice visits by key senior members	they undertake 4 practice visits a year	1
44	CMM	Council of Members Meetings	Invitation to full council meetings	1
44	PVKSM	Practice visits by key senior members	Member practice visits by CCG officers	1
45	CGM	Cluster Groups Meetings	Group meetings of 'clusters' whole CCG meetings	1
45	ON	Other networks	Via direct communication	1
45	PVKSM	Practice visits by key senior members	Visits to individual practices	1
46	GRKC	GP representation in key committees	Regular meeting with GPs	1
46	MM	Mass media	Regular email communications	1
46	ON	Other networks	Annual events	1
46	PMM	Practice managers' meetings	Regular meeting with ... Practice Managers	1
47	GRKC	GP representation in key committees	Locality structure with regular meetings	1

47	MM	Mass media	Weekly email	1
47	ON	Other networks	Regular citywide meetings	1
48	CMM	Council of Members Meetings	Council of Practices meets to discuss strategy	1
48	GRKC	GP representation in key committees	Locality meetings	1
48	PVKSM	Practice visits by key senior members	Practice visits	1
49	ON	Other networks	Occasional events	1
50	CMM	Council of Members Meetings	Regular council of members	1
51	OTHER	Other	By CMG meetings	1
52	GRKC	GP representation in key committees	GP Board members liaise very closely with Localities	1
52	MM	Mass media	All GPs know and use our telephone numbers and emails	1
52	PVKSM	Practice visits by key senior members	All practices are regularly visited by Board members	1
53	GRKC	GP representation in key committees	Locality meetings	1
53	ON	Other networks	Some one-to-one meetings	1
54	GRKC	GP representation in key committees	Through locality leads and meetings	1
54	PMM	Practice managers'	Direct communication with the practice managers.	1

		meetings		
55	GRKC	GP representation in key committees	There are 10 GPs both elected and appointed representing the whole GP membership on GB	1
55	GRKC	GP representation in key committees	Locality structure (clinical council & exec for local GP Practices), supported by defined locality managers	1
55	LM	Locality meeting	Executive Team members are 'attached' to each of the localities	1
55	ON	Other networks	The CCG engages with 'expert' GPs and nurses when embarking on specific programmes/projects of work in a 'co-produced' manner.	1
56	PVKSM	Practice visits by key senior members	There is good engagement with practices with regular meetings and a senior manager involved in dealing with practices	1
58	CMM	Council of Members Meetings	Council of Members meetings	1
58	MM	Mass media	Weekly email	1
58	PVKSM	Practice visits by key senior members	Individual practice meetings ad hoc	1
59	OTHER	Other	Often struggle	1
60	GRKC	GP representation in key committees	There is GP representation - "We have regular locality events as well as 6 weekly time out weddings facilitated by the ccg with all practices"	1
60	PMM	Practice managers' meetings	There is GP representation - "We have ccg practice manager groups"	1
61	GRKC	GP representation in key committees	This is done through the 15 localities that make up the CCG - they response and involvement is totally dependednt on the lead GP for that locality and their involvement	1
62	ON	Other networks	There are regular meetings, but they tend to be one way, with the CCg	1

			informing practices of decisions	
63	PM	Plenary meetings	Mostly through PLENARY meetings.	1
64	LE	Learning events	Bi-monthly GP parliament and education	1
64	LM	Locality meeting	Monthly meetings with LMC	1
64	ON	Other networks	Informal contact with other GPs	1
64	PVKSM	Practice visits by key senior members	Regular practice visits	1
65	GRKC	GP representation in key committees	Locality	1
65	LM	Locality meeting	Locality meetings	1
65	OTHER	Other	Full membership meetings	1
66	CGM	Cluster Groups Meetings	Cluster boards system	1
67	GRKC	GP representation in key committees	Monthly locality meetings	1
67	PM	Plenary meetings	Two or three meetings per year - all practices invited	1
67	PVKSM	Practice visits by key senior members	Meetings within individual practices	1
68	GRKC	GP representation in key committees	We have monthly locality meetings	1
68	PVKSM	Practice visits by key senior members	Each practice has a visit from a clinical lead and team twice a year	1
69	CMM	Council of Members Meetings	Mainly through the Council of Members	1

69	ON	Other networks	Also clinical network of practices model that is still developing.	1
69	ON	Other networks	Occasional meetings open to all GPs and Practice Managers	1
69	PVKSM	Practice visits by key senior members	Individual practice visits occasionally by officers	1
70	EV	Engagement events	Regular meetings and engagement events but poorly attended	1
71	GRKC	GP representation in key committees	Locality meetings	1
71	PM	Plenary meetings	CCG wide meetings	1
72	N/A	N/A	Not Applicable	1
73	CGM	Cluster Groups Meetings	Through Clusters	1
74	GRKC	GP representation in key committees	Our GP practices all belong to one of 4 localities. Each locality has reps on GB and CCC. There is a monthly City wide Locality Group attended by the reps and other senior CCG officers.	1
Grand Total				148

Appendix 7.8 Question 4b. Please list the “other committee(s)” that you sit on

Committees falling under code OTHER
Accountable Care Organisation
Assurance
Cancer Clinical Programme Group
CCG Clinicians Group
Clinical Guidelines
Charitable Funds
Clinical Effectiveness Group
Clinical Pathway Development
Clinical Policy
Clinical Senate Council
Community Education Providers Network
Community Support Services
Contact Management Board
Care Staff Committee
Cardiovascular Clinical Programme Group
Dementia Strategy Board
Empowering Parents, Empowering Communities
Estates
GP Members Committee
House of care programme board
Individual Funding Request
Integrated Governance and Performance
Information Management and Technology Programme Board
Integration Board
Learning Disability Healthchecks
Local Digital Roadmap
Medicines Safety Committee
Mental Health Board
Mortality Surveillance Group
Musculoskeletal

Committees falling under code OTHER
Never event panel
Out of hospital
Primary Care development Group
Service Development
Service redesign
Standards for microbiology investigations
Standardisation of care
Violence against women and girls