CRANFIELD UNIVERSITY

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CONTEXTUAL INTELLIGENCE AND CHIEF EXECUTIVE STRATEGIC DECISION MAKING IN THE NHS

SOM
DOCTOR OF BUSINESS ADMINISTRATION

DBA
Academic Year: 2004 - 2012

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ABSTRACT

CEO competence and development is a continuing concern in the NHS. As a key feature of any CEO leadership role is responsibility for organisationally critical decisions, and there is an increasing recognition of the role context plays in effective leadership behaviour. This study examines the role of contextual intelligence in relation to PCT CEO decision making behaviour. To do this, the research addresses four questions: a) what does the literature say about CEO contextual intelligence? b) what factors do PCT CEOs say they take into account in different decision making contexts? c) what contextual factors do they actually take into account? and d) what impact do the contextual factors have on their decision making behaviour. A systematic literature review resulted in a model of CEO contextual intelligence for CEO decision making. Semi-structured interviews with 24 PCT CEOs in a NHS region about factors influencing their decisions on generic strategies, national policies, regional strategies and local plans revealed a hierarchy among contextual factors applying to different decision strata. Semi-structured interviews and analysis of CEO diaries two months later of the same focal decisions show the real critical factors to be:- national policies themselves, the Strategic Health Authority and the decision making process, for regional strategies; and Top Management Team and structure for local plans.

Altogether, the research reveals that the PCT CEO's decision making context is rationally bounded; the relevant contextual factors differed significantly from the literature derived model; the actual factors in practice differed from what were espoused; choice of factors vary depending on decision trigger strata which links to degrees of CEO autonomy; and macro level factors which were indicated as significant from the systematic review were in fact ignored in practice. A PCT CEO model of contextual intelligence is developed together with a two dimensional model of underlying structures guiding PCT CEO decision making behaviour. The findings have implications for governance structures in the NHS, CEO decision making and senior leader development in

the NHS in the context of the 2012 Health and Social Care Act. Areas for further research in public sector, NHS and contextual intelligence are also identified.

Keywords:

Chief executive officers, context, contextual intelligence, strategic decision making, National Health Service

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LIST OF ABBREVIATIONS

CEO	Chief Executive Officer
DBA	Doctor in Business Administration
DH	Department of Health
KPIs	Key Performance Indicators
NHS	National Health Service
OSC	Overview and Scrutiny Committee
PCT	Primary Care Trusts
RHS	Regional Health Strategy
SHA	Strategic Health Authority
TMT	Top Management Team

1 BACKGROUND AND RATIONALE FOR RESEARCH

1.1 Introduction

I embarked on my Doctor in Business Administration (DBA) studies in 2004 when working as a Strategic Health Authority (SHA) Director of Performance. At the time, I had been in post for two years, since the inception of the SHA. A key strategic objective of the SHA was to ensure the delivery of national priorities and targets set by the Department of Health (DH) to which it was accountable, and performance was judged on the basis that constituent organisations delivered these requirements. For some time, the SHA had been concerned with issues of underperformance in a number of NHS Trusts and Primary Care Trusts (PCTs) and I was constantly asked to explain this variability in performance between organisations that seemingly have the same set ups, and for all sense and purpose, do the same things. I was also asked what I was going to do about it. The timing coincided with a new chief executive officer (CEO) starting at the SHA. One of the first actions taken by the new CEO was to bring new CEOs into the underperforming PCTs. I was aware from internal discussions and those the SHA had had with the DH that, where there were concerns or indeed successes with organisational performance, they were usually attributed to the CEO. This stimulated my interest in understanding the behaviour of CEOs working in the National Health Service (NHS), particularly how they take decisions that impact on organisational performance.

To me, the NHS' heroic expectations of its most senior managers, how these individuals carry out their roles, and how their performance can be improved, are worthy of further research. I chose to study for an executive doctorate as I wanted to gain this knowledge in a robust way that is applicable to practice. The study took over eight years due to disruptions in employment (see Appendix A) during which time the job of CEO in the NHS developed a reputation for high turnover and an impending succession crisis, which further reinforced the value and direction of focus for research. Although the NHS organisational landscape has and is changing and some of the relevant academic work has developed through this extended period of time, influencing my knowledge and thinking as

a researcher and practitioner, for practical reasons, I have chosen to leave as written, the early parts of the research as they were relevant both practically and academically at the time but would ask the reader to see them in their temporal context. This Linking Document will hopefully give a sense of the evolution in my thinking.

1.2 The business case

As the executive primarily responsible for managing the performance of 18 NHS Trusts and PCTs within the SHA area, I had observed wide variations in performance, as judged by the meeting of national targets and standards, in organisations operating under very similar circumstances. In my experience, when an NHS organisation fails, the custom and practice were to install a new CEO, and move the previous incumbent into another senior role in the NHS. This practice of recycling senior leaders has been criticised by both insiders and outside commentators as rewarding rather than helping to improve poor performance. Irrespective of whether the practice is appropriate, changing the CEO when everything else stays the same implies the ultimate responsibility being attributed to the role. As the key feature of any CEO job is leading his organisation to deliver the corporate objectives, it follows that organisational performance stems from how the CEO behaves in the contexts in which he operates. In the context of the NHS generally, and PCTs in particular, this can be observed in the coping behaviours of CEOs as they juggle the conflicting demands of operating in a complex system. There is also the issue of development for both the outgoing and incoming CEOs in learning the lessons of why things didn't work before so that both can be successful in their new roles. With decision making being central to the role of a CEO, I was interested in understanding what factors influenced CEO decision making in NHS Trust and PCTs. If decision making is a core CEO capability, the SHA as an organisation, and I, as the responsible executive, need to better understand how we can prepare aspirant CEOs through development for the role as well as support existing CEOs in their decision making capability so as to improve the

performance of their organisations, not least because I also aspired to forge a career leading NHS organisations.

When the research was first conceived, the NHS was undergoing structural change as a result of the White Paper “Commissioning a patient-led NHS” (CPLNHS) (Department of Health, 2005). The CPLNHS policy aimed to transform the NHS from being a provider driven organisation to a commissioner driven system. In a letter to CEOs of NHS organisations, the CEO of the NHS Nigel Crisp (2005) set out the proposed changes. They included reconfigurations of PCTs and SHAs, the creation of Practice Based Commissioning (PBC), changes to PCT-managed service provision, and preparing NHS Trusts (providers) to move towards NHS Foundation Trust status by 2008. As a result of the SHA restructure, I was seconded to be interim CEO in a PCT which, at the time, had had five changes of CEOs in two years and had recorded a large financial deficit resulting in the first public interest report for a PCT (Audit Commission, 2005). I was appointed to the permanent job after turning around the organisation. The relevance of studying PCT CEO behaviours was reinforced during this period, when it became clear to me that the role of CEOs in PCTs was subject to complex, diverse , critical and potentially conflicting demands but was crucial to the success of the PCTs. While the role of CEOs in the corporate sector have been widely studied and there is no shortage of academic and practitioner literature on what makes a successful CEO, I could find no such research on PCT CEOs. This research was therefore conceived to fill the evidence gap, by providing detailed evidence about the ways in which CEOs in PCTs make decisions and behave coping with the many competing demands to deliver the functions of PCTs.

1.3 The structure and functions of PCTs

It is important in seeking to understand CEO decision-making behaviour where context and contextual intelligence is anticipated to be potentially critical that the context the PCT itself presents by virtue of its structure and functions is understood.

PCTs are a type of NHS trusts that have formed an integral part of the NHS in England. The establishment order for PCTs laid down by legislation (National Health Service Act, 2000) sets out the statutory functions which PCTs are legally required to meet. These functions can be grouped under three headings: improving the health of the population by taking strategic decisions that reflect the health needs of local people; commissioning primary care, community services and secondary care services; and providing community services. PCTs are statutory bodies serving discrete geographical populations ranging from 170,000 to over 1million. In total, there were 302 PCTs across England until 2006 when the number was halved. Collectively, PCTs are responsible for spending around 80% of the total NHS budget. Operating within a national framework, PCTs are the local health authorities and have to comply with statutory duties, national policies and initiatives that are issued by the Department of Health (DH) or the SHA. SHAs are the regional headquarters through which PCTs are accountable to the Secretary of State. PCTs use their annual allocated budgets that are calculated based on weighted capitation to pay for NHS services. Service providers, in the main, are GPs who provide primary care, PCT provider arms which provide community services, and NHS Trusts and NHS Foundation Trusts which provide secondary and tertiary care. PCTs are managed by a team of executive directors led by a CEO. Executive directors are members of the PCT Board, which also has non executive directors (NEDs). One of the NEDs chairs the PCT Board. A key member of the PCT Board is the chair of the Professional Executive Committee (PEC). The PEC forms part of the governance structure of PCTs and provides clinical insights into commissioning decisions. The above structures comprised the PCT organisational context when the CPLNHS White Paper was published in 2005.

The main structural and functional changes introduced by the CPLNHS policy were aimed at strengthening the commissioning function, in particular by the introduction of Practice Based Commissioning (PBC). Under PBC, GP practices took on responsibility for indicative budgets devolved from PCTs for commissioning hospital and community services although responsibility for contract management stayed with the PCT. The DH saw it as a way of aligning

clinical and financial responsibilities and PCTs were given a year to fully implement PBC. For PCTs, the nuances around responsibility for commissioning functions, including a re-statement of their core functions, were set out in pages 6-7 of Nigel Crisp' (2005) letter:

> *The Department can confirm that it expects PCTs to make arrangements for 100% coverage of PBC by no later than the end of 2006* (paragraph 20)
>
> *PCT will ensure access and choice to a range of high quality health services and ensure that the Government's commitments to health, reducing health inequalities and health services are delivered for local people* (paragraph 21)
>
> *As custodians of their population's health budget, they are responsible for ensuring prioritisation and value for money in ways which have maximum impact on health and secure all necessary health services* (paragraph 22)
>
> *Their functions, which can be provided by external agencies, partners and consortia working on their behalf, will remain as follows* (paragraph 23)*:*
>
> - *Improving the health of the community and reducing inequalities*
> - *Securing the provision of safe , high quality services*
> - *Contract management on behalf of their practices and public*
> - *Engaging with local people and other local service providers to ensure patient views are properly heard and coherent access to integrated health and social care is provided*
> - *Acting as provider of services only where it is not possible to have separate providers- and with arrangements for*

separating out decisions on commissioning from provider management

- *Emergency planning*

PCTs will be accountable to their local communities and to the Secretary of State through Strategic Health Authorities (paragraph 25)

It is clear that in order for PCTs to deliver their core functions and to implement the policy changes as prescribed by Crisp, the PCT as an organisation is tasked with decision making and change in respect of multiple and potentially conflicting goals and would have to attend to the interest of a wide range of stakeholders. Crisp's letter also set out in detail the functions of the SHA, which include *performance management of PCTs* (paragraph 26).

The fact that the CEO of the NHS would send a letter to Trust and PCT CEOs asking them to implement quite fundamental structural changes within a very short time scale and expecting compliance, gives an indication of how policies developed by DH are then implemented in the NHS. The approach is essentially that of "command" that carries a strong flavour of Taylorism. It is a bureaucratic response which has, at its core, the notion that management needs to control the workforce by specifying in some detail what is to be done, how it is to be done, and in what quantity it is to be done. This approach, oriented to efficiency and predictability (Harrison et al, 1992), was first noted by Pollitt (1990) as having been applied to the UK public services, including the NHS, since the late 1970s and 1980s. Three decades on, and at the time of writing, the practice appears to be alive and well. This is illustrated not only by the implementation of the CPLNHS policy but is being repeated in the current restructure facing the NHS. PCTs (and SHAs) will be abolished in 2013 as a result of the Health Act 2012, which was enacted to implement the White Paper "Liberating the NHS" (2010). The majority of PCT commissioning functions are to be taken over by new Clinical Commissioning Groups (CCGs), with the exception of primary care commissioning which will be the responsibility of the new NHS Commissioning Board (NHSCB). The NHSCB will have regional offices that will take over some

of the SHA functions and sub-regional Local Area Teams (LATs) that will continue to provide strategic system oversight to clusters of CCGs. Far from being liberated, the shadow CCGs are finding their position within this complex infrastructure to be at the bottom of an even more bureaucratic hierarchy than the outgoing structure, and their autonomy tightly controlled by the NHSCB. This has implications for the new CCG leaders in how they lead their members while interfacing with a myriad of stakeholders and reporting up the chain.

1.4 What does a PCT CEO do, and why study PCT CEO decision-making behaviour?

In studying PCT CEO decision making behaviour and drawing on previous work on CEO behaviour, it is necessary to understand the PCT CEO role and how it is similar or different from that of CEOs in other sectors. Definitions of chief executive or CEO are surprisingly sparse. An Abi-Proquest literature search for "chief executive" and/or "CEO" and "definition" yielded 18 papers, which, bar two, focused on CEO compensation and succession, and did not define 'CEO'. Of the two that attempted to define the CEO, Zhi (2009) examined the legal status and legal liability of CEOs in the USA and found wide and generalised use of the term CEO internationally, with CEOs established not only in companies but also existed in various kinds of institutions including universities, Olympic Committees and state agencies. He argued that the CEO was the product of American corporate structural reform and innovation from the 1960s in response to inefficient decision making by the board of directors due to a disjunction between the management and decision level. The emergence of the CEO enabled some of the board decision making powers to be devolved to management level. The CEO therefore has not only a manager's authority of office but also some part of the authorities of the board, making the CEO an organisation's most senior manager. The second paper, by Wibowo and Kleiner (2005), examines who can be classified as a CEO. The authors found that the actual title might be different in different organisations but describes the CEO as having responsibilities to maintain and implement the company's goals, and being responsible for the success and failure of an organisation. With the

paucity of academic literature, a Wikipedia search defined the CEO as “the highest ranking corporate officer (executive) or administrator in charge of total management of an organisation” and typically has the following responsibilities: communicator, decision maker, leader, and manager. It describes the following CEO roles: “The communicator role can involve ….. management and employees; the decision making role involves high level decisions about policy and strategy. As a leader, the CEO advises the board of directors, motivates employees, and drives change within the organisation. As a manager, the CEO presides over the organisation’s day to day, month-to-month, and year-to-year operations”. What the limited evidence shows is that CEO is a widely used term but the actual definition is hard to pin down. However on the basis of the common usage Wikipedia definition PCT CEOs do fulfil the generic criteria of a CEO role.

In the absence of a body of literature from which to draw further insight about PCT CEO - specific role and behaviour, I decided to look to the broader literature on CEO. The relevance of findings here depends on the extent to which CEO roles in the public and private sectors on which the literature is based, are similar or different from the PCT CEO role. Since the mid 1970s, various UK governments had tried to introduce an internal market into the public services. For the NHS, it is really in the last decade that policies to promote competition have led to more tangible private sector involvement. These moves increase the need to think where and how each unit can compete and collaborate effectively for service provision with particular populations and where provision might more effectively ‘outsourced’. PCTs, like much of the rest of the NHS today, still operate in the public sector that is characterised by tight centralised control and a strongly unionised workforce. There is a hierarchy issuing instructions but delivery is still achieved through a large number of loosely coordinated operational units, with a mixture of contracting out and partnership arrangements at the margin. The majority of staff still hold some deeply rooted cultural assumptions about power relationships, markets and the private sector. Significant service change proposals can be expected to draw controversy, and the general public remains unwilling to “de-politicise” the NHS.

Dealing with these issues is integral to a PCT CEO's role as it is to other public sector CEO jobs. And in common with those, the service user is increasingly positioned as 'the customer' whose service experience, outcomes and satisfaction, are sought and are increasingly relevant to effective provision and performance of the provider.

I have discussed the aspects of a PCT CEO role that are generic to all CEOs. Nonetheless, there are other aspects of the PCT CEO job that differentiate them from their private sector counterparts. The PCT CEO does not have to worry about generating revenues, as income comes from taxpayers and the PCT receives this from the government in the form of an annual budget. They have to work with an arguably wide number of stakeholders and interest groups to achieve organisational goals that are ultimately about the provision of healthcare to their population within available resources. With the NHS being the most loved institution among the general public in UK, any strategic change can be high profile and draws political attention. As an integral part of the NHS, PCTs have to operate according to the rules and instructions issued by DH and other related arm's length bodies. They also have to meet nationally set targets and standards, the performance of which is closely monitored by DH. Finally although every PCT has a board of directors led by a chairman, the role of the PCT Board is primarily for governance purposes. PCT CEOs are accountable to the CEO of the NHS for the performance of the PCT in a direct line of accountability. In summary, the essence of the CEO role in terms of generic CEO responsibilities is similar. So whilst the job of PCT CEO may have some particular defining features that appear different from that of CEOs in the private sector, the parallels are clear and they differ mainly in the degree of job complexity.

1.5 Decision making in PCTs and CEO behaviours

As local health authorities, PCTs take decisions that have critical impact on population health. This has implications for how decisions are taken in PCTs. Of course in this dynamic and complex environment the CEO is not the sole decision maker. Beside the CEO, there are others involved in decision making

in PCTs (McDonald, 2004) and indeed middle managers are becoming increasingly engaged in shaping PCT strategic decisions (Checkland et al, 2011). However as the executive ultimately responsible for the decisions and their implementation and accountable for the success or failure of their organisations (Mayo and Nohria, 2005) how the CEO chooses to engage him/herself and others in and influence decision-making is key. Before we can research PCT CEO decision making behaviour however, it is pertinent to first clarify what being a PCT CEO means in practice and the expectations of PCT CEOs.

It is helpful here to distinguish between role expectations, received role and role behaviour. In a critical review of the literature, Hales (1986) made the conceptual distinctions between what stakeholders expect about the manager's performance in the job including behaviours that partially define the job (Katz and Kahn, 1978), how the manager believes she ought to behave in response to the messages she has perceived and which then influences her own perception of the job (Levinson, 1959), and the enactment or "emergence perspective" of decision making behaviour and action in response to their conception of how the job should be done (Fondas and Stewart, 1994). The three perspectives have been labelled by their respective authors as "role expectations" (Katz and Kahn, 1978), and "received role" and "role behaviour" (Levinson, 1959).

The role expectations of the PCT CEO are set out in the PCT CEO job descriptions (an example is included in Appendix A) and the Accountable Officer Memorandum (Appendix I) which were drawn up by the DH based on what PCTs were set up to do when they were created in 2002. The "accountable officer" status makes clear that the PCT CEO will be held to account for the financial performance of his organisation. The overriding objective of PCTs is to use their annual budget allocated by DH to commission healthcare for their local populations from NHS Trusts or Foundation Trusts other non NHS providers, and GPs.

According to a King's Fund report (Lewis, 2004), the term commissioning is used "liberally and variably within the NHS" (p3) but in practice include the following key functions: identifying effective and appropriate health service response to assessed patient needs; delivering national and local health care priorities, health service planning; contracting with service providers for the delivery of those services and allocating available resources against competing priorities. PCT CEOs are responsible for ensuring that their PCTs deliver these functions, which they normally delegate to a senior or top management team.

In 2006, the number of PCTs was reduced to 152 in order to achieve cost savings and improved commissioning from economies of scale. The reorganisation led to improved co-terminosity with local authorities in many places, resulting in closer working relationship between health and social care. The launch of "World Class Commissioning" (Department of Health, 2007), which consists of a vision statement and a set of organisational competencies PCTs had to demonstrate as evidence of their effectiveness as commissioners introduced an additional critical expectation. Between 2008 and 2010, every PCT had to undergo an annual process of external assessment against these World Class Commissioning competencies. Persistent under performance including a lack of progress would lead to the removal of the PCT CEO as organisational leader and accountable officer. These new expectations were added to existing SHA defined performance appraisal framework for PCT CEOs, and to the annual performance assessment of PCTs conducted by the healthcare regulator, the Healthcare Commission (and its successor organisation, the Care Quality Commission) creating an expanding set of CEO role expectations. However in practice, as revealed by an example of such a framework (Appendix B), CEO performance appraisal by the SHA only assessed certain parts of the PCT CEO job thereby highlighting a priority in role expectations, and *defacto* defining what "really" matters, which for a PCT CEO, would be the "received role". How the PCT CEOs then go about carrying out "the job" as reflected in role behaviours, is the subject of this research, examined from the perspective of contextual factors influencing CEO decision making behaviour. In 2010, the DH shifted its focus to improving productivity

and World Class Commissioning was discontinued just as the new conservative government proposed the abolishment of PCTs, whose commissioning functions would be passed to GP-led commissioning groups. Under the 2012 Health Act, these Clinical Commissioning Groups (CCGs) will be statutory organisations, led by a part-time clinical chair who is normally a GP, and supported by a full time manager with the job title of Chief Officer. As CCGs take over from PCTs as the new local offices of the NHS, there are clearly transferable lessons for the new leaders to be gleaned from this research.

1.6 Overview of research approach

The literature on the relationship between leader and context suggests that contextual intelligence of the CEO plays a potentially important role in the performance of organisations in the corporate sector (Mayo and Nohria, 2005). According to Mayo and Nohria, strategic decisions taken by CEOs in response to macro level factors are a determining factor in businesses success or failure. There is however little or no research that focuses upon CEOs in the NHS, and especially in PCTs, where the impact of macro level factors in the external environment tend to be mediated at the Trust level by the DH role, not the market, in setting everything from annual budgets and service scopes to standards and prices; performance is judged in different ways by different stakeholders based on a complex set of nationally determined indicators, not simply profit; and the Secretary of State remains accountable for the provision of health care to the population, to the taxpayers who are the ultimate shareholders. With PCTs spending up to 80% of the NHS budget, the roles of PCT CEOs are crucial, in that they lead the local office and providers will shape their services by the PCTs' commissioning decisions with resultant impacts on population health outcomes. This research was therefore designed to examine the decision making behaviours of PCT CEOs in how they cope with all the changing and diverse array of competing demands, stakeholder influences, and performance expectations that affect PCT decision making. The research design is therefore based on first articulating the concept of contextual intelligence, defined in this study as the ability to take account of relevant

contextual factors in decision making behaviour, followed by empirical research about the contextual factors CEOs in the NHS take account of when taking strategic decisions. The research is conducted in three interrelated projects:

1. Project 1, which took place in 2005/6, consists of a systematic review of the literature to conceptualise a model of contextual intelligence relevant to CEO decision making.
2. Project 2 involves interviewing a cohort of 24 PCT CEOs on the contextual factors they say they would take account of (in theory) in relation to specific focal decisions common to them all at that point in time. Data was collected in spring 2008 and the report written in 2009/10. This project offers the possibility of challenging, extending or amending the literature based model of CEO contextual intelligence in the context of the NHS.
3. Project 3 examines the contextual factors the PCT CEOs actually took into account (in practice) in these focal decisions, using diary reports and observational studies. Data was collected in summer 2008. The findings were compared with the literature-based model derived in Project 1 and with the “espoused” model from Project 2 to arrive at a NHS PCT CEO model of contextual intelligence and ultimately a richer understanding of PCT CEO decision-making behaviour in this complex organisational context, which is relevant to current and future practice in the NHS.

2 SUMMARY OF RESEARCH PROCESS

2.1 Philosophical perspective

As the subject of enquiry is PCT CEOs and how they think and behave in decision making contexts, I have adopted the philosophical tradition of social constructionism. The overall aims are: a) to understand the concepts and structures underlying contextual intelligence by studying decision-making in a community of PCT CEOs; and b) to understand how contextual intelligence influences PCT CEO decision making.

The focus of the research is on what the key players, individually and collectively, are thinking and feeling; as well as trying to understand and explain why they have different experiences, rather than search for external causes to explain their behaviour. The research design therefore exhibits the following distinctive features (Easterby-Smith et al, 2002): that the observer is part of what was being observed; human interests are the main drivers of science; the explanation is to increase general understanding of the situation; the research progresses through gathering rich data from which ideas are induced; concepts incorporate stakeholder perspectives with units of analysis possibly including the complexity of "whole situations"; generalisations through theoretical abstractions; and collecting data from a small number of cases chosen for specific reasons.

2.2 Research strategy

Project 1 "mapped the field" by a systematic review of previous research relevant to understanding contextual intelligence of CEOs. Data analysis involved qualitative synthesis of the collated evidence, followed by descriptive analysis of the papers reviewed, and the findings grouped under main conceptual terms and categories. The results were then synthesized to produce a literature-based model of contextual intelligence.

Project 2 and Project 3 adopted an abductive research strategy to "produce social scientific accounts of social life by drawing on the concepts and meanings used by social actors and the activities in which they engage"

(Blaikie, 1993, p176). In both projects, the enquiry is about PCT CEOs' decision making behaviour. PCT CEOs were asked to describe their actions in response to common focal decision contexts. Their accounts contain the concepts that the CEOs use to structure their world. By basing the enquiries on a set of pre-determined scenarios, I hope to gather reflections from across the PCT CEOs in order to discover the meanings and theories that can then be pieced together to generate social theories around the concept of contextual intelligence with respect to decision making by PCT CEOs.

2.3 Research design and data collection

The research contains three projects - a systematic literature review and two empirical studies.

Project 1 used a systematic review protocol to produce a comprehensive and replicable analysis and synthesis of the available evidence, from which to develop a conceptual model of CEO contextual intelligence. Using ABI-Proquest and EBSCO as search engines, key words and search strings were applied to the databases. The key words for the search strings were "chief executives" and "CEOs", "context", "managerial cognition" and "organisational performance", and the overlapping domains of "intelligence", "sense making" and "NHS". The emergent references were then reviewed against set selection criteria and quality appraisal to identify appropriate studies for data analysis. The literature review was supplemented by searching by key authors on Cranfield University library databases and Google Scholar.

The research design for the empirical projects was both prospective (Project 2) and retrospective (Project 3) in relation to common focal decisions to enable the collection of data in a "before" and "after" way. Semi-structured interviews were used to elicit what the PCT CEOs saw as their decision making context and to study variations between individual conceptions of their context. Interviews were structured around common decision contexts (that faced all PCT CEOs in parallel) in the form of policies from DH and the SHA. This design addressed:

- The need to identify individual differences in the number and frequency of contextual factors taken into account
- Variations in decision making that come from responding to different types of decision contexts, that is, national, regional or local plans
- Variations in individual conceptions of the contextual factors

Data from Project 2 came from the first round of face to face interviews conducted personally by me. The semi structured interviews used an interview guide to ensure consistency in questioning, with each interview lasting on average 1.5 hours. All interviews were recorded and transcribed. Every CEO was asked four standard questions:

a) What factors they take into account in making any (generic) important strategic decision
b) What factors they take into account when making decisions about a key national policy
c) What factors they take into account when making decisions about a new regional policy proposing service centralisation
d) What factors they take into account when making decisions about the polyclinic plans for their PCT

Data from Project 3 came from three sources: face to face interviews based on each PCT CEO's electronic work diary covering a two month period, paper print-outs of the diary, and each CEO's accounts of a significant strategic decision making event that occurred during the data collection period. Recognising the difference between 'espoused theories of action' and 'theories in use' (Argyris and Shon, 1974), what the PCT CEOs reported as taking into account in Project 2 was followed in Project 3 by study of what they did take account of in practice. A gap of two months was deemed to provide sufficient timeframe for decisions to be progressed. The CEOs agreed to keep a diary for the two month period to provide an additional source of evidence of decision making activity. During the data collection period, an unanticipated and decision-making event concerning a major strategic decision was instigated by the SHA, which brought together all of the PCT CEOs (including me) to make a

"joint" decision. This provided a rare opportunity to participate and observe behaviour and later to explore in depth with the CEOs their experience of a critical decision making event. These findings provided additional insights into other factors influencing the decision making behaviour of PCT CEOs in practice.

2.4 Selection of study population

To minimise the effect of different SHAs having different regional strategies, the study focused on 24 permanent PCT CEOs operating within a single NHS region in England. The choice of SHA region was influenced by my own position as an incumbent PCT CEO in the region. Engaging colleagues as participants has the benefits of ease of access, a common language and understanding, and having insider knowledge of the CEOs' operating environment. This is especially relevant when the study participants are elite professionals to whom access has traditionally been difficult. There are however potential risks relating to biases and ethics. Avoidance of potential bias was managed by strict adherence to agreed methods and being systematic in data collection, reduction and analysis. There were also risks relating to compromising subjects and to data quality. To avoid and mitigate these risks, potential participants were provided with an information sheet about the nature of the project, what was expected of them, how the research procedures may affect them and how their anonymity would be assured, as well as reassuring them that the information provided will be treated in strict confidence, that nothing would be attributable or identifiable, and of their right to withdraw at any time. The study satisfied the ethical standards laid down by Cranfield University Research Ethics Committee who gave approval to proceed.

2.5 Data analysis

Project 1 employs descriptive analytical technique which used standard data extraction forms to extract information from the reviewed papers in a consistent manner. Findings were then categorised by: top 10 journals contributing the most articles to the systematic review; year of publication; country of origin,

industry category, themes, and contextual analysis to reveal patterns of factors previously found relevant to a description of CEO decision-making context.

Project 2 consists of a qualitative analysis of semi-structured interview data using NVivo8, a qualitative data analysis computer software package.

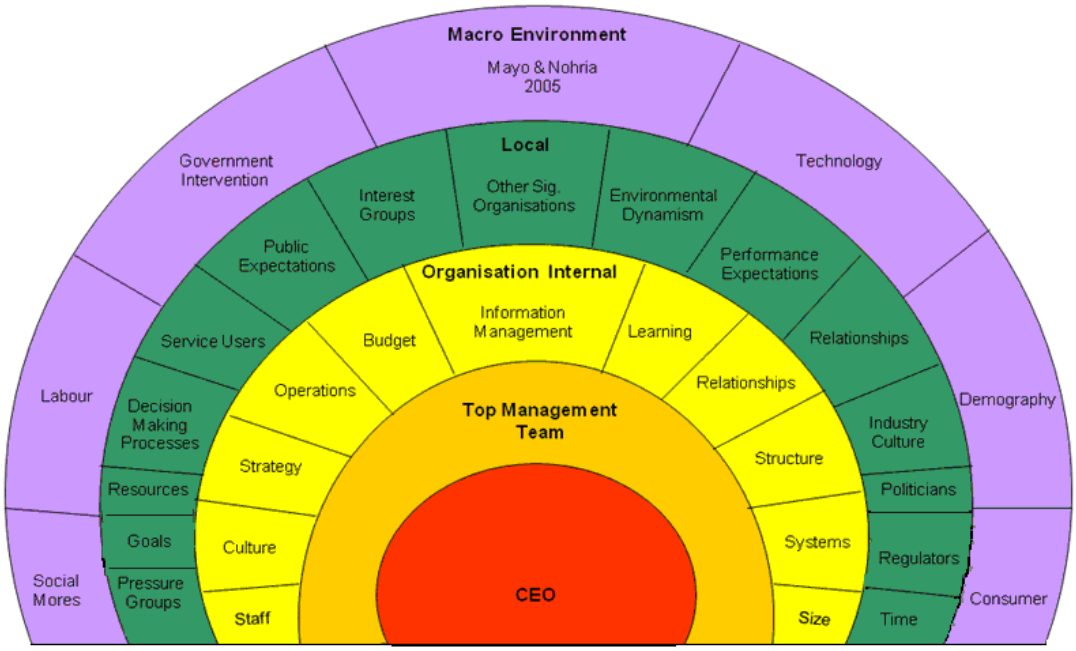
Project 3 data were analysed in two ways: diary activities were assigned to decision making categories using Microsoft Excel, with data measured by frequency (count) and time spent (sum in hours). The approach assumed that both frequency and duration of exposure to contextual factors have commensurable influence on CEO decision making behaviour. Interview data relating to the joint decision making event were analysed taking an interpretive approach after applying NVivo 8 to individual descriptions of the event.

3 SUMMARY OF KEY FINDINGS

3.1 Summary of research findings

Project 1, which consists of a systematic review enabled me to build a stratified "rainbow" model of contextual intelligence that extended an earlier model (Mayo and Nohria 2005) as shown in Figure 1. The different strata of the 'rainbow' represent layers of factors in the organisation and external environment from the CEO's perspective. Within each stratum are categories of factors that have been found to be relevant to CEO decision making.

Figure 1 A literature based contextual intelligence model for CEO



What the diagram shows is that

- the decision making world of a CEO is potentially complex
- there are a large number of factors apparently relevant to effective decision making

- the factors range from consideration of the top team through to factors in the internal organisational environment to the external local environment to macro level factors
- each stratum contains numerous factors, each of which can have sub-factors of relevance

While only some literature was specifically derived from the public sector or healthcare settings, the identified factors clearly exist in the health care setting, as present in the context of the PCT CEO so that they are at least potentially relevant to PCT CEO decision making behaviour.

Project 2 found the PCT CEOs to espouse the following decision making behaviour “in theory”:

- There is a hierarchy in contextual factors that influence CEO decision making
- Different factors are taken into account in different decision making situations
- There is a group of critical factors that are always considered by PCT CEOs irrespective of decision making contexts. These are organisational strategy, stakeholders, goals and decision making processes
- Some factors in each stratum were not mentioned at all in any decision scenario. This includes the whole macro level stratum
- The contextual factors that most define PCT CEO decision making behaviour are source of decision trigger, local flexibility in decision making, extent of stakeholder involvement required, and degree of anticipated resistance.

Project 3 found the PCT CEOs to exhibit the following decision making behaviour “in practice”:

- Far fewer factors were taken into account, with decisions being made on a far simpler set of contextual factors
- There is a clear distinction between factors taken account of in different types of decisions

- The factors that have the most impact are those constructed within the NHS (in contrast to macro level factors in the corporate sector)
- The most important factors are “other significant organisations” (the SHA in particular), decision making processes, TMT and structure
- There is an underlying layer of contextual factors relating to structures and rules of varying transparency. The CEOs’ tacit knowledge about how these operate in practice contribute to the effectiveness of CEO decision making behaviour.

3.2 The context in which PCT CEOs make decisions

The findings were consistent with what has long been argued about decision making in the public sector, in that there are key constraints on the decisional behaviour and the choices of public service managers compared to those in the private sector (Stewart et al, 1980; Ring and Perry, 1985; Dawson et al, 1995). For public sector organisations such as PCTs, having the government setting the operating contexts can mean a restriction on local flexibility and discretion, which can be problematic if the central directives do not match local aims and objectives. I found this with top down policy directives, and especially with non diktat policies or policies that were ambiguous. As an integral part of the national health system, PCTs are required to implement national policies, but as local health authorities, they also have local strategic objectives. In many ways, the PCT CEOs found it easier to deal with *diktats*, as what needed to be done, and by whom, are normally clearly prescribed. This makes decision making easier, as the organisation of work, including stakeholder engagement and governance structure, are clarified from the outset. Implementation takes on a “command” approach from DH through the SHA, with support from “regulatory bodies” or through “performance management”. For non diktat policies, the PCT CEOs would attempt to comply but should they find it difficult for whatever reasons, they will attempt to use appropriate evidence to negotiate for changes in scope and pace. Many CEOs described a routine for decision making. They will first assess the request from the perspectives of “sanctions for non delivery” and “degree of performance management” by DH or the SHA. They will also

assess the relative “priority of the policy” against other national requirements, and decide whether it is “do-able within the timeframe”, or to “negotiate for more achievable” deadlines. If they were unsure, the CEO would “check with the SHA” and also try to “find out what other PCTs were doing”. This behaviour highlights an additional constraint of the PCT CEO operating context, that of the “artificiality of time constraints”. The CEOs will consider the “strategic fit” of the new policy with existing strategies or plans, and whether it is possible to “re-badge” or “adapt existing local plans”. As with the case of the RHS, the CEOs would use the opportunity afforded by top down requirements to expedite local strategy plans. They will want to be able to demonstrate to the SHA that their PCT is “complying” with the requirements, at the same time showing stakeholders that local priorities are still being met. Their priorities will be about “aligning strategic goals”, “managing key players” and “keeping abreast of issues in the local environment”, “establishing decision making processes” to structure the work, “demonstrating governance” and to “lock in” the strategic decisions.

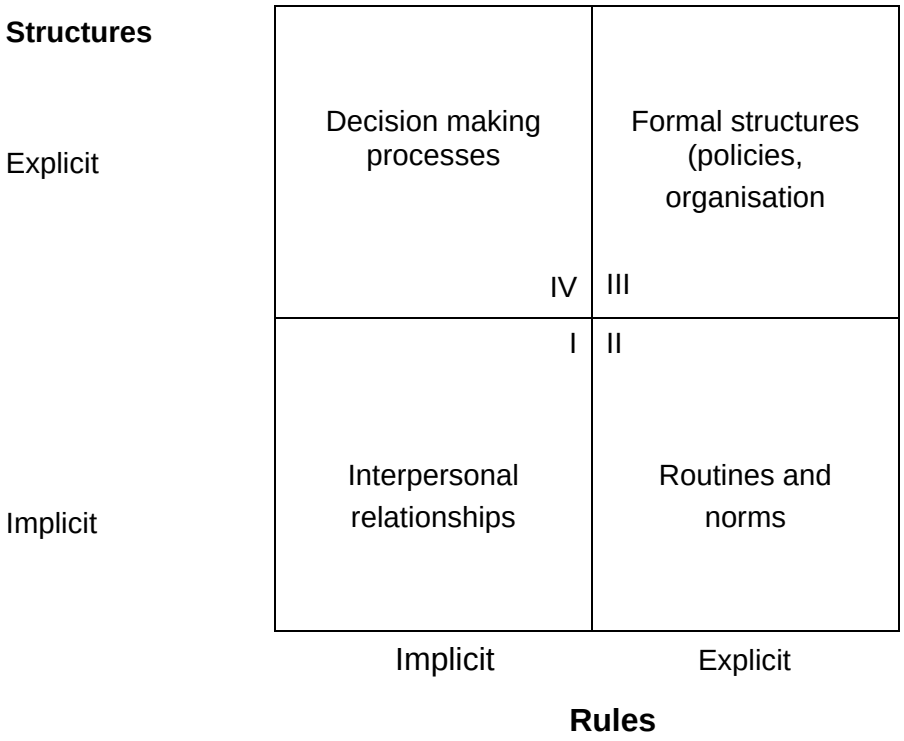
Another aspect of the context in which PCT CEOs work, and which the literature identified as additional differences in public service is the managerial attitudes to change (Dawson et al, 1995). I found this in the PCT CEOs’ response to the concept of polyclinics. According to Dawson, there is a tendency in the public service to criticise managerial mistakes. PCT CEOs know they were pursuing managerial agendas within a highly politicised context; and working in the spotlight of intense media interest resulting in uncertainty, turbulence and intra-organisational defensiveness. As public bodies, PCTs have to demonstrate relative openness of decision making, which often result in the need to engage with a greater number of stakeholders. The local community and staff have long memories, and the history and ethos of local services need to be considered in any strategic planning decision or it runs the risk of resistance. The “availability of resources” is another obvious factor, especially at times of financial austerity. Other potential constraints are the “expectations of local players” of the “CEO’s leadership style” and “interference from the management tier above”. According to Goodwin (2006), as a result of the often strong external controls exerted on

public service bureaucracies, the penalties for failure are high, which add to the challenges for the strategic management of public services.

Over and above explicitly recognised contextual factors the research revealed another dimension to the complexity of the CEO decision-making context in the degree of the transparency of rules and structures. These rules and structures are not merely physical entities but extend to the organisation of people, system, arrangement, design, framework, and patterns of how things work. Relationships between PCTs, SHA and DH are normally structured, while those of interpersonal nature between senior leaders tend to be informal and unstructured. The diary data showed significant organisations and key individuals involved in varying structures and modes of engagement. The away day saw PCTs and SHA organised in a formal hierarchical relationship, but the CEOs' decision to merge PCTs still had to go through formal decision making process by the PCT boards as part of the governance structure. Even the social norms have elements of structure that resulted in standard behaviours among PCT CEOs.

What was apparent from the data was that structures themselves also influence how they operate, governed by rules which also vary in their transparency. Explicit or formal rules include policies and legal requirements that are usually put in writing but even then may not operate accordingly. Formal structures normally have explicit rules but interpretation and flexibility of the rules may be known only to experienced insiders. The tacit knowledge of informal rules, which include norms and routines that guided PCT CEOs' behaviour at the away day, are not written down but are apparent to any informed observer. The PCT CEOs knew from experience that new rules can be created, and existing rules changed or deleted, unilaterally and without prior warning by the SHA or DH. The process for decision making provided further opportunities for tacit rules to be exercised. Figure 2 shows a two dimensional model derived from the analysis of explanations of CEO decision-making behaviour, of structures and rules influencing decision making behaviour on a regional strategy on an away day event.

Figure 2 A two dimensional model of underlying contextual factors of structure and rules



3.3 PCT CEO decision making behaviour in complex environments

The ways PCT CEOs responded to the Regional Health Strategy (RHS) gave further insights into their decision making behaviour in complex environments. The RHS proposed two strategic changes to local health system: one, the centralization of certain specialist services, namely stroke and trauma, at fewer hospitals; and two, the setting up of community health service hubs called polyclinics. The PCT CEOs were aware that significant service changes, such as that proposed by both the centralisation and polyclinic strategies, require stakeholder support. The majority of PCT CEOs identified common stakeholder groups. Internally, “staff” would be needed to implement the plans, which brings up the interplay between top management with middle managers. Externally, a number of organisations, post holders and individuals were identified as playing

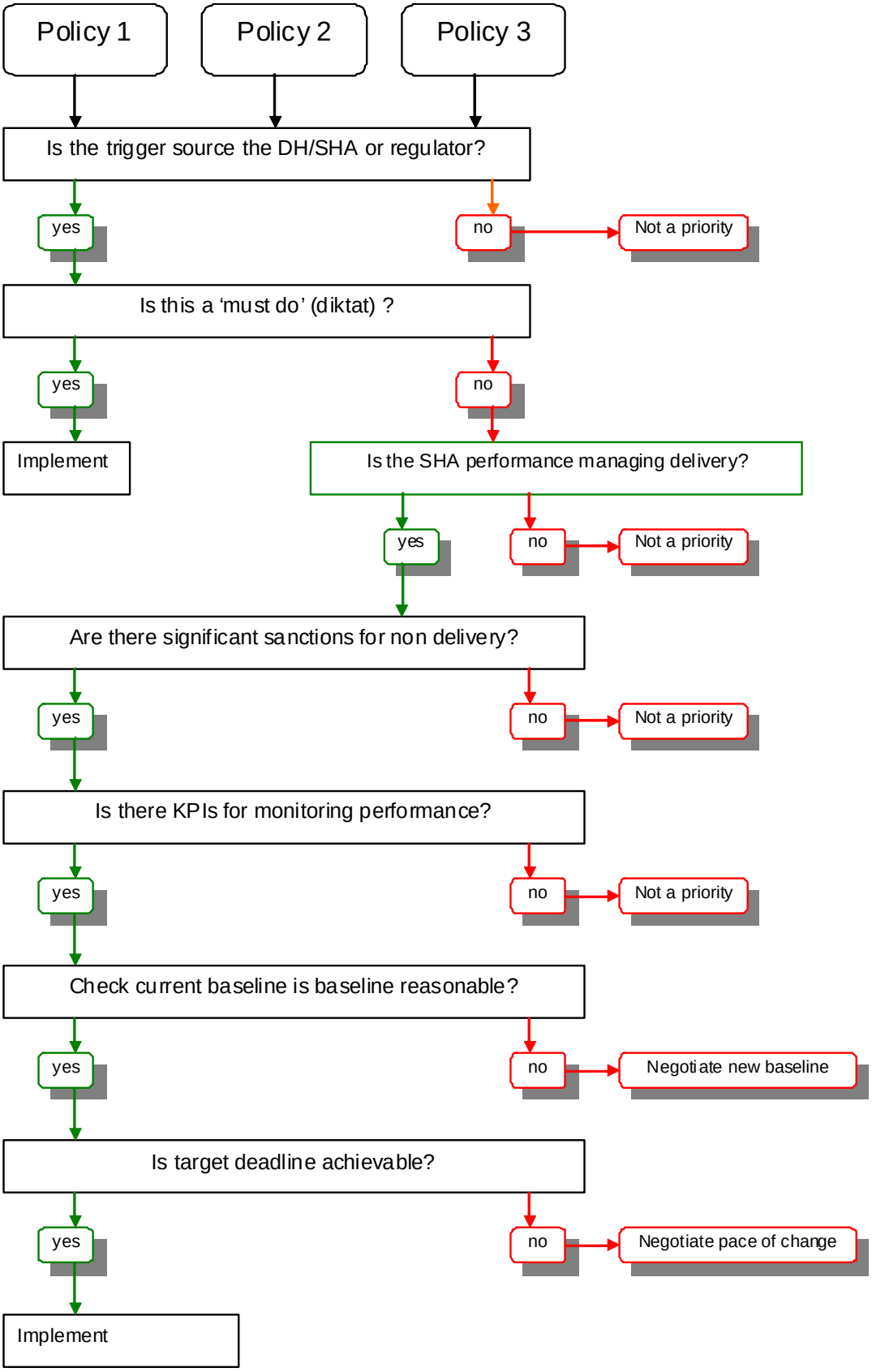
one of more significant roles, either as implementers or critical supporters. For PCT CEOs, the most significant players include the “local hospital trust”, “local GPs”, and in some areas, the “local politicians” and “community groups”. In contrast to organisations in the private sector, PCTs have a legal duty to publicly consult on major strategic changes that could affect its local population. In the consultation process, PCTs have to be able to demonstrate that they have taken account of the local context when making their decisions, which would explain why the CEOs reported prioritising strategic and information factors internally, and stakeholders and environmental factors externally. It would also explain why, even when a decision had been taken in private, as happened at the joint decision Away Day, the PCT CEOs still have to follow due process in governance terms. The research found PCT CEOs to be following a routine in the ways they balance central control against local accountability when taking this range of strategic decisions. The CEOs will want to ensure “appropriate governance” for the taking of any strategic decision. The more experienced CEOs said they set up “formal decision making processes” to give legitimacy to those decisions, and to stop unpopular decisions unravelling. Some said they used “programme management” and “business cases” to support the decision making process. Being able to demonstrate transparent governance processes are especially important if there were resource implications.

3.4 Decision making when priorities compete

On the occasions when they are faced with competing priorities and stakeholders with conflicting interests, the PCT CEOs will prioritise their time and efforts following a routine. They start by identifying where the requirement for action comes from, with those from the DH, SHA or regulators carrying the most weight. The CEOs then decide whether they were dealing with a “must do”, that is, diktat or edict from the DH. If yes, the CEOs would just proceed with the task of implementation. If no but the required action was aligned with the PCT’s own strategy, the CEOs would use the opportunity to step up the pace on local plans. If the answer is no and the required action does not

support local strategies, the CEOs would either ignore it, if possible, or attempt to negotiate with the SHA for alternative deadlines or deliverables. Actions with targets or key performance indicators (KPIs) will prompt the CEOs to check the levels of current performance, and to attempt to negotiate the baseline to improve their achievability. If there were deadlines, the CEOs will want to know if the required action is do-able within the timescale; if not, they would want to know the degree of "flexibility" and to negotiate for a different pace of change. Finally, the CEO will consider implementation issues, starting with who within the PCT is going to lead the work, and who else needs to be involved to make the action happen. Internally, the CEOs would normally delegate the organisation of work to a member of the Top management Team who will work with middle managers to implement the plans. For major strategic decisions or where there are significant resource implications, the PCT Board will also need to be engaged for governance purposes. Externally, the CEO may focus her time and effort on engaging major stakeholders, notably key post holders in significant "other organisations" that need to be involved in implementation, such as GP leaders and CEOs of local hospitals and councils. In addition, there may be influential local groups and individuals such as local politicians. Finally, depending on issue, the PCT CEOs will assess the dynamics of the local environment in terms of place, facilities, infrastructure, demography and the resources required, including affordability. Figure 3 illustrates the PCT CEO decision making process that emerged from the empirical study.

Figure 3 PCT CEO decision making tree



3.5 Achieving top down requirements and local goal synergy

One of the most important priorities identified by the PCT CEOs was to achieve synergy between top down requirements with local strategic goals. The critical factors that are always or almost always taken into account in strategic decision making by the PCT CEOs are “organisational strategy”, “stakeholders” and “decision making process”. It is understandable that organisational strategy plays a major role in directing PCT CEO behaviours. Different stakeholders carry differential status, which can be classified into three groups. The most important group of stakeholders consists of other statutory organisations such as the “local council”, the “local hospitals”, “GPs” and the “SHA”; these players either have key roles in implementation or whose support is formally required. The next group of stakeholders consists of those who have a direct interest in the outcome. They include the GPs’ trade union, the “Local Medical Committee”, relevant “community groups” and “local politicians” who, because of their positional or expert power, can obstruct a decision. The final group of stakeholders are those who have a more remote interest in what is going on, namely the “public”, “patients” and “service users”. In addition to these considerations, the majority of CEOs would also take into account “structure”, “information”, “finance” and “operations” internally and “environmental factors”, “time”, “relationships” and “public engagement” externally. So far, all of the above factors are non specific and apply to all PCTs. CEO behaviours that are unique to each PCT include engagement of the “TMT” and “staff” such as middle managers, and dealing with cultural issues internally, and “patients” and “regulators” externally. Interestingly, macro economic factors are rarely mentioned.

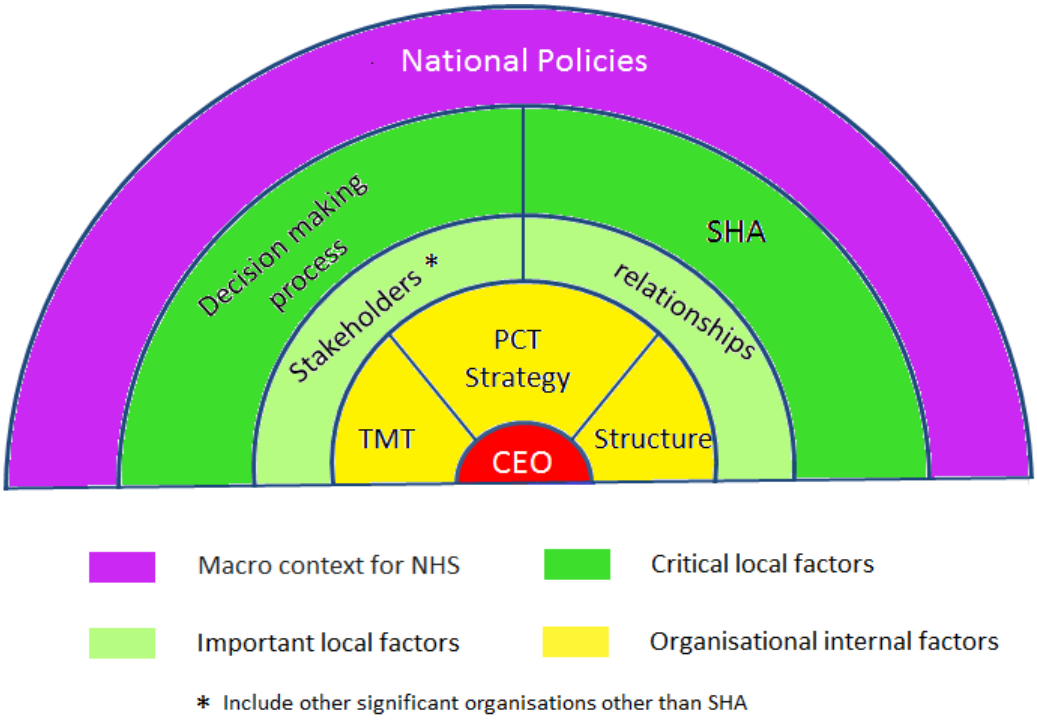
The emerging picture of PCT CEO decisional behaviour in how they do their job shows the following patterns. The higher up the reporting line a decision trigger comes from, the less likely the CEOs will question their validity and the more likely the CEOs will accept the requirement and focus on implementation. Directives from higher up the structure are also more likely to have targets or measurable objectives, which leave less room for manoeuvre or negotiation leading to a “just get on with it” attitude among the CEOs. In contrast, the more

locally developed the strategy, the greater is the need for the CEOs to engage with local stakeholders and to take into account local factors. Where decisions are contentious, or resistance are anticipated, there is a greater need to evidence good governance, which the CEO will demonstrate by using formal decision making processes. In trying to manage within a complex environment, the PCT CEOs would “look up” to the “centre” when dealing with top down requirements and “look out” to local stakeholders when responding to local plans.

On the basis of the research findings, the following conclusions can be drawn.

- The contextual factors taken into account by PCT CEOs relate directly to the decision context of national, regional or local policies, strategies or plans.
- PCTs are required to implement national policies, which the CEOs prioritise over any other decision trigger.
- The most important contextual factors for regional strategies are the SHA, due to reporting lines, and decision making processes, to demonstrate governance.
- When taking strategic decisions on local plans, the CEOs focus on having the right structures for decision making and engaging stakeholders, especially significant local organisations such as the council, local hospitals and GPs.
- In all cases, the CEOs delegate implementation to their TMT.
- As a group, PCT CEOs demonstrate a uniform pattern of strategic decision making behaviours that reflect contextual intelligence as summarised in the new conceptual model in Figure 4.

Figure 4 A new model of contextual intelligence for PCT CEO strategic decision making (new rainbow model)



3.6 Interplay between CEO behaviour and middle managers contribution to decision making in PCTs

The need to have a better understanding of the interplay between CEO behaviour and the impact of others within the PCT such as middle managers in decision making was` referred to earlier in response to the growing recognition of the contributions that managers can and need to make for effective service provision decisions and concern about limitations upon that. The research has shown that policy implementation in the NHS adopts a top down approach, from DH to SHA to PCT, and within the PCT, from the CEO to the Top Management Team who then presumably passes on the tasks to middle managers. A limited number of studies have examined the roles middle managers in the NHS play in policy implementation (Langley, 1986; Currie, 1999; Checkland et al, 2011). All acknowledged that a top down initiative is likely to restrict the influence of middle managers in policy development, however, the conception and implementation of strategic change is critical for the role of middle managers.

Langley (1986) raised the issue of control and the importance of negotiation and persuasion in her study of formal planning in healthcare. She found that using planning as a mechanism of control being strenuously resisted by those outside top management. Currie (1999) in his study of the influence of middle managers in the business planning process in an NHS hospital found the middle managers modifying the implementation of deliberate strategy by contesting the performance indicators that form the basis of the business planning framework. In particular, they drew upon the inner and outer contexts of the organisation to question the legitimacy of the plans. Currie also shows that the middle managers are purveyors as well as recipients of change, and that they can have upward influence that adds value to the organisation, but the high degree of centralisation in the NHS can militates against their contributions. In terms of upward influence, roles taken by middle managers are "championing alternatives" (Floyd and Woodridge,1992) and "synthesizing information" (Nonaka, 1988). The former is seen as a product of divergent ideas from organisation thinking whereby there is persistent and persuasive communication of strategic options. The latter is more integrative, since middle managers interpret and evaluate information concerning internal and external events, which they then supply to top management. According to Shilit (1987), the primary role of middle managers is downward influence – that is the carrying out of the strategy, which they achieve by "facilitating adaptability". That the key strategic role of middle managers is to align organisational action with strategic intention is also observed by Nutt (1987). Pettigrew et al (1992) refer the actions taken by middle managers to create legitimacy for their upward influence generally and their downward influence in adapting flexibility as the "management of meaning". The concept was used by Pettigrew et al to describe the process designed to create legitimacy for one's own ideas, actions and demands, and to question the legitimacy of the demands of one's own opponents, and is a way actors in the change process mobilise the contexts around them, and in doing so, provide the legitimacy for change.

The extent the concepts apply to the roles and behaviours of middle managers in PCTs was studied by Checkland et al (2011). The researchers use qualitative

case study methods to produce a detailed and theoretically informed picture of the interactions of PCT managers and draw from the results more general conclusions about the role of middle managers in PCTs and their impact on the functioning of the organisation as a whole. They identified a number of managerial roles enacted by PCT middle managers, some of which are identifiable from general managerial literature, but also identified a unique role performed by PCT middle managers who were responsible for Practice Based Commissioning (PBC), a national policy of engaging GPs in commissioning. The roles include managing information upwards, ensuring that particular interpretations were disseminated to the top management team; networking outside the PCT with groups whose needs and aims are not necessarily aligned with those of the PCT, although there were times when their painstaking work were over-ridden by top managers; and the unique role of “animateur” which saw PBC managers participating in high level meetings within the PCT as a result of their PBC role. Checkland et al conclude that the role of PCT middle managers is a difficult one and the way in which it is performed can have a significant impact upon the overall performance of the PCT.

As the detailed literature described, middle managers have a contribution to make not only in policy implementation in PCTs, but also plays an important role in policy formulation and strategic planning. Their involvement in the organisational internal planning process can affect the quality of decision making in PCTs as well as how decisions are then implemented. The evidence also found that organisational practices can have a profound impact on the ability of managers to function in role. While it may be obvious that decision making and policy implementation in PCTs can improve significantly if middle managers are engaged in ways that maximise their contributions, what is interesting from my research findings are three folds. The first is that I found limited evidence of PCT CEOs taking account of the middle management’s contribution when decisions are taken in PCTs. Only one in five PCT CEOs mentioned staff engagement when asked about contextual factors they would take into account in strategic decision making. When the diaries and interview transcripts were analysed, they show that none of the PCT CEOs had directly

engage with staff below board level on matters relating to national and regional policies as they have been delegated to the TMT, but the majority had spent some direct time with staff on issues relating to local strategy plans. This suggests that when decisions have largely been made further up the reporting line, PCT CEOs perpetuate this command chain within the PCTs which has implications for effective strategy and policy implementation. This may not matter if there are processes within the PCT that enables middle management to input into the strategic planning process but knowing that organisational practices can impact on their effectiveness, the engagement of middle managers would benefit from having a more systematic approach within PCTs. Secondly, my research reveals that structures and rules vary in their transparency and tacit knowledge of operational practices beneath the surface is essential to effective management. This has implications for both the TMT (including the CEO) and middle managers as it indicates a need for the mutual learning of each other's contextual intelligence as different data is needed for different types of decisions or in their implementation. Thirdly, involving middle managers in the strategic planning and decision making processes of PCTs is not only beneficial from the organisational perspective in terms of better decisions through aligning strategy with operations, it is also developmental and motivating for middle managers as it brings them into direct contact with the top management team and widens their network.

In conclusion, Checkland and colleagues are right to highlight the benefits of involving middle managers in PCT decision making activities. However, the current top down culture of the NHS suggests that there is some way to go before this benefit could be realised. At the PCT level, it requires a change in organisational practice that has to start with the PCT CEOs changing their decision making behaviour. With the advent of CCGs, these findings offer valuable insights to those responsible for establishing and leading CCGs.

4 CONTRIBUTIONS

4.1 CEO coping behaviour in complex and ambiguous contexts

The findings confirm the prevailing view of executive decision making , which is that executives are “boundedly rational” (Simon, 1976) and must satisfice rather than optimise (Eisenhardt, 1989). PCT CEOs do not take every potential factor into account in making decisions.

As Project 2 and Project 3 found, PCT CEOs take account of far fewer contextual factors than those identified by the numerous studies cited in the systematic review (Project 1). In particular there was no evidence in thought or action in this PCT CEO context of certain factors in the literature derived Contextual Intelligence model for example size, and factors from the macro environmental strata were absent. It is argued that sensitivity to relevant contextual factors helps CEOs to take the most appropriate strategic decision for the benefit of their organisation, and accordingly, themselves. The ability to know which contextual factors matter for which strategic decision is what I have called contextual intelligence. Contextual intelligence enables the CEOs to apply tacit knowledge to play in relevant contextual factors into decision making, confirming that contexts can shape leader thinking and action (Mayo and Nohria, 2005). But whereas the research to date has failed to make a distinction between types of decision in analysing contextual considerations nor to find any particular relationship, this study has demonstrated that in the PCT CEO context there are distinctly different factors taken into account in taking different kinds of ‘strategic’ decisions.

A further distinction provided by this study is that unlike CEOs in the corporate sector who need to be sensitive to macro environment level factors, CEOs in the NHS appraise their decision making contexts by what triggers the strategic decision and the implications for non compliance. Being statutory organisations, certain things need to happen before a strategic decision can be taken by PCTs, such as managing the dynamics of local environment, ensuring stakeholder support, and having proper decision making processes in place.

The NHS strategic decision making process may seem complex and bureaucratic, but it presents a pathway for the consideration and involvement of relevant contextual factors that are required for implementation.

4.2 Extending the Contextual Intelligence literature

The research reveals the extent of the complex and ambiguous environment in which PCT CEOs operate. Unlike their counterparts in the corporate sector who in the main are guided by macro level factors when formulating strategy, PCT CEOs operate in a more opaque world where a complex set of rules and structures of different transparencies govern strategic decision making. So PCT CEOs cope by simplifying the range of factors they take into account by prioritising politically according to the decision trigger and the consequences of non-compliance, and by being informed about and acquiring tacit knowledge about the formal and informal rules and structures of varying transparency. Importantly, their contextual intelligence appears to miss out on the potential contributions from managers at other levels. The CEOs do not routinely seek the inputs of middle managers in either the intelligence gathering process or when taking decisions. This is of concern when evidence shows that the involvement of middle managers can lead to better decisions and improved implementation. For PCT CEOs to improve both their decision making effectiveness and therefore the performance of their organisation, as a group, they need to change their behaviour with respect to how they involve other managers in decision making in the PCT. Instead of perpetuating the command and control model by issuing top down directives, they need to engage middle managers in building their contextual intelligence. This has implications for the current reorganisation of the NHS, especially in light of the ambition of the 2010 White Paper to “liberate the NHS”.

4.3 Theorising the role of contextual intelligence in PCT CEO decision making

I used Whetton’s (2002) modelling-as-theorizing systematic methodology to build my model of how contextual intelligence contributes to PCT CEO decision making behaviour in the complex and ambiguous context of the NHS. Three

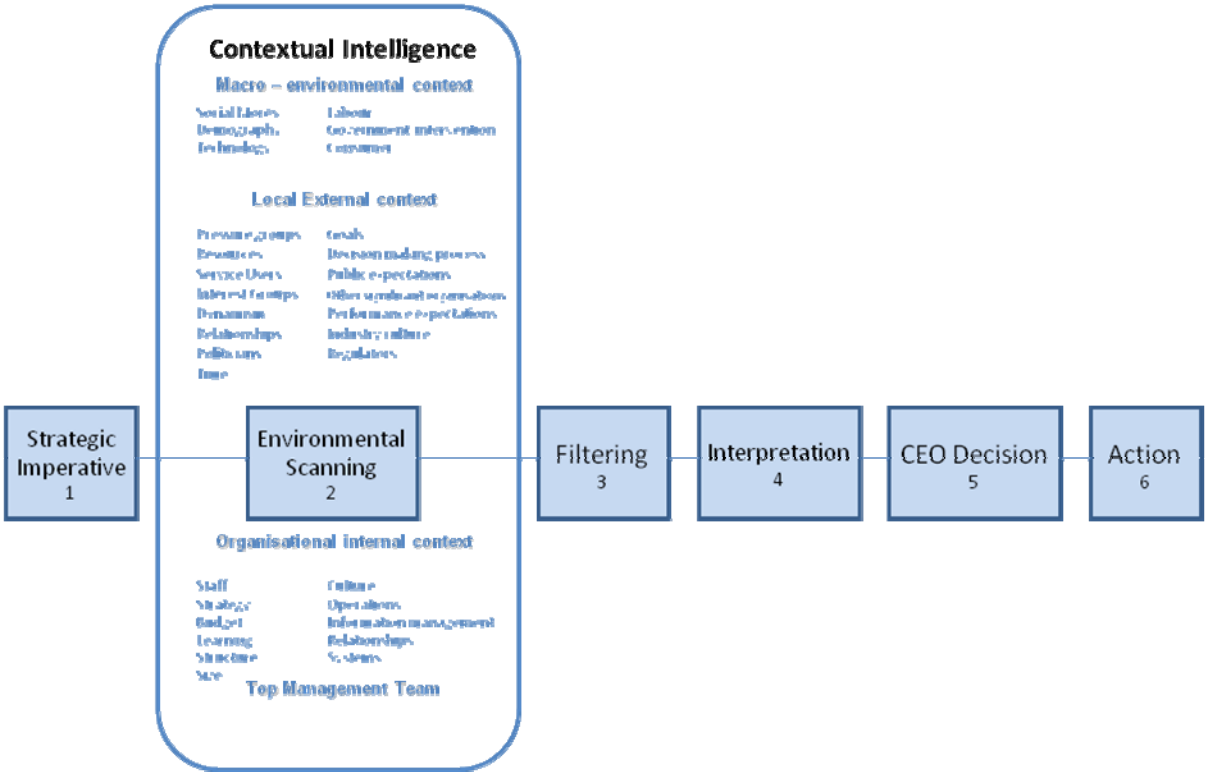
models were developed showing how the conceptualisation of the role of contextual intelligence in PCT CEO behaviour has evolved over the course of the research from Project 1 to Project 3. The first model is based on a conception of CEO contextual intelligence as conceived from the systematic literature review of Project 1. The second and third models represent “in theory” (as perceived by the CEOs) and “in practice” how contextual intelligence is found to play a role in PCT CEO decision making behaviour, as derived from the empirical findings of Project 2 and Project 3.

Project 1, which led to the development of the first model, “Model 1” as shown in Figure 5, was prompted by the need to understand the role that contextual intelligence plays in relation to PCT CEO decision making behaviour and effectiveness. While CEOs are ultimately responsible for all organisational decisions, their organisational leadership responsibilities require their specific personal attention to organisationally critical or strategic decisions. What they take into account and how in making these decisions, is the focus of this study.

The initial literature review was designed to find out what was known about contextual intelligence in relation to CEO decision making and effectiveness. It revealed contextual intelligence as fundamentally about the scanning of a vast array of potentially relevant factors in the decision making environment. Scanning of the environment (box 2) to gather intelligence is prompted by a “strategic imperative” (box 1) creating a need for organisational decision or action that requires CEO attention. The CEO filters (box 3) and interprets (box 4) the intelligence before arriving at a decision (box 5) which then leads to action (box 6). The “decision making” sequence is conceived as linear. In this model, derived from the literature, the role of contextual intelligence is a discrete consideration at the beginning of a rational decision making process initiated by a strategic imperative that could be externally or internally generated and brought to the attention of the CEO in a variety of ways. The detection of a strategic imperative then triggers environmental scanning. The literature review identified layers of explicit factors in the CEO’s environment which theoretically CEOs take into account in making important organisational decisions. There is

however limited insight provided by the literature about how these contextual factors were processed and how they influence decision making. Depicted in the rainbow model of contextual intelligence (page 19), each layer comprises of a number of potentially decision-relevant factors which the CEO scans.

Figure 5 Literature based model of the role of contextual intelligence in CEO decision making



The macro environmental factors were identified by Mayo and Nohria (2005). The local environmental factors include environmental dynamism (Lant et al, 1992; Bourgeois and Eisenhardt, 1988; Johnson & Hoopes, 2003; Beekun & Ginn, 1993; Oliver & Roos, 2005), finance or resources (Tucker et al, 2005; Rhodes & Keegan, 2005; Learmouth, 2005), politics (Blackler & Kennedy, 2004), time, interest groups (Ring & Perry, 1985), decision making processes (Dutton & Duncan, 1987; Schwenk, 1995; Eisenhardt, 1992; Mintzberg et al, 1990), time (Ring & Perry, 1985), relationships, goals, stakeholders and

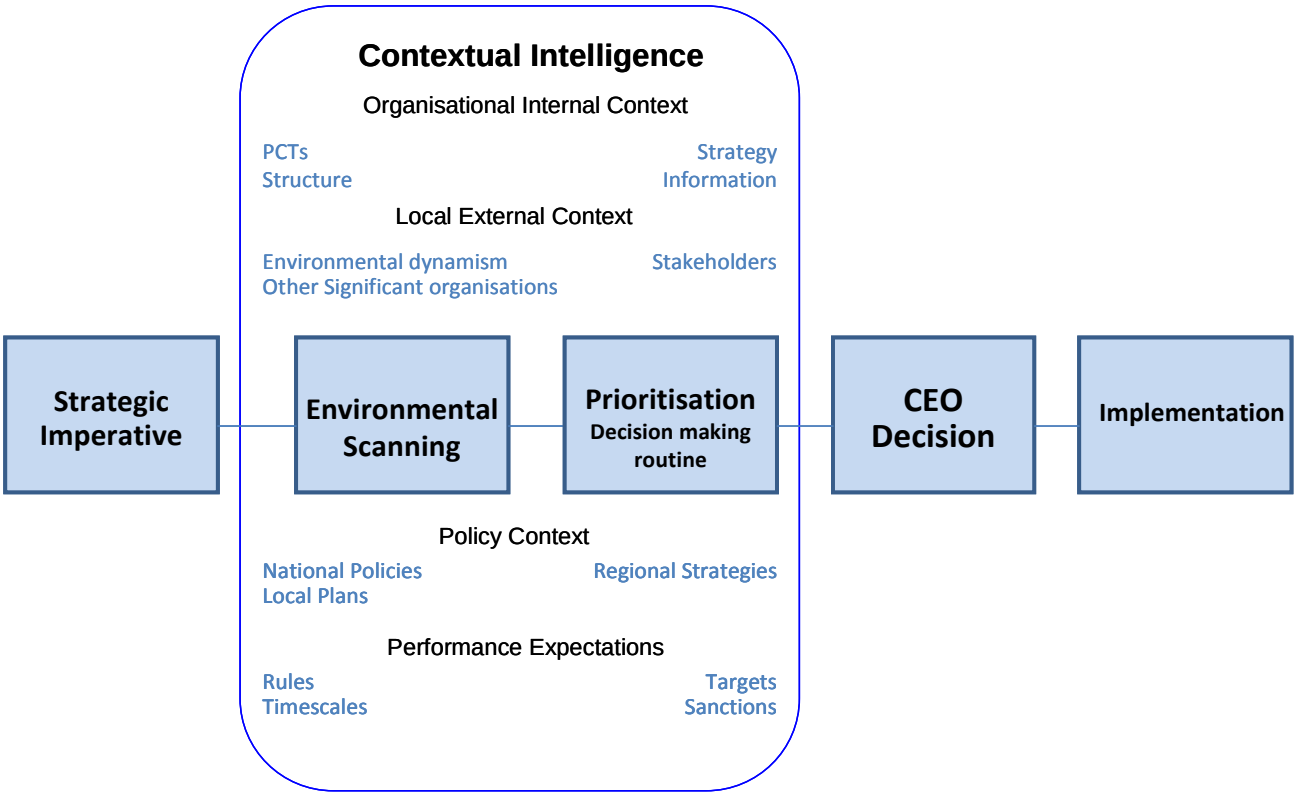
performance expectations (Euske, 2003) and regulators, government policy, culture, goals and other significant organisations (Goodwin, 2006). Of these, only decision making processes, performance expectations and other significant organisations emerge as being particularly important in PCT CEO decision making. On decision making processes, the sub factors relate to pace (Baum & Wally, 1992), time available (Dutton & Duncan, 1987), information processing capacity (Schwenk, 1988), complexity Schwenk, 1995), choice (Hambrick & Snow, 1977) and perceived degree of discretion (Carpenter & Golden, 1977). Performance expectations refer to targets and actions required by a policy. Other significant organisations include other NHS organisations, GPs, independent providers, the voluntary sector and councils. These organisations share a common feature of being public service providers in health and social care, as distinct from stakeholders who include subgroups that have expectations of the NHS.

Factors seen to be of decision making relevance in the internal organisational environment are information management (Staw et al, 1981; Auster & Choo, 2004; Walters & Priem, 1999), organisational strategy (Duhaime & Schwenk, 1985; Thomas et al, 1991), size (Hitt & Ireland, 1985), structure (Thomas et al, 1991; Hitt & Ireland, 1985), systems (Bettis & Pralahad, 1995; Tucker et al, 2005), relationships (Hellgren & Lowstedt, 1998), staff (Connor & Baker, 2003; Goodwin, 2006), culture (Harris, 1994; Sternberg & Grigorenko, 2006), organisational learning (Schwandt, 2005; Fiol, 1994), operational efficiency (Staw et al, 1981; Short et al, 2002; Garg et al, 2003) and Top management Team (Bourgeois & Eisenhardt, 1988; Finklestein & Hambrick, 1990; Kaplan et al, 2003; Lant et al, 1992). In my research, interestingly, of all these factors, only structure and Top Management Team (TMT) were found to play significant roles in PCT CEO decision making and then only in relation to local plans. Organisational internal factors were not significant considerations for PCT CEOs when dealing with national or regional strategies. In contrast, structure appears to influence both CEO and staff interpretative schemes while the TMT has a role to play in issue interpretation (Gioia & Thomas, 1996).

Project 2 and Project 3 led to the development of Model 2 and Model 3, respectively. The models illustrate on one hand how PCT CEOs say they would use contextual intelligence and on the other how they do use contextual intelligence in practice, to mediate the competing policies, strategies and plans prior to taking decision leading to implementation.

In Model 2 (Figure 6), based on the CEOs' reports of what they would take into account, five constructs emerged of their decision making processes namely, "strategic imperative" (box 1), "environmental scanning" (box 2), "prioritisation" (box 3), "CEO decision" (box 4) and "implementation" (box 5). They are arranged from left to right to show a temporal dimension. Unlike Model 1, the relationship between the strategic imperative and implementation is mediated by the intermediate constructs of "environmental scanning", "prioritisation" and "CEO decision. Prioritisation does not appear in Model 1 and is a refinement of the model. Environmental scanning and Prioritisation are both moderated by the "contextual intelligence" construct, which in contrast to Model 1, comprises of four main concepts: "Policy context" refers to policies, strategies and plans instigated at national, regional or local levels. According to CEOs, this context is a prime consideration in how to respond. "Performance expectations" refers to the rules, targets, timescales and sanctions accompanying the policies. And "organisational internal context" and "local external context" contain a much more limited array of factors reported to be taken into account by PCT CEOs, than were identified in model 1. In that sense decision making is "boundedly rational". A moderating construct is one that changes the relationship between the other two constructs when it is present (Baron and Kenny, 1986). In the case of PCT CEOs, decision making will take into consideration "performance expectations" when deciding how to prioritise competing policy requirements. "Prioritisation" is a process of filtering for decision competing contextual intelligence. The CEOs' reports revealed a process of prioritisation which was depicted by a decision tree (Figure 3). The process follows a routine that enables decision relevant factors in the environment to inform decision making and implementation.

Figure 6 PCT CEOs' perception of the role of Contextual Intelligence in decision making



This model suggests that in describing how they think they make decision, the CEOs demonstrate a process of boundedly rational choice. According to Becker (1992), rational choice theory assumes individuals will maximise welfare "as they conceive it" (p 1). When faced with constraints, their choices will be guided by their stable preferences and they will balance costs against benefits to maximise personal advantage. People will try as best as they can to anticipate the uncertain consequences of their actions. Rational choice theory provides an underlying explanation for CEO behaviour when faced with conflicting decision making contexts. For example, despite the governance structure of PCT Boards being responsible for local health issues, PCT CEOs apparently will prioritise top down requirements over local priorities as they are accountable to the NHS CEO through the SHA CEO who judges their personal performance on the basis of how well national policies and regional strategies are implemented,

rather than the implementation of local plans. Rational choice theory would also explain why the CEOs look “upwards” rather than “outwards”, as they need to focus their actions on those things that matter to the SHA and DH. However, as PCTs have their own local contexts, both within the organisation and external to the organisation in the local health economy that may not be aligned to wholesale implementation of national priorities, the CEOs will use their contextual intelligence to balance the competing priorities when deciding on implementation or compliance at the local level.

So far, the model is assumed to hold for the self perceptions of decision making behaviour of PCT CEOs who are operating in the particular context of DH and SHA. Project 3, which studied actual CEO decision making behaviour, provides further evidence to refine the model of the role that contextual intelligence plays. Project 3 found that PCT CEOs in practice did the following when taking decisions: Far fewer factors were taken into account, with decisions being made on a far simpler set of contextual factors. Different factors were taken into account in different types of decisions. The most important factors, as measured by the frequency and total amount of time CEOs expended on the factors, are “other significant organisations” (the SHA in particular), decision making processes, TMT and structure. Significantly, there is an underlying layer of contextual factors relating to “structures” and “rules” that inform how the moderators are interpreted. In themselves, the factors form part of the contextual intelligence. Structures is a term I have adopted to describe actual physical constructions such as organisational structures and committees, in contrast to rules which is a term I am using to describe procedures and routines governing human behaviour and practice at work. My research has shown that structures and rules can be both implicit and explicit, and having the knowledge about how they operate would improve individual CEO effectiveness. Experienced CEOs know that structures and rules can vary in their degree of explicitness and transparency so should not be judged on face value. They can also be unstable and so can be created, negotiated or changed without warning. Structures and rules are not only moderating constructs, they are also mediators, through providing the nuances behind the contextual intelligence.

Relationships and pace are particularly important mediators that may not be transparent. Using the polyclinic policy for example, some CEOs sounded out SHA managers to attempt to renegotiate expectations, while others spoke of “repackaging” existing local developments to give the impression of compliance. Where necessary, the CEOs would seek formal PCT Board approval for key strategic decisions as a rubber stamping exercise to demonstrate formal public accountability. It is the tacit knowledge about how these contextual factors operate in practice that contributes to the effectiveness of the CEO decision making behaviour.

Model 3 (Figure 7) shows that, in practice, the role of contextual intelligence in PCT CEO decision making is more complex than originally envisaged. The decision making process is also non sequential. The model shows several refinements on Model 2. First, the position of “policy context” moves from moderator to mediator, as PCT CEO decision making is shown to be primarily instigated by the policy context which also sets the reference point for subsequent prioritisation process. Second, as contextual intelligence is found to play a role before, during and after decision making including throughout the implementation process, it has been removed as a discrete construct from the horizontal sequence and instead, set out in the background as a continuous consideration throughout a rational and political decision making process. Third, a limited number of contextual factors in the form of new moderating constructs were added to our understanding of the decision making process in practice, namely “decision-making processes”, “stakeholder management” and “Top Management Team (TMT)”. Unlike Model 2 which has the CEO implementing her decision singularly, in practice, once a decision has been made, it appears that she may delegate implementation to a TMT member. She would also seek to manage key stakeholders, in particular those from other significant organisations such as the council, GPs, hospital trusts and the SHA. These stakeholders have a moderating effect on implementation through their roles as participants, enablers (or resistors) and additionally in the case of the SHA, as the performance manager. Formal decision making processes allow the CEO to manage stakeholders and to demonstrate good governance. The decision

making pathway between prioritisation and implementation is usually bi-directional due to the nature of implementation being a dynamic process. It is also iterative.

As policies, strategies and plans are implemented, new insights may come to light from contextual factors in either layer of the model, prompting the PCT CEO to review the original decision which will include repeating the prioritisation process. The cycles of prioritisation, decision and implementation (as shown by the red arrows) enable PCT CEOs to make appropriate adjustments in response to emergent contextual intelligence. An example of this decision making behaviour can be seen in the case of the polyclinic policy which proposed centralising large numbers of GPs in large purpose built health centres that will also provide diagnostic and treatment services currently provided in hospital outpatients. The policy was neither popular with GPs and hospitals nor with PCTs, many of whom could not afford to fund the capital investments. When the policy was first set out by the SHA, the performance expectations were unclear, so the majority of PCT CEOs chose to ignore it. Then the SHA set out the service specifications and timelines for implementation, causing several CEOs to re-prioritise the policy, and all to develop action plans. From the CEOs reports of actions taken by their PCTs, the action plans appeared to be wide ranging, and were influenced by their organisational and local contexts. Overall, a minority of PCTs embraced the policy; in those PCTs the policy was aligned with the existing PCT's strategy. Some PCTs set the deadlines for implementation at a distant future in the hope that the policy will pass them by. Others modified existing local plans. Still others developed action plans that their CEOs felt would give an impression of compliance, despite there being no intention to implement the plan. A few months later, the SHA announced that some financial support could be available to support early implementers. This resulted in a few PCTs bringing forward their plans. It was not until the SHA included polyclinic implementation in the PCT CEO annual performance assessment framework that serious action planning took place across all PCTs. Eighteen months later, a change of

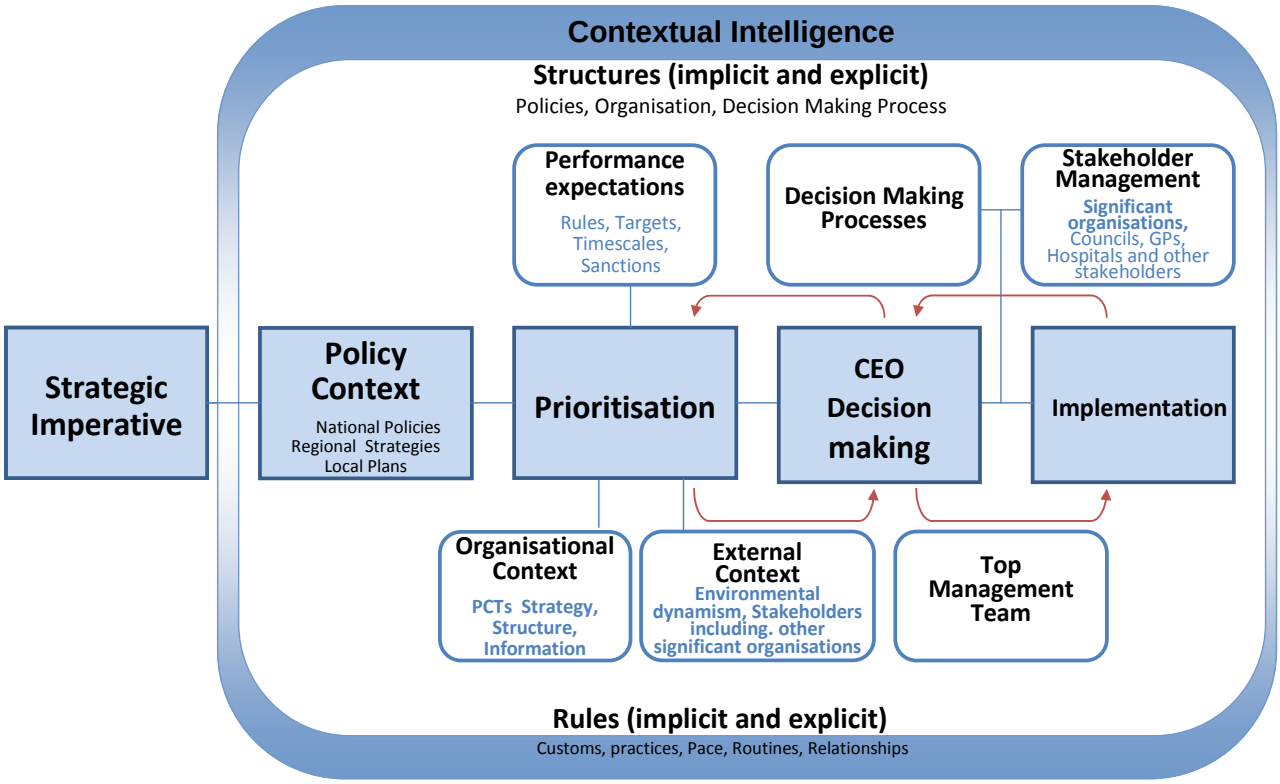
government led to the polyclinic policy losing favour and it was discarded by the SHA, followed quickly by the PCTs.

The above example provides a mini case study of how top down policies are implemented in PCTs and the role of contextual intelligence in guiding PCT CEOs' decision making behaviour. Compared to the literature based Model 1 and the perceived practice in Model 2, what Model 3 shows is that the role of contextual intelligence in PCT CEO decision making is complex, multi-level and is a continuous and iterative process rather than discrete steps leading to a discrete decision and then implementation in a temporal sequence. Unlike the model derived from the literature which drew from studies in the private and public sector, the PCT CEO model of contextual intelligence shows a unitary purpose by the CEOs to focus decision making on policy implementation issues. While this may not come as a surprise, seeing PCTs are part of a national public organisation, what was unexpected was the general acceptance by PCT CEOs to the dual accountability position where the SHA trumps the PCT Board, and the significant amount of CEO time and effort that went into managing relationships upwards.

The empirical research has revealed new insights into how contextual factors influence PCT CEO prioritisation, how the CEOs prioritise (as illustrated by the decision tree) and their decision response regarding implementation. In contrast to the array of potential contextual factors that were identified in Model 1, the research found that only a limited number of contextual factors have impact in practice. These factors are set in a hierarchy. The rainbow model of contextual factors derived from Project 1 is now distinguished by the role they play in prioritising decisions to be taken, how decisions not taken are managed, how different types of decisions are responded to, how they are implemented and what needs to be managed in the implementation context. These intelligences are summarised in Model 3. They include, in the background, structures and rules that can be neither explicit nor transparent, yet have an impact on implementation. Just knowing about contextual factors is not enough. The PCT CEOs also have to know when, and how, to play these contextual factors in.

New and aspirant PCT CEOs may need help in developing the contextual intelligence around how some of the structures and rules operate to improve their personal effectiveness in decision making and to facilitate the smooth implementation of a decision, .

Figure 7 The role of contextual intelligence in PCT CEO decision making in practice



In summary, the main findings of the thesis are

a) The rational model of CEO decision making derived from the literature and the role that contextual intelligence apparently plays is not an accurate reflection of how PCT CEOs make decisions
b) PCT CEO decision making, as perceived by the CEOs themselves, follows a rational model, with contextual intelligence helping to prioritise a limited number of contextual factors. The CEOs while having a more elaborate view of the factors that lead them to prioritise decision making imperatives and differentiate their responses, still maintain a rational perspective on the process and their decision making behaviour

c) In practice, PCT CEOs do not follow a rational pathway when taking decisions; the range of contextual factors actually take into account is less than predicted by the literature but more than the PCT CEOs thought they would take into account, with some of these factors being implicit and not transparent. As decisions in the NHS tend to be of an evolving nature, there may be times when the decision is not to take a decision, to delay taking a decision and to let events run their course, or to give the impression that a decision has been taken but with no implementation plans. This strategy is sometimes used by PCT CEOs and their boards in the hope that, with time, either the policy itself will be super ceded, or the context for taking the decision would have changed and enabling a more amenable decision to be taken. One experienced CEO described the strategy as “running on the spot”. What this means, in effect, is that decisions in the NHS are rarely made and final. Rather there is a continuing process of decision cycling, as new information changes the contextual intelligence informing CEO decision making, which in turn leads to the CEO changing his decision making behaviour.

The findings raise a number of issues for practice. PCT CEOs have to balance the multiple and multi-level interests that are at stake in delivering the national agenda at the same time meeting local population health imperatives. To be effective, they have to appreciate the complexity of the system and to learn to navigate the NHS structures and rules with their varying transparencies, whilst acknowledging that the NHS is a top down driven system in which those at the top will always want to retain a degree of control. According to Harrison et al (1992), such an approach favours a centralised organisation run on hierarchical lines with the headquarters in control through direct command-type instructions to its constituent parts. The commissioning structure of the NHS reflects such a model, with SHAs and PCTs forming integral parts of the one unified organisation held together by uniform regulations and by a master plan developed at or near the top and then promulgated down the hierarchy. A “one size fits all” approach has the benefit of standardisation throughout the entire health system but runs the risk of losing local sensitivity and ownership of the

decision. Not only could it result in PCT CEOs not prioritising the right policies and plans due to their attention being focused on demonstrating compliance over whether the proposed change is needed by or would benefit the local PCT, it could also disenfranchise PCT boards and other stakeholders who may feel disengaged by the loss in local autonomy. Imposing a diktat of questionable relevance for a PCT could create at best a distraction for PCT managers, or at worst, leads to the wrong strategic decisions being taken with adverse impact on the local population health. PCT CEOs are expected to manage the situation of their dual accountabilities to DH and SHA, and to the PCT Board. What it therefore requires of PCT CEO contextual intelligence in the decision making process, where multiple and multi-level interests are at stake in delivering the national agenda and at the same time meeting local population health imperatives, is to appreciate the complexity of the system and to learn to navigate the NHS structures and rules with their varying transparencies. They could then apply this tacit knowledge to optimise the impact of their decisions, whilst acknowledging that top down priorities are likely to take priority.

In the face of inherent conflicts between the local and national agenda, PCT CEOs have to be adept at recognising the decision-relevant contextual factors from the many legitimate factors that in theory could be taken into account. Given the conclusions above about CEO coping behaviours in complex, ambiguous, conflict ridden circumstances, there is a risk of an imbalance in organisational and personal interests and therefore a risk of inappropriate decision–making.

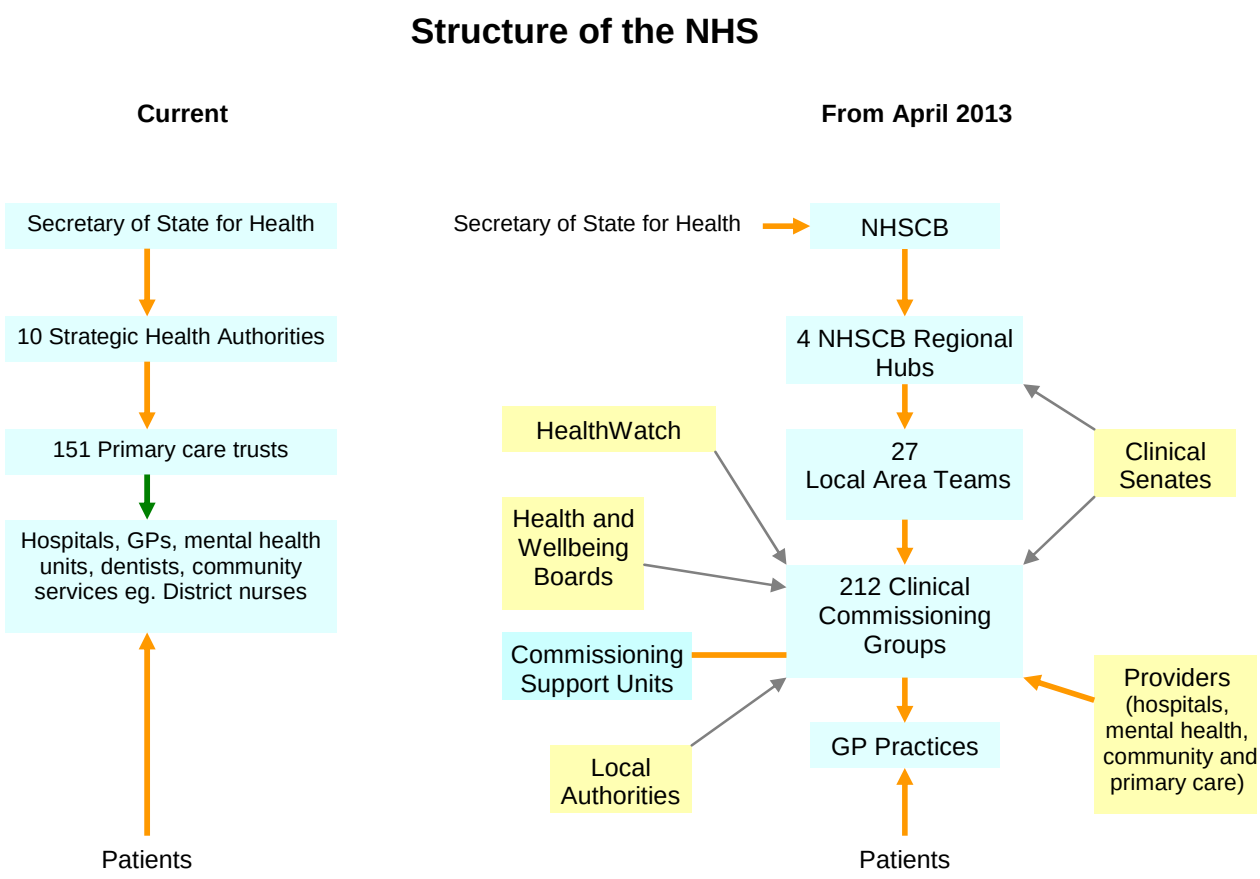
Model 3 extended our understanding of the role of contextual intelligence in PCT CEO decision making by challenging one of the contextual assumptions of Model 2 (that PCT CEO decision making process is linear and in one direction) as it was derived from the findings of actual behaviour rather than espoused behaviour. However it is assumed to hold for PCT CEOs working in the same SHA and DH context. As current changes to the NHS have removed the PCT CEO role as well as changed the structure and roles and responsibilities, this does challenge the underpinning contextual assumptions of Model 3. It is

therefore important to consider the applicability, relevance and implications for the current NHS reorganisation.

4.4 Implications for the current NHS reorganisation

The 2012 Health and Social Care Act is reorganising the NHS commissioning structure with the creation of an independent NHSCB that is separate from the DH, several new NHS bodies, and replacing PCTs with CCGs and CSUs. CCGs will be the new local health authorities replacing PCTs. Figure 8 compares the current and new structure of the NHS from April 2013.

Figure 8 Current and new NHS commissioning structures of the NHS



In examining the new NHS structure, it would appear that the new context comprises at least similar conditions for the new CCG leaders to those which contribute to the PCT CEO decision making behaviour described above. The

rationale for the restructure stems from the government's belief that PCTs are bureaucratic organisations that are too remote from patient care while decision making would be more effectively carried out by GPs who are closer to patients. To support GPs whose membership makes up the CCGs, clusters of CSUs are being set up to provide commissioning support. Both organisations will then be performance managed by the Local Area Teams (LATs). From April 2013, the commissioning budget for secondary care and community services in England will be managed by 212 CCGs. Like their predecessors, CCGs will take on the commissioning responsibility for the health services of patients registered with their constituent practices within a defined geography. But unlike PCTs, CCGs have been given a reduced management allowance and instead of having internal commissioning expertise, are expected to source them from their local CSU. The DH has described CSUs as an interim measure to support the transition of PCTs to CCGs. Altogether, 27 LATs are being established as sub-regional outposts of the four NHSCB regional offices to manage clusters of CCGs and to take the lead role in service reconfigurations, a responsibility currently held by SHAs. LATs are also to be responsible for commissioning primary care and a number of them will also take the lead roles for commissioning specialised services. Finally, the commissioning of public health services will be undertaken by local councils.

The new Act has created not only new layers of bureaucracy but a larger number of new organisations with which CCGs have to interface. This new situation is undoubtedly more complex than the structure it is replacing, with the risks compounded by the need to save £20 billion by 2015. It has been widely commented that the new commissioning structures will centralise power and authority in the NHSCB which has already issued several policies, guidance and toolkits on governance, constitution and remuneration that shadow CCGs have to implement before they can be authorised as CCGs. They include requiring applicants for the top leadership roles in CCGs, CSUs and LATs to undergo a national diagnostic, assessment and developmental process organised by the NHSCB. While the NHSCB (2012) asserted that this was to quality assure the process and to give prospective candidates the opportunity to

access development support ahead of their organisations taking up their formal responsibilities in April 2013, it could be argued that the selection process itself was reinforcing the status quo.

4.5 Implications for CCG AOs

As one of the goals of the restructure is to improve the quality of decision making, it is unclear why CCGs should be better in this regards than PCTs. Admittedly it is early days, but there is no reason why the same lessons and insights gleaned from this research that apply to PCT CEOs would not apply to CCG Accountable Officers (AOs). The situations that will be faced by the new AOs in decision making are likely to be at least equivalent to that experienced by PCT CEOs due to the CCGs' position as the local health authority. In terms of contextual intelligence, CCGs will still have to implement national and regional policies while responding to the health priorities in their constituency. They will also have to achieve the performance expectations set out in those policies as well as meet existing national standards and regulations. The cap placed by DH on management costs has resulted in CCGs having a simpler organisational internal structure compared to PCTs. The CCGs will therefore have to work with and achieve through CSUs, making the decision making processes potentially more complex. For the AO, it could also mean a virtual TMT that straddles two organisations. As with PCTs, the local external contexts will continue to provide CCGs with additional boundaries for prioritisation, as stakeholders, in particular, the other significant organisations including the LATs, are likely to want to have a say on decision making and implementation at the local level and will have to be managed accordingly. All of these changes increase the complexity of the new situation, suggesting there is at least the likelihood that there will still be the range of explicit and implicit rules and structures that influence AO decision making behaviours.

The situation clearly demonstrate that the context facing the new AO has sufficient equivalence to the PCT CEO role and that the new NHS context shares the critical features of its predecessor that prompted the "coping" behaviours to warrant examining what could be learned by the application of it

to the AO role. If anything, the new structure is more complex, has more layers, more relationships are involved, policy contexts are more complicated and still emerging – all contributing to a more complex decision making context. What this means for the AO role is that the role of contextual intelligence in decision making becomes even more critical. As the AO steers her CCG through the complexity of the new system, she has to balance central demands with local sensitivity, aligning top down policies and local strategies while taking into account both the organisational internal and local external contexts, engaging and managing key stakeholders, notably from other significant organisations, in delivering the expected performance, ensuring that decision making processes are robust and inclusive, and working with her TMT to implement the agreed decisions. To help her navigation, the AO has to be aware of how the relevant structures and rules work in practice. If we were to use Model 3 to analyse the decision making pathway from the perspective of the CCG AO in place of the PCT CEO, then it is apparent that each of the elements in the model is relevant to the new CCGs, except that the decision making context itself is more complex as well as unclear. While "performance expectations", "organisational internal context" and "external local context" will remain critical contextual factors, the main differences in the model are

a) More complex and tenuous decision making processes arising from the additional layers of the hierarchy and the need to involve many more organisations, not least all of the constituent GP practices in each CCG.
b) More complex and challenging stakeholder management as a CCG will have to relate to a much larger number of "other significant organisations" including the newly created CSUs, LATs and NHSCB (replacing SHAs), Health and Wellbeing Boards, the Local Education and Training Board (LETB), Public Health England and Health Watch.
c) Instead of every member of the Top Management Team (TMT) being located within the CCG, the TMT will have to form virtual teams with CSU staff who will be acting as CCG agents. They will also have to be much more involved in the decision making process

d) Responsibility for implementation of commissioning intentions will sit with another body, the CSU, thus interrupting the seemingly important process of decision-making adjustment
e) An increase in the complexity of the structures and rules due to the compounded effects of the additional layers and players in the NHS organisational structure, with areas that are implicit and not transparent causing confusion and delay in decision making.

There will still be a focal point for national, regional and local policy decision making which needs to be taken at the CCG level. The job descriptions and person specifications for CCG AOs have similar requirements as those for PCT CEOs, despite the job title and pay reflecting the lower status of CCGs in the new organisational hierarchy, which may make it more difficult for AOs to navigate the new system. It is inevitable that in any transition period, there will be more complexity and more uncertainly, as structures are still emerging and the rules are still changing. The situation replicates and exaggerates the complexity issues as the entire system becomes unstable due to changes in leadership and personnel, new ways of working, new individual identities and roles, and loss of previous relationships and organisational memory. These complexity issues could give rise to adverse decision making behaviours such as delays in taking decisions, delays in taking actions, more (rather than less) central control, drop in performance due a lack of focus, and staff disengagement and poor morale leading to underperformance. In placing the AO within the CCG and giving them the same critical responsibility as the CEO had in the PCT, we can make tentative predictions on the situations that could arise and their coping behaviour. Reflecting on how PCT CEOs deal with complexity, we can expect bounded rationality as the AOs simplify and prioritise competing contextual intelligence; get political, and delay making decisions. Sometimes it is about being seen to make decisions (than about the decision itself). They are also likely to continually negotiate and to focus their attention on meeting national performance targets, managing upwards to the LATs and NHSCB, and outwards with CSUs, GPs and other stakeholders, building a strong TMT and seeking out and responding to the contextual intelligence on

structures and rules as they evolve. While the model is evolving, predictions can only be tentative, but this is the coping behaviour that could ensure the AO is able to maintain the momentum of progress to date and not let them unravel. As such “coping” behaviours are likely to impact adversely on decision quality, timeliness and implementation, what needs to be avoided is a one size fits all approach form the NHSCB and further centralization of power and decision making. Instead, what is needed at the CCG level is to anticipate decision making issues and to take pre-emptive actions in the form of better understanding of the structures and rules underpinning the contextual factors in order to enhance decision effectiveness.

The implications for the new commissioning structure are the need to create as much clarity as possible about each of the elements in Model 3, and in particular about the rules and structures. While some of these will remain the same as before the reforms were implemented, others will be different. In the short term, everybody will have to learn afresh about the new implicit features such as where the power bases are located. Longer term, the AOs’ context will change, making it more imperative for the players to understand the nuances of the underlying factors. Given the imperative of delivering the challenging national health agenda and policy for improving clinical leadership and engagement of stakeholders at the grass root level, the development of CCG AOs would importantly include learning about the underpinning rules and structures in the NHS, both to improve their personal effectiveness, and the performance of their CCGs. It is clear that, despite the rhetoric of “Liberating the NHS” (DH, 2010), this analysis finds that the factors which comprise critical contextual intelligence that heavily influences key decision makers are still present. In addition, the system is more complex. It is likely therefore that the new organisational arrangements could well serve to increase the difficulty of appropriate decision making, making it more important than ever that the new CCG leaders understand and develop their contextual intelligence in decision making.

5 LIMITATIONS OF THE STUDY AND AREAS FOR FUTURE RESEARCH

5.1 Study limitations

The systematic review of published evidence on the whole reported positive findings, based on quantitative methods or structured interviews, which could have missed out on thick descriptions of theories in use. he peer status of the interviewer in Project 2's structured interviews despite risk avoidance measures may have constrained participant openness and honesty. .

Project 3 used diary analysis and an interpretive analysis of interview transcripts relating to an away day event. As the accounts are retrospective, they depended on good participant recall and could suffer from the same constraints as Project 2.

In participant observation there is always a concern in field work that the researcher "goes native". To minimise any potential bias, I was conscious of my own frame of reference throughout, and intentionally took a dispassionate view of events as a researcher (Gill and Johnson, 2002).

5.2 Areas for further research

This research study prompts several potential areas for potentially productive research.

a) The research concluded with a derived model of the informal / formal, explicit/implicit structure and rules that govern CEO decision-making behaviour. The next step in developing this model would be to explore it with members of the study population to clarify and elaborate understanding of the mechanisms in practice.
b) This study focussed on PCT CEOs whose function defined a specific arena of strategic decisions. Using similar methodology, with another population of NHS CEOs leading different types of NHS organisations, for example NHS Trusts or NHS Foundation Trusts, would potentially be both theoretically valuable as well as of increasing practical importance and relevance as in contrast to PCTs who were commissioners of health

services, NHS Trusts are providers, so are likely to have a different conception of the operating context. And it is where the balance of top down and local considerations is explicitly undergoing change. An appreciation of different relevant factors, the rules and structures and the extent to which Foundation Trust CEOs (and their staff) recognise these in practice may be critical to success.

c) The 2012 Health Act is introducing new NHS organisations to replace PCTs and SHAs. While it would be interesting to study how they work and how contextual intelligence might apply at this stage I can only speculate on the implications for AOs and CCGs as it is still very early days in the formation of the NHSCB, CCGs, CSS and LATs for them to be the focus of study. What is clear is that the NHS landscape has become more crowded with new players and new rules being introduced, which make the role of contextual intelligence in decision makers more relevant than ever. It would be worthwhile in due course (say, two years), to explore how the model applies in the context of the new NHS senior leadership decision-making roles.

d) As Project 2 demonstrates NHS sector specific contextual intelligence factors and Project 3 some institutional specific contextual factors, the insights and methods can be applied to derive a contextual intelligence model for CEOs of other public or not for profit organisations. Equally as sector contexts appear to be important, CEOs from different industry sectors could provide a more informative basis on which to define sector specific contextual intelligence requirements.

e) Specific findings emerging from this study which warrant further investigations includes

   - The salience of the CEO advisor as a commonly cited factor in CEO decision-making raises a number of questions about their strategic role, In an increasingly complex decision-making environment, it would be useful to understand how context affects the use of formal versus informal advisory systems and how advisors are selected and used

- Explore the productivity of engaging patients and service users in strategic planning. In this study patients and service users featured low down in factors taken account of by PCT CEOs decision-making both in theory and in practice. Not only is this surprising against the policy backdrop of patient–led NHS in place at the time of this research but if these decision-making behaviours are sustained by the factors identified here then they pose a challenge for the strategic direction of a patient centred NHS and the principle of “no decision about me without me” promoted by the Secretary of State in the “Equity and Excellence” White Paper (Lansley, 2010). A potential research question to be addressed in the future is the impact of involving patients in the strategic decision making process and whether they lead to a change in CEO decision making behaviour.

6 PERSONAL REFLECTIONS

The executive doctorate has been an eye opening experience for me into the world of research and academia. From a research skills point of view, I have learnt about research methods and how to conduct primary research. My conceptual thinking skills have also developed which have improved my ability to communicate clearly, succinctly and precisely, orally and in writing. It has been a very long journey that has been attenuated by changes in employment and roles at work, during which time I have also developed as an executive and been appointed as a CEO. The 2012 Health and Social Care Act is implementing further changes to the NHS landscape, making the contribution of contextual intelligence to CEO competency development more important than ever.

Appendix A

Chronology of DBA journey as a result of work pressures and demands

Year	Job situation	DBA process
2004-05	SHA Director of Performance	Project 1 scoping study
2005-06	SHA executive restructure led to role change	Project 1 systematic review Delay due to learning new job
2006-07	SHA reconfigurations led to redundancy	Project 1 completed Delay due to job insecurity
2007-08	Interim and then substantive CEO of a failed PCT	Project 2 started Suspension (8 months) June – Jan due to work pressures
2008-09	CEO of PCT in turnaround	Project 2 and Project 3 data collection Suspension (6 months) Jan 09-July 10 due to work pressures
2009-10	CEO of PCT in recovery	Project 2 completed
2010-11	PCT reconfigurations led to redundancy	Project 3 completed Suspension (6 months) June-Nov due to job insecurity
2011-12	CEO of NHS Trust	Linking Document completed DBA submission (extension of thesis handing in date)

CRANFIELD UNIVERSITY

SCHOOL OF MANAGEMENT
DOCTOR OF BUSINESS ADMINISTRATION

DBA

Academic Year 2005 - 2006

YI MIEN KOH

PROJECT 1:
CONTEXTUAL INTELLIGENCE: A SYSTEMATIC LITERATURE REVIEW OF UNDERLYING CONCEPTS AND THEORIES

Supervisor: DR CATHERINE BAILEY
JUNE 2006

This thesis is submitted in partial fulfilment of the requirements for the degree of DBA

7 INTRODUCTION

Project 1 is the initial project of three designed to address the overarching question of how contextual intelligence influences Primary Care Trust (PCT) CEO strategic decision making in the English National Health Service (NHS). The question arose following widespread concerns expressed by senior leaders in both the NHS and Department of Health (DH) about the high turnover of Chief Executive Officers (CEOs) in the service.

At the time of study, I was working as Director of Performance at a Strategic Health Authority (SHA), the intermediate tier between the DH and PCTs and NHS Trusts, and was responsible for managing the performance of 18 NHS organisations within the SHA area. I had read *In Their Time – the greatest business leaders of the twentieth century* by Mayo and Nohria (2005) who use the term *contextual intelligence* to describe executives who took account of macro level contextual factors in strategic decision making. I was interested in exploring the concept's applicability to CEOs operating in the NHS for reasons of CEO performance development, not least because I also aspired to forge a career leading NHS organisations.

The rest of this report goes on to, one, explain why contextual intelligence is worthy of research and what are its features; two, describe what is involved in a systematic literature review and how the process was carried out in this research; three, present the results in a systematic way that enables the findings to be synthesised; four, discuss the findings to build theories and, finally, allow conclusions to be drawn. On the basis of the evidence, a literature based model of contextual intelligence is proposed.

7.1 Context matters for organisational performance

Today's organisational leaders have to deal with increasing complexity in a dynamic environment where success is dependent on how they adapt to continually changing contexts. As managers carry out their role, the one thing of which they can be sure is that things will change. The "nothing endures but change" wisdom from Heraclitus, a Greek philosopher from 535-475 BC, implies

that leaders need to understand, diagnose, and respond to their changing contexts to remain effective. This assertion challenges the conventional views of organisational leadership which have so far largely focused on personal qualities and what leaders do, over why they do what they do, or how they formulate strategic intent.

Much of the research into leader behaviour and contexts has been in large US corporations. Miles et al., 1978; Porter, 1980 and 1985). A key study from Lieberson and O'Connor (1972) on organisational and environmental constraints and leader influence found non leadership factors to account for the vast majority of performance variations. Similar findings were reported by Salancik and Pfeffer (1977) when they looked at mayoral effects on city budgets. Samuelson, Galbraith and McGuire (1985) found changing CEOs did not significantly affect firm performance, although new CEOs tend to be more risk averse. In an extension of Leiberson and O'Connor's work, Weiner and Mahoney (1981) modelled corporate performance as a function of environmental, organisational and leadership influences and concluded that situational factors affect organisational performance, and the independent impact of individual leadership on performance is not more than 15%.

From these studies, it can be surmised that contextual factors have some impact on organisational performance, as, in each case, the vast majority of performance variation was accounted for by non-leadership factors.

7.2 . Relationship between leader and context

Evidence of senior leaders needing to understand and take into account context in strategic decision making to ensure organisational health and survival include, at the extreme, major world events such as the wars in Iraq and Afghanistan where not just lawyers and commentators but governments are scrutinising decisions made by presidents and prime ministers. In that sense, the normative organisations are no different.

The perspective on leader-context relationship is rooted in the work of organisational contingency theory. The organisational contingency framework

(Burns & Stalker, 1994; Lawrence & Lorsch, 1967; Miles, Snow, Meyer, & Coleman, 1978) was first introduced in the late 1950s and early 1960s in response to interests in the concept of the environment in organisational relations. Prior to this, a closed systems view of organisations was predominant, especially in classical management theory where organisations were treated as if their internal operations were the sole concerns of management. Once the idea that organisations are open to their environments was established by the systems theorists (Bertalanffy, 1972; Boulding, 1956)(Boulding, 1956), the concept further developed over the next few decades and now, the environment is assumed to be influential.

The organisational contingency approach has two sub-schools – the deterministic and the strategic choice thinkers. Deterministic researchers were the early contingency researchers. Woodward (1965), Thompson (Thompson, 1967b)(1967a) and Perrow (1967) focused on technological determinism while Lawrence and Lorsch (1967) studied environmental determinism. By the 1970s, the later contingency researchers were proposing that it is managers who create and shape the environments to which their organisations adapt. The environmental strategic choice perspective holds that managers' perceptions of their organisations' environments are the basis for their decisions (Miles et al., 1978). While some environmental factors will be included, perception theory states that others will be filtered out and ignored (Tyler and Steensma, 1998; Kassinis and Panayiotou, 2006). Hence exactly the same environment may be perceived differently by two managers depending on how they make sense of their contexts, which would then influence their decisions on everything from organisational design to developing their firm's strategy and process. Managers thus *enact*, rather than react to, their environments. That is, they change them, rather than are changed by them (Weick, 1979). So, over a 40 year period, the preferred managerial model shifted from that of a reactive actor into a proactive sensemaker.

With the strategic choice theory gathering momentum, Salancik and Pfeffer (1977) advise managers to pay more attention to identifying the critical

contingencies of their environments, which they see as determining most of the structure affecting organisational outcomes and problems. In order to manage the environment, managers should systematically construct an accurate contextual model that would also deal with the changing contingencies. It follows that organisational leaders need to be able to "diagnose" the organisational context in which they are working before they could decide on the "best fit" response. Miles et al. (1978) believe that such strategic decisions will be directed at maintaining the organisation's alignment with its environment as well as managing its major internal interdependencies, arguing that organisational behaviour is only partially pre-ordained by environmental conditions and that the choices top managers make follow a general model of the adaptive process, which determine the strategic typology of their organisations.

Accordingly, it is important to understand how organisational leaders such as CEOs make sense of the factors or variables that lend themselves to a contextual diagnosis, and use this knowledge to inform their strategic decision making. It is the ability to understand and diagnose one's changing contexts and take appropriate strategic decisions that I am choosing to call "contextual intelligence".

7.3 Conceptualising contextual intelligence

Context sets the milieu within which a CEO operates. According to Jenkins (1998), to be an effective operator requires having reasons and acting intentionally, which is the character of intelligence. Therefore a simple construct of contextual intelligence would imply being mindful of the different dimensions of context and deciding on appropriate actions.

The processes comprising intelligence are guided by individual cognitive structures variously known as assumptions, mental models (Johnson-Laird, 1983), schematas (Harris, 1994) and belief structures (Walsh, Henderson, & Deighton, 1988) which facilitate and influence action by filtering incoming information as well as being the radar for sensing relevant information in the environment. It is recognised that their mental representations are subject to the

influence of collective mindsets such as industry recipes (Spender, 1989) and dominant logic, which have been defined as the “mindset or world view of the business and the administrative tools to accomplish goals and make decisions” which is stored as “a shared cognitive map (or set of schemas) among the dominant coalition” (Prahalad & Bettis, 1986).

Attempts to understand how things happen have used cognitive mapping to provide the missing link between environmental conditions and strategic action (Huff, 1990; Jenkins, 1998; Stubbart, 1989) but it is still unclear why some leaders choose to consider certain elements of context and not others in their decision making processes and what factors influence their strategic choices. To understand what may constitute contextual intelligence necessitates understanding the different types of context.

That context is relevant to cognition has been proposed by Pettigrew (1990) and Suchman (1987). Elsbach et al. (2005) use the term “situated cognition” to describe the interaction of cognitive schemas and contexts. According to Gronhaug and Falkenberg (1998), people come to understand their internal and external environment by making inferences about causes, as well as learning cause-effect (consequence) paths, with such paths becoming the knowledge structures that would facilitate future attributions. Weick (1995) calls this cognitive process sensemaking, which consists of a series of activities grounded in both cognition and context. More recently, Mayo and Nohria (2005), in a retrospective review, describe contextual intelligence as the key determinant of great business leaders and argue that, although CEOs often face the same contextual factors, it is their individual adaptive capacity that will be pivotal to their overall success.

In order to understand what contextual intelligence is and how it could be developed, two questions need answering:

- What are the features of contextual intelligence?
- What are the mental processes of contextual intelligence?

7.4 Features of contextual intelligence

Despite numerous studies on how leaders have coped with or taken advantage of the key contingencies facing their organisations (Pfeffer & Salancik, 1977a; Pettigrew, 1987; Mayo & Nohria, 2005; Pettigrew, 1987; Mayo & Nohria, 2005), the processes underlying how CEOs make sense of and respond to their environments are not well understood. Sternberg (1988) uses the term "contextual intelligence" to describe a set of three behavioural qualities: one, the ability to adapt to one's environment; two, instead of adapting, choosing to shape or modify the environment in order to increase the fit; and three, to select one's environment by exercising choice in strategic decision making.

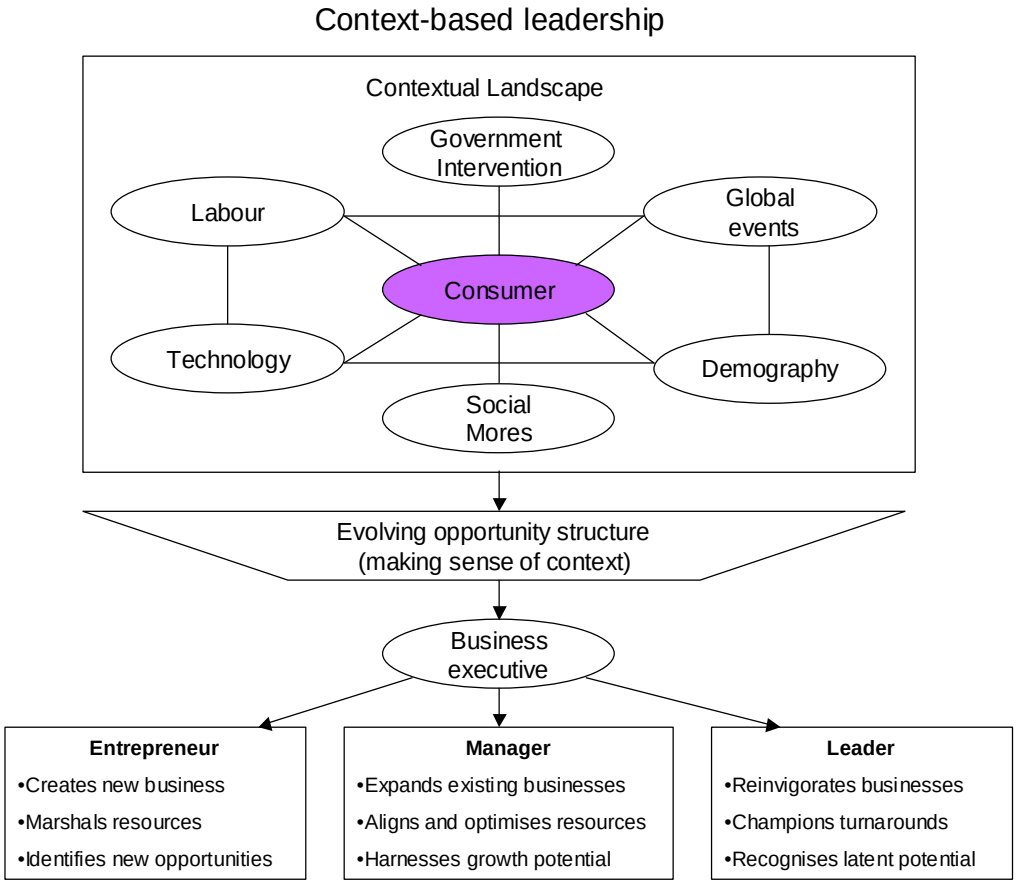
While both researchers and practitioners have moved towards a more rounded approach in contextual analysis in terms of levels of analysis (ranging from intra-organisational level, through to sector, broad economic and political context levels) and degree of complexity (Pettigrew, Woodman, & Cameron, 2001), the elements of contextual intelligence are not clear from the literature. Sternberg (2003) believes leaders need to be able to retrieve information that is relevant to leadership decisions and to analyse and evaluate different courses of action, so abilities to recall, recognize, analyse, evaluate and judge information are particularly important. For Mayo and Nohria (2005) the ability to identify, understand and adapt to different situational contexts, so called adaptive capacity, will be pivotal to a CEO's overall success. So a construct of contextual intelligence needs to include elements of contextual variables that are both non-linear and multi-levelled and a sequence of information processing activities that makes up the sensemaking pathway.

7.5 Process of contextual intelligence

A contextual intelligence process would consist of sequences of events, actions, and activities unfolding over time to enable an individual to make sense of the changing contexts and to take strategic decisions. An example of such an approach is used by Mayo and Nohria (2005) in their retrospective study of 1000 successful US business executives selected on the basis of financial performance and/or they have led a business or service that changed the way

Americans lived, worked or interacted in the twentieth century. When they analysed the reasons for the CEOs' success, six factors - government intervention, global events, demography, social mores, technology, and labour – were found to be especially influential. Mayo and Nohria used the term "contextual intelligence" to describe the manner in which the executives were sensitive to macro-level contextual factors in the creation, growth or transformation of their business. Their model of context-based leadership is shown in Figure 9.

Figure 9 Contextual model of leadership (Mayo and Nohria, 2005)



In the model, contextual factors are set out in the top box titled "contextual landscape". The consumer is placed at the centre as the authors believe that the consumer is often the focus of the effects of the other six contextual factors.

Government intervention in the forms of regulation and protection would influence the degree of autonomy that a CEO could exert. Globalisation could be either threats or opportunities and the ability of CEOs to adapt and optimize global events had significant consequences for their businesses' sustainable performance. Population demographic changes influenced both the marketing of products and services as well as the management of the workforce. While consumers shaped and were shaped by the social mores of their time, due to their cyclical nature, Mayo and Nohria regard the interpretation of this contextual factor as requiring the greatest amount of adaptability and flexibility on the part of business executives. As increasingly sophisticated consumers became pivotal to the acceptance or rejection of new forms of technology, it often requires a CEO who can understand and then fulfil the potential of a specific technology. Finally, as the workforce experienced cycles of progress and redundancy tied to the country's overall levels of economic prosperity, CEOs who invested in employee development were proactively managing this contextual factor as a source of human capital.

The trapezium in the middle, labelled "evolving opportunity structure", refers to the executive sensemaking process which leads subsequently to business strategy. Mayo and Nohria classify the business executives they studied into three archetypes (bottom three boxes): entrepreneur, manager and leader, based on their approaches to context. They emphasized that executives must be keenly attuned to the macro context of the times to be successful, and that contextual intelligence plays a critical role in building and shaping lasting business success.

From their analysis, Mayo and Nohria (2005) draw the following conclusions:

1. Context matters, and in contrast to the "great man" theory, long term success is derived not from the sheer force of an individual's personality and character but is related to sensitivity to context.
2. Leaders need to consider the temporal context in terms of life-cycle stage of the company or industry and choose approaches that are most aligned with their strengths and capabilities.

3. To be successful in the long term, the leader must possess the flexibility and courage to change direction when the environment changes, which requires both an awareness of the changing landscape and the ability to adapt with it.
4. Success in one time and in one place does not necessarily translate to success in another time and in another context. When recruiting CEOs, boards are advised to focus on the individual's unique ability to identify, understand and adapt to different situational contexts.
5. Individuals considering career choices should align their personal strengths and preferences with the life-cycle stage and context of their potential employer.
6. Enhancing contextual intelligence means becoming a "first rate noticer": Mayo and Nohria advise individuals to not only develop an awareness of context but also possess the ability and desire to act on that awareness.

Mayo and Nohria's (2005) model provides a useful starting point for analysing contextual intelligence and its impact for a number of reasons. First, it connects contextual intelligence with organisational and personal success, thereby linking CEO sensemaking of context and organisational outcomes. Second, the model uses the contextual intelligence concept to link context and firm performance. Mayo and Nohria were able to show that the business strategy of successful firms matches the prevailing contextual landscape. Third, the model identifies and explains the macro-economic dimensions of context, namely government interventions, labour, technology, social mores, population demography and global events, and their impacts on business strategy. It also links contextual factors to each other and to a focal point - the consumer – thereby presenting different perspectives on the competitive landscapes. Fourth, it offers a systematic way of describing the macro-economic context. And fifth, it usefully conceives of an iterative, evolving and dynamic sensemaking and decision making process.

Nevertheless, the model has a number of limitations. One, the contextual landscape of six macro dimensions does not cover the full range of contextual features. The model neither took into consideration intra-organisational factors,

nor, for that matter, the local environmental context. Two, the model does not adequately address or expand the contextual intelligence process beyond summarising it as the “evolving opportunity structure”. Three, Mayo and Nohria had neither measured nor evaluated the CEOs’ contextual intelligence as defined by their own model. Four, the model assigned the 1000 business leaders into one of three types based on how their actions were perceived and interpreted by the authors. While a typology could be useful, the case definition for each type was unclear. Five, it was Mayo and Nohria’s own interpretation that the business leaders had intentionally taken advantage of contextual opportunities without considering that successes could be down to luck or chance. Six, as the data were based on available secondary source information about their subjects as well as general knowledge about the historical context, it was difficult to correlate particular CEO decisions to specific organisational outcomes to demonstrate how contextual intelligence affected organisational performance. And finally, the focus on success stories further limits the model’s explanatory value.

Despite the criticisms, Mayo and Nohria’s thesis is still a valuable contribution to contingency theory of leadership as it diverts attention from general leader qualities or behaviours to the interactions between environmental factors and conditions under which the leader operates. Unlike previous contingency theories which focus on more immediate conditions such as the nature of the task or characteristics of the followers, the emphasis here is on the constraints and opportunities faced by the organisational leader, the importance of contextual intelligence and adaptive capacity. It highlights the importance of leader sensitivity to context and their ability to adapt strategically.

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7.6 Purpose of the systematic review

What is missing from the knowledge so far is an understanding of the components of the relationship between context and the organisational leader. The systematic review set out to examine the different ways CEOs conceive of their contexts and how this sensemaking process influences how they make decisions. By deconstructing contextual intelligence, the systematic review is designed to lay bare prior concepts, including how they are defined, observed and analysed, and critically examine the underlying theoretical models. It is unclear what role context plays in influencing CEO strategic decision making,

and whether a CEO's contextual intelligence impacts on organisational performance.

As an executive whose daily activities involve monitoring the performance of NHS organisations and supporting CEOs and their top management teams to improve performance, my personal observations of NHS CEOs are that they differ in their consideration of contexts in strategic decision making and actions. The systematic review will therefore concentrate in part on establishing whether any such models have been used or written about before and, if so, what models have been used and how useful they have proved to be. It aims to clarify each of the important concepts associated with contextual intelligence, their sub-components, structure, how they relate to each other and any specific evidence in the NHS context.

Based on the above aims, the systematic review will explore the following questions:

a) What are the key dimensions or aspects of context that a CEO needs to consider?
b) What are the key dimensions or aspects of context in relation to a CEO of an NHS trust?
c) What is the process of executive sensemaking and how can it be captured?
d) What is the relationship between context, sensemaking and decision making?
e) What is the research evidence that contextual intelligence impacts on organisational performance?

8 METHODOLOGY

8.1 Overview

This chapter sets out the systematic review protocol used for the review. A systematic review aims to produce a comprehensive and replicable analysis and synthesis of the available evidence, to enable summary conclusions to be drawn and gaps identified for future research.

8.2 Conducting a systematic search

8.2.1 The review panel

A review panel was formed to advise the review process at each stage of its development. Members of the panel are set out in Table 1 below.

Table 1 Membership of systematic review panel

Person	Title/Organisation	Role in the review
Dr Catherine Bailey	Director, Cranfield General Management Programmes	Supervisor
Prof. Kim James	Director, DBA programme, Cranfield SOM	Review panel chair
Nina Bhatia	Partner, McKinsey's	Practitioner (external)
Dr David Denyer	Senior Research Fellow, Cranfield SOM	Advisor of systematic review method
Heather Woodfield	Information Specialist, Cranfield Library	Advisor for literature search process

I also took advice from two external academics: Professor Andrew Pettigrew, Dean and Head of Management School of University of Bath and an expert on contextual analysis; and Professor Anne Huff, Visiting Professor at Cranfield University and the Institute for Information, Organisation Management, Technische Universitat Munchen.

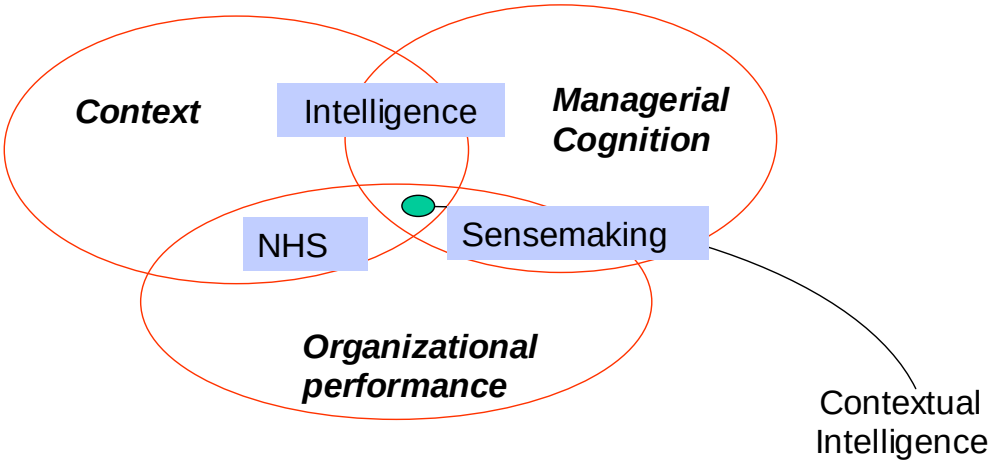
8.2.2 Search strategy

8.2.2.1 Mapping the fields

To develop the contextual intelligence construct requires an understanding of the key concepts underlying context and sensemaking as well as knowledge of the connection between these concepts and organisational outcomes (performance). A systematic review verifies the existence of a potential gap in the management literature identified during the scoping study and specifies the depth to which I would go. As the research focus is on how CEOs make sense of their context and if and how that affects how they make strategic decisions, the systematic review will cover what is published in the scholarly literature about the concepts and sub-components of context, sensemaking, managerial cognition, action and organisational outcomes. It will also include any relevant evidence about the NHS context from published reports and practitioner literature.

The scoping study identified the following search fields (see Figure 10). Intelligence was located at the intersection of context and managerial cognition as the aim was to gather evidence concerning primarily CEOs that approaches intelligence as per its original Latin verb *intelligere* which means to “pick out” or discern, and is also the medieval term for understanding, rather than as a purely cognitive function. Similarly, sensemaking is located at the intersection of cognition and organisational performance, as Mayo and Nohria regard the making sense of context by the senior leader as a contributor to organisational performance. In the case of the NHS at the intersection of context and organisational performance, I was looking for NHS specific evidence where there is a relationship between context and organisational performance. Where all of the search fields overlap, they contribute to make up the contextual intelligence construct.

Figure 10 Mapping the fields



8.2.2.2 Key words and search strings

The aim is to generate as comprehensive a list as possible of primary studies, both published and unpublished, which may be suitable for answering the questions posed in paragraph 1.6. As the development of a search strategy is an iterative process, one attempt will rarely produce the final strategy. The initial searches conducted for the scoping study helped to identify the literature gap and provided key words for the search strings. As part of the systematic review process, I carried out numerous searches, discussed the results of the searches with my supervisor and other academic advisors on the panel, as well as consulted experts in the field to ensure that all relevant search items are covered. The keywords and their variants capturing essential concepts with which to conduct the review are listed in Table 2.

Table 2 Keywords and phrases used in systematic review

Chief executive officers (chief execute* or CEO*) or executive*	Managerial cognition (or percep* or belief* or knowledge* or recogni* or insigh*)	Mental or cognitive representation (mental represen* or model* or schem* or frame or recipe* or mindset*)
Strategic capabilities or management	Context (context* or environmen* or situation)	Decision making

Intelligence or information processing	Environmental scanning	Strategic choice
Organisation (organis* or firm)	Performance (perform* or effective* or failure)	Sensemaking
Performance	Managerial behaviour or behav* or act*	National Health Service or NHS

The following search strings were used in the systematic review (Table 3):

Table 3 Search strings used in systematic review

string	Key words
S1	Chief executive* (or CEO*) OR executive* AND Managerial cognition (or percep* or belief* or knowledge* or recogni* or insight) OR Mental representation (mental represen* or model* or schem* or frame or recipe* or mindset*)
S2	Chief executive* (or CEO*) OR executive* AND Sensemaking
S3	Chief executive* (or CEO*) AND Context (context* or environmen* or situation) AND Intelligence
S4	Chief executive* (or CEO*) AND Intelligence
S5	Chief executive* (or CEO*) AND Context (context* or environmen* or situation) AND information processing
S6	Chief executive* (or CEO*) OR executive* AND Decision making
S7	Chief executive* (or CEO*) OR executive* AND Strategic choice
S8	Chief executive* (or CEO*) OR executive* AND Behaviour (behav* or act*) AND performance
S9	Managerial cognition (or percep* or belief* or knowledge* or recogni* or insigh*) AND Organisation (organis* or firm) AND Performance (perform* or effective* or failure)
S10	Context (context* or environmen* or situation) AND Environmental scanning
S11	Managerial cognition (or percep* or belief* or knowledge* or recogni* or insigh*) AND Performance (perform* or effective* or failure)
S12	Strategic capabilities or management AND Decision making OR Strategic choice
S13	Strategic decision making AND performance (perform* or effective*

	or failure) AND CEO*
S14	Information processing AND performance (perform* or effective* or failure)
S15	Sensemaking
S16	Environmental scanning AND Performance (perform* or effective* or failure)
S17	Mental representation (mental represen* or model* or schem* or frame or recipe* or mindset*) AND CEO*
S18	Chief executive* (or CEO*) AND National Health Service or NHS

In addition to key words, I also searched key authors, to ensure that important publications were not overlooked. Secondary references cited in primary papers were also searched.

8.2.2.3 Databases

To achieve the aims of the review, I had to balance sensitivity (ability to identify relevant articles) against specificity (ability to exclude irrelevant articles). Two electronic databases were used as the main search engines, namely, Abi Proquest and EBSCO (see Table 4 and Table 5), although, because there was significant overlap in the journals between the two databases, Proquest was used as the principal search engine with backup from EBSCO. This strategy proved to be helpful, especially when following up secondary references or searching for older papers, as Proquest tends to hold more recent literature. The search for most of the older (pre mid-1980s) literature took place using EBSCO, which holds more full text documents. The search process was iterative, based on subject, title and abstract of scholarly journals and dates.

Table 4 Systematic review using search strings with Proquest search engine

Search strings	Database	Timeframe	Number of hits	Number relevant
S1	Abi-Proquest	All dates	142	21
S2	Abi-Proquest	All dates	5	1
S3	Abi-Proquest	All dates	150	10

S4	Abi-Proquest	All dates	30	2
S5	Abi-Proquest	All dates	21	6
S6	Abi-Proquest	All dates	99	15
S7	Abi-Proquest	All dates	21	6
S8	Abi-Proquest	All dates	16	6
S9	Abi-Proquest	All dates	4	2
S10	Abi-Proquest	All dates	18	4
S11	Abi-Proquest	All dates	15	6
S12	Abi-Proquest	All dates	6	1
S13	Abi-Proquest	All dates	24	4
S14	Abi-Proquest	All dates	53	5
S15	Abi-Proquest	All dates	165	33
S16	Abi-Proquest	All dates	52	8
S17	Abi-Proquest	All dates	156	20
S18	Abi-Proquest	All dates	44	4
Total			1021	154

Table 4 summarises the number of journal articles identified from using Proquest as a search engine. The most productive strings were S1 (CEO or executive cognition), S3 (CEO, context and intelligence), S6 (executive decision making), S15 (sensemaking) and S17 (CEO mental representations). This reveals that research in these areas had largely focused on cognitive processes and intelligence as a psychological function.

Similar patterns were found with EBSCO, as shown in Table 5, with search strings S1 (CEO or executive cognition) and S15 (sensemaking) being most productive, followed by S6 (executive decision making) and S17 (CEO mental representations). Of significance with both search engines were the low returns for search strings S2 (CEO intelligence), S12 (strategic capabilities and decision making) and S18 (CEOs operating in the NHS) showing gaps in evidence. The search string S15 (sensemaking) drew many papers that were theoretical and non specific to context.

Table 5 Systematic review using search strings with EBSCO search engine

Search strings	Database	Timeframe	Number of hits	Number relevant
S1	EBSCO	All dates	222	35
S2	EBSCO	All dates	32	6
S3	EBSCO	All dates	150	10
S4	EBSCO	All dates	23	2
S5	EBSCO	All dates	13	6
S6	EBSCO	All dates	82	15
S7	EBSCO	All dates	16	6
S8	EBSCO	All dates	16	6
S9	EBSCO	All dates	4	2
S10	EBSCO	All dates	18	4
S11	EBSCO	All dates	8	2
S12	EBSCO	All dates	1	1
S13	EBSCO	All dates	122	4
S14	EBSCO	All dates	38	5
S15	EBSCO	All dates	194	28
S16	EBSCO	All dates	25	8
S17	EBSCO	All dates	99	13
S18	EBSCO	All dates	25	2
Total			1088	155

8.3 Inclusion and exclusion criteria and appraisal

8.3.1 Selection criteria

By setting selection criteria, it helps to identify articles that would answer the review questions. It enables both inclusion and exclusion criteria to follow logically from the questions and to be defined in terms of the study population, the topic under study, and the study designs of interest. In order to be selected, a study should fulfil all of the inclusion criteria and none of the exclusion criteria.

The selection criteria were piloted on a subset of primary studies. There were three stages to the selection procedure:

- Criteria were applied to the citations generated to decide whether to obtain full copies of those potentially relevant
- Full copies were obtained
- The inclusion/exclusion criteria were applied and decisions made about inclusion of each study

The subject areas were delimited by using broad selection criteria initially, starting with titles and abstracts of papers retrieved from searches. The criteria include:

- country (UK, US, Europe, Australia), year of publication (after 1970)
- CEOs as the study population
- focus (CEO, performance, cognitive processes, intelligence)

***General selection criteria**:*

Criteria used when reviewing titles and abstracts

- Only primary and review studies published in scholarly journals
- Studies focusing on CEOs, but will include the top management team
- Prioritise studies on health care and public sector organisations but will include other sectors due to limited literature in this field from scoping study
- Only empirical papers published in last 30 years will be included in review
- Studies conducted in UK, US, Europe, Australia

***Selection criteria for full text papers**:*

Conceptual / theoretical papers must contain:

- Discussion of the theories or conceptual frameworks used to guide the development of a new approach for understanding

CEO cognition and performance. They should not be mere discussions of managerial competencies or leadership theories but contain the dynamics of interactions between CEOs, context, the intervening processes such as perception/ conception of job, managerial cognition, human information processing and decision making

- Explicit consideration of a theory, model or conceptual framework to support this
- Construction of a framework or model for linking different concepts e.g. contextual intelligence and sensemaking
- A theoretical conceptual review of ideas about earlier work e.g. different approaches, qualitative or quantitative
- A purpose /goal (which may be identifying a gap/demonstrating a new application of existing ideas in a new field, “why you are doing what you are doing”

Empirical papers must contain:

- Experiments or cases or interventions designed to enhance understanding of the impact of different cognitive models and processes on CEO performance, the link between sensemaking, performance and context, and relationship between information processing, context and managerial cognitive models
- Factors impacting on the performance of the CEO, relationship between sensemaking, outcomes and context, reviews of above
- Factors behind the success of CEOs, implications for selection, training and development, the barriers or reasons for failure or success

Methodological papers must meet the following criteria:

- Clear and consistent in their initial assumptions, field of study, sample and also in their limitations
- Can be conceptual or empirical or independent paper
- Research design is sound and concepts are well grounded from

theories

- The results obtained should make sense with respect to assumptions and conceptual backgrounds; if not, then explanation of deviance
- Review of methodologies earlier adopted in address same question

8.3.2 Quality appraisal

Quality appraisal of primary studies was used at various stages in the review process, from study selection to generation of recommendations for practice and research. The approach used was based on the following four quality constructs: methodological quality, evidence of avoidance of systematic error or bias, evidence of internal and external validity.

The appraisal criteria based on a framework by Popay et al. (1998) was also used as a checklist:

a) A primary marker: is the research aiming to explore the subjective meanings that people give to particular experiences of interventions?

b) Context sensitive: has the research been designed in such a way as to enable it to be sensitive and flexible to changes occurring during the study?

c) Sampling strategy: has the study sample been selected in a purposeful way shaped by theory and/or attention to the diverse contexts and meanings that the study is aiming to explore?

d) Data quality: are different sources of knowledge /understanding about the issues that are being explored compared?

e) Theoretical adequacy: do the researchers make explicit the process by which they move from data to interpretation?

f) Generalisability: if claims were made to generalisability do these follow logically and/or theoretically from the data?

8.4 Data analysis

The standard Cranfield- designed data extraction form in the Procite database was used to extract data, which helps to accurately extract relevant information and results from the selected studies, and minimise the biases of human error. As there was no specific hierarchy of qualitative evidence, I was conscious of the need to be consistent in my rating, to ensure that the findings reflect whether or not a standard had been reached.

8.5 Amendments to final review methods

The review departed from the protocol for a number of reasons:

a) Some of the key words and search strings were not sufficiently refined, resulting in a very large number of items. In this case, I added other key words to the search strings, reduced the date-range and limited the search to scholarly journals.
b) Some of the key words and search strings were too narrow, picking up few citations. In this case, I expanded the case definitions, for example accepting research that involved managers other than CEOs.
c) As it became obvious there were a number of key authors and researchers, additional searches were performed by authors.
d) A number of key textbooks helped to provide an overview of the research construct and cross-referenced other key authors.
e) As Proquest and EBSCO identified few relevant studies on the NHS, advice was sought from the NHS CEO, as well as a number of leading researchers on leadership in the NHS.

9 FINDINGS

9.1 Results from review process

The literature was reviewed using a numerical approach to quality assessment, as shown in Table 6. A summary of the selected papers that passed the quality review is listed in Appendix B. Every paper that scored 2 or higher in at least two of the four elements was accepted. This may appear to be a low threshold but was necessary due to the paucity of literature in the subject areas. A full tabulation of all of the included studies is set out in Appendix B.

Table 6 A numerical approaches to quality assessment (adapted from Denyer, 2006)

Elements to consider	Level				
	0 – absence	1 – low	2 – medium	3 – high	Not applicable
Contribution	The article does not provide enough information to assess this criteria	The paper adds little to the body of knowledge in this area	Contribution to knowledge is trivial in importance and significance	Significant addition to current knowledge; fill an important theory gap	This element is not applicable to this paper
Theory	The article does not approve enough information to assess this criteria	Literature review is inadequate; failure to motivate study with practical implications; no underlying story	Theoretical base is acceptable; having practical rationales for study in some extent	Excellent review of prior literature; strong theoretical basis; study has important implications for practitioners	This element is not applicable to this paper
Method	The article does not	The idea of study is	Justified research	Research design	This element

	provide enough information to assess this criteria	poorly executed; inappropriate quantitative methods; failure to justify proxies for variables	design; acceptable proxies for variables; the idea of study is not fully executed	adequately examining the theoretical argument; proxies are adequately defined	is not applicable to this paper
Data analysis	The article does not provide enough information to assess this criteria	Data sample insufficiency; weak connection between statistical results and economic story; inconclusive statistics	Appropriate data sample; statistical results relate to study aims; adequate statistics but inadequate explanation	Adequate data sample; statistical results support theoretical arguments; well explained statistics; include limitation analysis	This element is not applicable to this paper

9.2 Descriptive analysis

This section provides an overview of the emerging study characteristics.

9.2.1 Citation information

A full list of citations appears in the Bibliography.

9.2.2 Tabulation of data

Table 7 lists the top 10 journals which together accounted for 111 out of the total 143 papers. The top six journals that contributed more than 10 articles each to the systematic review are the *Strategic Management Journal* (23), *Administrative Science Quarterly* (18), *Journal of Management Studies* (17), *Academy of Management Review* (15), *Academy of Management Journal* and *Organisation Science.*

Table 7 Top 10 journals contributing to the review

Rank	Journal	Field	A List citations
1	Strategic Management Journal	Strategic management	23
2	Administrative Science Quarterly	Administration	18
3	Journal of Management Studies	Organisation theory and behaviour	17
4	Academy of Management Review	New theory of management and organisations	15
5	Academy of Management Journal	Management theory and practice	11
6	Organisation Science	Operational research and management	11
7	Organisation Studies	Organisation behaviour	7
8=	California Management Review	Management practice	3
8=	Management Science	Management	3
8=	Human Relations	Social science	3

An analysis of the papers reviewed according to year of publication is shown in Table 8. The subject areas reviewed are relatively new, with the earliest studies reported from mid 1970s onwards and the trend staying relatively low and stable until the mid 80s, since when there has been fluctuating but still low activity until more recently, with steady growth in interest in the fields of managerial cognition and sensemaking.

Table 8 Papers reviewed according to year of publication

Year	No of publications	Year	No of publications
2006	5	1987	4
2005	11	1986	3
2004	4	1985	3

2003	8	1984	7
2002	7	1983	2
2001	6	1982	3
2000	5	1981	3
1999	2	1980	3
1998	2	1979	1
1997	7	1978	1
1996	1	1977	3
1995	6	1976	2
1994	7	1975	0
1993	5	1974	0
1992	7	1973	0
1991	5	1972	3
1990	3	1971	1
1989	6	1970	0
1988	7		

The papers were analysed according to the country setting or location (Table 9). The US dominates research in this area, followed a long way back by the UK.

Table 9 Country analysis of papers reviewed

Country	No. of papers (A list)	% sample
UK	18	12.6
North America USA Canada	 115 2	 80.4 1.4
Europe Netherlands Denmark France Hungary	 2 1 1 1	3.5
Asia Malaysia	 1	 0.7

Other Australia	2	1.4
Total	143	100

When the studies were analysed by industry (Table 10), the most common industries were manufacturing, service (notably healthcare) and institutions (notably universities). Healthcare organisations and universities together accounted for one third of all studies. This is unsurprising as the NHS was a search word and as hospitals and universities provide relatively easily accessible study populations.

Table 10 Industry analysis of papers reviewed

Industry	No of papers	% sample
Primary Energy (utilities) Forestry	**3** 2 1	4.8
Manufacturing and production Clothing Food Wineries Furniture General	**12** 2 2 1 1 6	19.4
Service Financial Insurance Restaurant Healthcare	**15** 2 1 1 11	24.5
High technology Pharmaceutical Computer Unspecified	**7** 1 2 4	11.7
Institutions Religious order Fine arts museum	**12** 1 1	19.5

University	10	
Entertainment Orchestra	**3** 3	4.8
RD	**1**	1.7
Transport Airlines Shipping	**3** 2 1	4.8
Business Multinationals SMEs	**5** 2 3	8.1
Not for profit	**1**	1.7
Total	**62**	100

All of the 143 review papers were categorised by subject area in Table 11. The majority of papers cover several subject areas. For example, a study examining managerial cognition and mental representations in decision making would be categorised under all three subject areas. In this case, the paper was included in more than one subject category.

Table 11 Analysis by subject of all the papers reviewed

Subject area	No of papers	%
Managerial cognition	46	32.2
Environmental scanning	13	9.1
Information processing	51	35.7
Decision making	30	21.2
Organisational behaviour	8	5.7
Performance	14	9.8
Contextual factors	137	95.8

The literature on managerial cognition focused mainly on mental representations (15 papers) and sensemaking (11 papers), with the rest

covering managerial beliefs and knowledge and strategic issue interpretation. Where studies referred to specific settings, they were categorised according to their specific context. If the study covered more than one contextual category, the study was included in all the relevant contextual categories. Within contextual factors, there were seven contextual categories and 38 sub-categories, as summarised in Table 12.

Table 12 Contextual analysis of papers reviewed (A list)

Context	No of papers	% of sample
Environmental dynamism	**11**	6.5
Stable	1	
High velocity	3	
Turbulent/unstable	2	
Uncertain	4	
Hyper competitive	1	
Information management	**17**	10.0
Search	7	
Interpretation	3	
Processing	5	
Transmission (sensegiving)	2	
Financial	**26**	15.3
Corporate (Profit making)	21	
Not for profit	2	
Public sector	3	
Decision making processes	**29**	17.1
Speed of decision making	3	
Flexibility/preferences/choice	6	
Time/Urgency	3	
Human information processing capacity	11	
Complexity of problems	1	
Cognitive perspective	4	
Perceived degree of discretion	1	

Organisation Autogenic crisis Relationship Learning Acquisition and divestment Size Structure Complex adaptive system Adaptation, change Culture, values Top management team Strategy Operations Staff	**29** 1 1 3 1 1 2 2 2 3 6 1 5 1	17.1
Temporal Time History	**4** 2 2	2.2
Managerial characteristics Identity Experience Significant events Relationships	**8** 2 4 1 1	4.7
Total	124	100

9.3 Narrative summary

The systematic review identified seven subject areas. Of these, environmental scanning, information processing and decision making relate to contextual factors of the environment, information and decision making processes and are therefore discussed within those contextual factors. Although performance was a key word in the search strings, on detailed review and analysis, the results did not identify performance as a contextual factor. The remainder of the subject areas are discussed below.

9.3.1 Contextual factors

Contextual factors can be categorised by whether they are internal or external to the organisation.

External contextual factors

9.3.1.1 Environmental dynamism

Eleven papers focused on the dynamism of the external environment. The industry (or sector) environment was found to have a major influence on executive strategic scanning behaviour and objectives (Hough & White, 2004). There was a direct relationship between the state of environmental dynamism and speed of strategic decision making (Baum & Wally, 2003) and CEO scanning emphasis (Garg et al., 2003; Hough & White, 2004). In times of high sector uncertainty, CEOs of high performing firms were likely to scan more broadly and more frequently as well as reporting greater use of personal information sources compared to their counterparts in low performing firms (Daft, Sormunen, & Parks, 1988). There was also a relationship between CEO scanning emphases, environmental dynamism and firm performance, such as prioritising innovation-related internal functions when the external environment was dynamic and increasing broad scanning of the external environment and efficiency-related internal functions when the external environment was stable (Garg, Walters, & Priem, 2003). Nevertheless, how CEOs perceive and interpret environmental change might be affected by organisational and resource dependence factors (Milliken, 1990).

Other environmental contexts identified in the review include turbulent or unpredictable (Lant, Milliken, & Batra, 1992; Nastanski, 2004; Wang & Chan, 1995) and high velocity environments (Bourgeois & Eisenhardt, 1988; Eisenhardt & Bourgeois, 1988; Oliver & Roos, 2005; Eisenhardt & Bourgeois, 1988; Oliver & Roos, 2005). Johnson and Hoopes (2003) found that in hyper competitive environments, managerial beliefs tend to converge, and the pattern of strategies that emerges is consistent with those predicted by economic theory. Beekun and Ginn (1993) found turbulent environments to result in different inter-organisational coupling strategies. In total, five environmental

contextual types were identified in varying degrees of dynamism: stable, uncertain, turbulent or unpredictable, high velocity and hyper-competitive.

9.3.1.2 Finance

Of the 26 papers that made specific reference to finance, three were about non-profit organisations (Tucker, Cullen, Sinclair, & Wakeland, 2005; Rhodes & Keogan, 2005; Krug & Weinberg, 2004; Rhodes & Keogan, 2005; Krug & Weinberg, 2004), three were about publicly (state) funded organisations (Blackler & Kennedy, 2004; Learmonth, 2005; Alimo-Metcalfe & Lawler, 2001) and the rest were about the corporate (private) sector. Whether an organisation was a private, non-profit or public sector organisation was itself an important contextual factor for the following reasons.

9.3.1.2.1 Public sector organisations

Public sector organisations often face difficulties attracting appropriately skilled staff and having to work with resource limitations and an unstable environment (Tucker et al., 2005) impacting on their strategy formulation (Rhodes & Keogan, 2005) and strategic decision making (Krug & Weinberg, 2004).

Leaders of public sector organisations, on the other hand, have to deal with direct **political** interference and hence function in a highly politicised arena (Blackler & Kennedy, 2004). They have to manage discursive changes (Learmonth, 2005) and in the context of the NHS, lead a professional bureaucracy (Alimo-Metcalfe & Lawler, 2001). According to Ring and Perry (1985), the contextual factors particular to the public sector mainly concern:

a) ambiguity of **policy** directives
b) relative openness of **decision making**
c) the greater number of influencing **interest groups**
d) artificiality of **time** constraints and
e) relative instability of policy coalitions

Euske (2003) identified additional contextual factors for the public sector:

a) The public sector's goal of providing high quality efficient public services meant that its approach to **relationship** or partnership was one of collaboration instead of (the private sectors') competition.
b) As **funding** was dependent on government allocation rather than earned from fees and charges, the scope for income generation was limited and relatively inflexible. The incentives of working in the public sector included job security, power, and recognition compared to financial rewards in the private sector.
c) In contrast to private sector's shareholders, the nature of **stakeholders** in public sector organisations meant that the latter were much more open to the external environment and therefore subjected to greater scrutiny. Public organisations have to deal with public expectations and direct political interference hence function in a highly politicised arena.
d) The influence of stakeholders in public sector organisations meant that **goals** in public sector were often shifting, complex and conflicting, compared to the clear goal of maximising shareholder value in the private sector where authority is vested in organisational leaders.
e) **Performance expectations** were vague and in constant flux rather than being clear and fixed (as in maximising shareholder values).

9.3.1.2.2 NHS context

According to Goodwin (2006), the impact of these constraints means local senior NHS leaders have to consider the following contextual factors:

a) **Government** setting the national operating context restricts local flexibility and discretion
b) the ethos and **history** of local services
c) availability of **resources**
d) power of the **professions** (clinicians)
e) expectations of local players and
f) interference from the management tier above through **performance management** and **regulations**

Goodwin's study of **NHS** CEOs found that those who were able to overcome their constraints with resultant organisational and personal success did so by tackling significant local challenges in an inclusive way. They developed positive and influential interpersonal relationships with key players who saw themselves as local leaders with their own networks of influential relationships. He concluded that to be successful NHS CEOs would need to devote greater energy to managing the interface between the organisation and the political process. In other words, NHS organisations and their leaders need to make sense of their contexts and transact with those environmental elements in order to survive. As all NHS Trusts have local catchment areas, the local health economy is especially important. In addition to the macro contextual factors identified by Mayo and Nohria (2005), and internal operational contextual factors, 10 NHS-specific contextual factors relevant to a Trust CEO derived from the search is shown in Table 13.

Table 13 Contextual factors in NHS specific contexts

Government (interference) Policy Performance management (strong central controls)	**Relationships** Inter-personal Inter-organisational Media
Regulators (scrutiny) National – Healthcare Commission Local –Strategic Health Authority, Overview and Scrutiny Committees	**Ethos (industry culture)** Public service values Collaboration History of local services Professional bureaucracy Openness of decision making
Stakeholders (expectations) Politicians pressure groups Trade unions Interest groups Clinicians Patients Public	**Other significant organisations** Other NHS Trusts Independent sector providers Primary care providers (GPs) Voluntary sector Other public organisations, e.g. councils
Resources	**Goals**

Financial People	Complex, shifting, unclear Contingent upon stakeholders
Time Artificial time constraints	**Performance expectations** Vague and in constant flux

9.3.1.3 Decision making processes

In total, 29 papers referred to the context of strategic decision making processes. The sub-factors included the speed of decision making (Eisenhardt, 1992; Baum & Wally, 2003), time available for decision making processes (Dutton & Duncan, 1987), human information processing capacity (Schwenk, 1988), complexity of problems (Schwenk, 1995), choice or preferences of decision makers (Corner, Kinicki, & Keats, 1994; Hambrick & Snow, 1977; Hambrick, Finkelstein, & Mooney, 2005a), perceived degree of discretion (Carpenter & Golden, 1997) and individual CEO perceptions (Kassinis Panayiotou, 2006). A number of papers made reference to the cognitive perspective on strategic decision making (Schwenk, 1984; Schwenk, 1988; Schwenk, 1995). Pettigrew (Mintzberg, Waters, Pettigrew, & Butler, 1990) recommends understanding decision making as a continuous process in context.

While proper processes were clearly important in strategic decision making, Mintzberg et al. (1976) argued that such processes were characterised by novelty, complexity and open-endedness, and despite variations in decision type, they all had a basic structure. To support the case for contextual factors to be considered as part of strategic decision making, Mintzberg et al. (1976) developed a contextual framework that complemented Hambrick and Snow's (1977) strategic decision making model.

Accordingly, decision making processes are identified as a separate contextual factor as there are aspects of the process that could impact on the eventual outcome. The quality of strategic decisions would be affected by contextual sub-factors including the operation of decision making process itself,

information processing capacity of organisational leaders, and individuals' preferences.

Organisational internal factors

Differentiation of context into that which is internal and external to the organisation had been alluded to earlier (Walters, Jiang, & Klein, 2003; Walters & Priem, 1999; Kumar, Subramanian, & Strandholm, 2001; Weiner & Mahoney, 1981) although missing from Mayo and Nohria's model. Of the 28 papers that studied the organisational context, finance was a relevant factor in both internal and external factors. The rest of the internal elements of context were:

9.3.1.4 Information management

Studies that looked at roles played by information as a contextual factor were focused on how information was searched, gathered, processed and conveyed by the top management team. Firms' information search strategies appear to be influenced by the CEO's cognitive schemas (Lant Hewlin,(Lant & Hewlin, 2002) (2002), the corporate strategy of the firm (Walters Priem, 1999; Garg et al., 2003) and the performance level of the CEO (Auster & Choo, 1994; Yunggar, 2005; Garg et al., 2003; Walters & Priem, 1999; Kumar et al., 2001; Analoui & Karami, 2002). Walters and Priem (1999) found that CEOs changed their patterns of information search if their firm's strategy changed, and CEOs of the highest performing firms conducted external and internal scanning to match their business-level strategy. While environmental information can be acquired from multiple, complementary sources (Auster & Choo, 1994) there was a tendency to seek, in a crisis, fewer sources of information and to restrict new information to that which the organisation already possessed (Staw, Sandelands, & Dutton, 1981). Lant and Hewlin (Lant & Hewlin, 2002) recommend that cognitive schemas and team decision making structure be used to focus the CEO's attention on different types of information for different categories of decision.

The ways in which information is transmitted also have an impact on recipients (O'Reilly & Roberts, 1974) due to attribute framing influencing the content of

people's thoughts (Kuvaas & Selart, 2004). In the workplace, how information is communicated to employees, a process Weick (1995) describes as sensegiving, affects their interpretation at the organisation level, with implications for information management strategies to help employees better understand strategic actions, organisational change and learning (Thomas & McDaniel, 1990; Thomas, McDaniel, & Anderson, 1991; Thomas et al., 1991). Dutton (1993) advises that in order to not miss potentially significant events, developments and trends, design and process interventions may be necessary to engage active strategic issue diagnosis. As the process of information management impacts on strategic decision making, the search, gathering, processing and transmission of information are important considerations when analysing the contextual landscape.

9.3.1.5 Organisational strategy

Organisational strategy accounted for a significant part of the variance in CEOs' interpretations of strategic events (Thomas et al., 1991); how they acquire information (Walters & Priem, 1999) and make strategic decision (Duhaime & Schwenk, 1985) and is a positive predictor of firm performance (Hitt & Ireland, 1985).

9.3.1.6 Size

Depending on industry, being of a certain size may be a positive predictor of company performance (Hitt & Ireland, 1985).

9.3.1.7 Structure

Structure influenced CEO's interpretations of strategic events (Thomas et al., 1991) and employees' interpretive schemes (Bartunek, 1984) but did not affect firm performance (Hitt & Ireland, 1985).

9.3.1.8 Systems

The review identified a number of new frameworks for describing systems, such as: complex adaptive systems and dominant logic (Bettis & Prahalad, 1995), executive support systems and top management perception of strategic information processing (Wang & Chan, 1995), personal value systems and

decision making styles of public managers (Connor & Becker, 2003) and taking a systems approach to making effective strategic decisions (Tucker et al., 2005).

9.3.1.9 Relationships

Relationships relate to the interactive character of the organisation (Hellgren & Lowstedt, 1998).

9.3.1.10 Staff

Connor and Becker (2003) found that public sector managers' personal values were related to their decision making styles. When there is organisational restructuring or change, leaders can facilitate change by: managing the changing interpretive schemes among its members (Bartunek, 1984), adopting specific behaviours and taking specific actions to facilitate innovation and adaptation (Yukl & Lepsinger, 2006), taking advantage of the momentum in organisational adaptation (Miller & Friesen, 1980), using autogenic crisis to initiate strategic "pre-adaptations" to future crises, thereby using latent threat to generate organisational flexibility, learning, renewal and, possibly, longer life. (Barnett & Pratt, 2000) Goodwin highlights the power of the professions.

9.3.1.11 Culture

Culture influences individual sensemaking (Harris, 1994), affects how intelligence is understood (Sternberg & Grigorenko, 2006) and undermines performance when it entraps decision makers in unfortunate courses of action from which they cannot disengage (Weick & Sutcliffe, 2003).

9.3.1.12 Organisational learning

Organisational learning which involves critical reflection and social structuring contributing to meaning making (Schwandt, 2005), acknowledging that a firm's predominant managerial mental model has a significant impact on its learning capability (Harrison & Boyle, 2006)(Clapham & Schwenk, 1991), tendency to make external attributions for poor performance outcomes (Lant et al., 1992), and developing enough consensus for organized action to result, through framing and labelling of communications (Fiol, 1994).

9.3.1.13 Top Management Team

Top management team (TMT) characteristics, which include:

a) duration of tenure (Finkelstein & Hambrick, 1990) with long-tenured teams following more persistent strategies as well as strategies that conformed to central tendencies of the industry, and exhibiting performance that adhered to industry averages

b) level of discretion, with the strongest results occurring in contexts that allowed TMT high discretion (Finkelstein & Hambrick, 1990)

c) mental models of TMT members that recognized opportunities (Kaplan, Murray, & Henderson, 2003)

d) politics within TMT found to be associated with poor firm performance (Eisenhardt & Bourgeois, 1988)

e) having a powerful, decisive chief executive and a powerful TMT who can make major decisions carefully but quickly, and who seek risk and innovation but execute a safe, incremental implementation. (Bourgeois & Eisenhardt, 1988)

f) members' perceptions of identity and image, especially desired future image (key to the sensemaking process) serving as important links between the organisation's internal context and the team members' issue interpretations (Gioia & Thomas, 1996)

g) TMT heterogeneity increases the likelihood of strategic change (Lant et al., 1992).

9.3.1.14 Operational efficiency

In order to overcome poor efficiency, managers need to monitor closely group membership as well as the interaction between resource utilization within a given group (Short, Palmer, & Ketchen, 2002). When financial performance is unsatisfactory, attention should be focused on better capitalizing on extant resources as well as developing new resources (Short & Palmer, 2003).

Comparing efficiency-related internal functions against external players produced higher performance (Garg et al., 2003) which in times of resource scarcity, increased efficiency and control may be functional (Staw et al., 1981); (Harrison & Boyle, 2006; Gioia & Manz, 1985).

Managerial characteristics

The final group of contextual factors is ***managerial characteristics***. Empirical research demonstrates strong associations between the characteristics of managers, in terms of tenure, age, formal education, and functional experience (Montserrat Entrialgo, 2002), international experience (Collinson & Houlden, 2005) and network relationships (Collinson & Houlden, 2005) and performance (Jenkins & Johnson, 1997).

Gavetti and Levinthal (2001) believe that an actor's mental models of the world came from experiential wisdom that had accumulated as a result of positive and negative reinforcement of prior choices, and cognition itself may change as a result of prior experiences. Similar findings were reported by Hambrick et al. (2005a) who found that executives who were intensely prepared – by virtue of their prior experiences, training, and readiness for difficult conditions – were less likely to feel under pressure compared with colleagues who are less well prepared. This is an important consideration when executives may react to objectively stressful situations with denial (Hambrick, Finkelstein, & Mooney, 2005b) or, as Gupta and Govindarajan (1984) found, be intolerant of ambiguity.

Furthermore, Daniels et al. (2002) propose that CEOs' beliefs or mental models were shaped by the different events earlier in their careers, a point iterated by Porac et al.'s 1989 study of the Scottish knitwear industry which revealed that the cognitive foundation of mental models came partly from how organisations managed issues such as recruitment and career paths. When the CEOs were middle managers they dealt with operational issues and had similar day-to-day experiences across the same industry. They were likely to have belonged to social networks comprising other senior managers within the industry. Such events and processes influenced how managers were socialised into the

professional culture of the industry, which therefore influenced their mental model development.

9.3.2 Managerial cognition

Altogether, 46 papers referred to cognition in a major way. Cognitive processes and structures help individuals make sense of the available information from their environment which facilitates and influences action. The papers have been grouped under six concepts:

a) *Managerial beliefs* that allow managers to define competitive boundaries, make sense of interactions within these boundaries (Porac, Thomas, & Baden-Fuller, 1989; Johnson & Hoopes, 2003), to support innovation and change (Yukl & Lepsinger, 2006; Greenwood & Hinings, 1988) and to conduct strategic issue diagnosis (Dutton et al., 1983)

b) *Framing* to influence the content of people's thought and subsequent decision-making (Kuvaas & Selart, 2004), scanning habits and inter-organisational relationships (Bluedorn, Johnson, Cartwright, & Barringer, 1994). A type of framing is using *labels* to convey pictures of reality (Fiol, 1994)

c) *Commitment* in decision contributors were encouraged through promotion of specific cognitive *heuristics* and biases (Schwenk, 1986) as well as issue interpretation (Ginsberg & Venkatraman, 1995). There was a tendency for people, after a setback, to escalate their commitment of resources to the same course of action to recoup the losses

d) Managerial judgement reflecting perceptions of causal relationships influences both organisational alignment and firm performance (Priem, 1994)

e) The single largest subgroup, consisting of 15 papers, identified mental representations, also known as *cognitive structures* such as schematas (Harris, 1994), scripts (Gioia & Poole, 1984), and mental models (Johnson-Laird, 1983), as central to understanding cognition and information processing. These knowledge structures act as frames of reference (Bartunek, Gordon, & Weathersby, 1983) in the processing of

information for making decisions (Walsh, 1995; Swan, 1995), creating meaning necessary for action (Schwandt, 2005), influencing choice (Gibbons & O'Brien, 2001) and managerial perception (Benson, Saraph, & Schroeder, 1991). Cognitive structures used by managers to filter and make sense of information are influenced by dominant logic (Bettis & Prahalad, 1995), collective beliefs (Walsh et al., 1988), industry mindsets (Phillips, 1994) or recipes (Spender, 1989) as well as being linked to bandwagon behaviours (Fiol & O'Connor, 2003)

f) The mental frames not only operated as the basis for evaluating choice alternatives, but more importantly, determined the space of alternatives that were considered in a given decision problem, what Gavatti and Levinthal (2001) called the *cognitive space* of the actor. The size and shape of this space had been shown to be a critical determinant of managerial choice and action (Huff, 1990; Fiol & Huff, 1992; Walsh, 1995). According to Simon (1991) a firm's choice of strategy was often a by-product of actors' representation of their problem space. Dutton and Jackson (1987) believed that decision makers' intelligence and motivation systematically affect how issues are processed and the types of organisational action taken

g) These mental frames can be modified through learning (Bartunek et al, 1983; Barnett and Pratt, 2000; Broussine, 2000)

h) In 11 papers, *sensemaking* was a dominant feature and will be discussed below. The effects of sensemaking on organisational outcomes could be seen in the results of various interventions on the mental models of managers and the decisions and actions they took (Porac & Thomas, 1994; Johnson, Daniels, & Asch, 1998; Daniels, Johnson, & de Chernatony, 1994).

9.3.2.1 Sensemaking

Emanating from the fields of psychology and organisation studies, sensemaking sought to reveal how individuals construct meaning, interpret their world and function within it (Gioia & Sims, 1986; Weick, 1995). Sensemaking drew on the development and use of cognitive structures in which individuals accumulated

and extrapolated understandings and assumptions about the environment, roles and events that shaped their lives (Louis, 1980). These structures acted as filters through which actors gleaned salient cues from the 'noise' that constantly surrounded them and also provided a mechanism to explain and to account for actions 'post hoc' (Lant & Hewlin, 2002). Elements of the sensemaking process included the concepts of problem sensing (Kiesler & Sproull, 1982) which comprises noticing, interpreting and incorporating stimuli, mindfulness which describes purposeful noticing (Seiling & Hinrichs, 2005), scanning (Thomas, Clark, & Gioia, 1993), information processing (Thomas & McDaniel, 1990; Priem & Harrison, 1994) and decision making (Child, 1997).

Weick (1979; 1995)'s seven properties of sensemaking which incorporate action and context, have remained the fundamental construct of sensemaking, despite criticism from Gioia and Mehra (1996) that sensemaking as construed by Weick was a purely conscious control process and things only make sense if they fitted into prior structures of understanding. They believe that such knowledge structures can be modified and adjusted via assimilation of subtle cues over time and argue for automatic unconscious cognitive process to be included in sensemaking formulation. Gioia and Mehra (1996) also contend that *prospective sensemaking* provides an impetus for action and suggest expanding the sensemaking domain to include both retrospective and prospective elements. Weick et al. (2005) updated his1995 seminal text which recognises that the central features of sensemaking needed to be "more future oriented, more action oriented, more macro, more closely tied to organising, meshed more boldly with identity, more visible, more behaviourally defined, less sedentary and backward looking, more infused with emotion and with issues of sensegiving and persuasion" (p409). In summary, sensemaking utilises cognitive structures that are constantly renewed by new experiences, has both prospective as well as retrospective elements, is both conscious and unconscious, and is linked to action.

9.3.3 Information processing

There were 11 references about mental processes involved in individual decision making. They are discussed here rather than under managerial cognition as they relate to the cognitive aspects of decision making. Corner et al. (1994) proposed a process model of individual level information processing which recognizes that people process information in six stages: attention, encoding, storage/retrieval, decision, action and outcomes. The stages as defined by Corner are explained below with additional evidence from the search:

a) Selective attention is the focus of consciousness and acts as an information 'filter' (Hambrick & Mason, 1984)(Kiesler & Sproull, 1982)
b) Encoding, also known as interpreting or understanding, gives meaning to the information. Encoding determines what information is retrievable from memory for decision making and is the critical 'point of entry' for cognitive biases (Duhaime & Schwenk, 1985; Schwenk, 1984)(Jackson & Dutton, 1988). For example, the way an issue is labelled or framed would mobilise action in a particular direction (Dutton, Fahey, & Narayanan, 1983)
c) Storage is the preservation of interpreted information. A strategic decision opportunity triggers a search of memory for information (Mintzberg, Raisinghani, & Theoret, 1976)
d) Strategic decisions are based on information retrieved from storage (Mintzberg et al., 1976; Nutt, 1984), as well as information emerging from previous process stages, a view consistent with Mintzberg's (1979) notion of strategic decisions as emergent phenomenon
e) Action is the enactment of a strategic decision within the individual's sphere of responsibility. Effective action often depends on an ability to implement decisions based on scanning strategies and subsequent interpretation of strategic information (Pfeffer & Salancik, 1977b). Outcomes are the result of a decision enactment.

While the Corner et al. (1994) decision making process model was dependent on the information processing capacity of individuals, it was also subject to

distortions and deceptions that can arise from the cognitive biases of human nature (Lavallo and Sibony, 2006). The biases that distorted the way people collected and processed information could arise from interactions in organisational settings where judgement might be coloured by self interests (Roxburgh, 2003). Lavallo and Sibony (2006) believe that two cognitive distortions, namely optimism, which is a judgement based on the likelihood of a given outcome, and loss aversion, which is about the human tendency to experience loss more acutely than gain, were most likely to lead decision makers astray; the former generating unrealistic forecasts as well as underestimating risks, and the latter leading to inaction and under commitment.

Deceptions could happen as a result of a conflict of interest that arises between an “agent” (in this case the CEO) and the “principal” (the corporation) on whose behalf the agent acts (Jensen and Meckling, 2001). An example could be a CEO proposing an investment that is being reviewed and evaluated by an executive committee. Agency problems occurred when the agent’s incentives were not perfectly aligned with the principal’s interest (Fama, 1980). Lavallo and Sibony (2006) identified three contexts that create agency problems between individuals and organisations: misalignment of time horizons, differing risk profiles, and asymmetry of information.

In summary, the systematic review has identified 12 contextual factors within the organisation, and 15 contextual factors external to the organisation that have not been considered in Mayo and Nohria’s contextual intelligence framework. It also identified 10 new contextual factors specific to the NHS.

10 DISCUSSION

10.1 Types of contextual factors

Mayo and Nohria (2005) highlighted a connection between context, sensemaking and organisational performance and asserted that behind every successful organisation was a CEO who had regard for macro level contextual factors. The systematic review found evidence in support of Mayo and Nohria's contextual landscape (Albright, 2004; Daft et al., 1988; Pettigrew, 1987; Analoui & Karami, 2002; Hitt & Ireland, 1985) but also identified nine new contextual factors.

10.1.1 The environmental

It was surprising that across the studies, environmental contexts were defined in a rather narrow way, with references limited to describing the macro-economic states of the industry or sector in which the business operates. In total, five environmental contexts along a continuum of dynamism (defined as rate of change) were identified, with labels such as stable, uncertain, turbulent or unpredictable, high velocity and hyper-competitive describing the perceived speed of change in the sector. While conceptual names might be self explanatory, they were unhelpful when it came to specificity and generalization of the findings. As none of the studies had critically defined what constituted those conceptual labels, it was unclear if the attributions to environmental factors were valid, both in terms of internal validity as well as construct validity.

The lack of case definition extended to the assessment of CEO environmental scanning behaviour which also appears to be focused at the industry level. As managerial beliefs tend to converge especially in hyper competitive environments, there is a real risk that the myopia would eventually disadvantage an entire industry (as in the case of the Scottish knitwear industry) as a result of the information seeking behaviour of organisations being biased towards confirmation. This group think on an industry scale runs the risk of ignoring changes in global and micro-environmental or local factors, because the "big picture" was framed by organisational leaders' conception of their

operating environment, which influenced their approach to business intelligence.

As this review is concerned with identifying the key dimensions or aspects of context for CEO strategic decision making, a final but significant criticism of the literature is the absence of research evidence on local environmental factors. The range of factors that could fall within the definition of “local” would differ depending on product or place. For example, local factors within the NHS would include significant buildings, the population within a catchment area, infrastructure including roads and transport, local health community stakeholders and geography. None of the studies had examined the environment from these perspectives. This is not to say that the factors were not taken into account by CEOs, but it was unclear if these and other possible contributory factors could have and should have been considered as being part of the “environment” and therefore be included in the scanning frames of CEOs. As such, any link between environmental dynamism, CEO scanning behaviours and organisational performance may not be straightforward despite it being intuitive to relate broad frequent scanning by CEOs in periods of high environmental dynamism with positive outcomes.

10.1.2 Information management

Information management involves collecting and making sense of data, then codifying them to produce knowledge and intelligence to inform corporate strategy. It was interesting to find the dominance of environmental scanning literature in the field to the detriment of almost all other aspects of information management. While much strategic effort was expended on gathering information from the external environment, no firm studied seemed to have taken a systematic approach to data management, and none that had a comprehensive strategy for dealing with the information pathway as a whole. This is of concern especially as the literature review showed that firms’ information search strategies were influenced by CEO cognitive schemas(2002), corporate strategy and the performance level of the CEO -

factors that are susceptible to cognitive bias, bandwagon effect or individual variations.

To avoid missing potentially significant events, the literature concluded that organisations should consider setting up process interventions for information management that takes account of cognitive schemas, internal and external environments, crisis situations as well as data quality issues in terms of timeliness, accuracy, reliability and completeness. Every firm will benefit from having a corporate information management strategy that ensures the integrity of data. By taking a systematic approach to information management, CEOs and their organisations will be able to facilitate active strategic issue diagnosis (Dutton, 1993) and help employees to better understand strategic actions and organisational change, as well as promote organisational learning.

10.1.3 Finances

Most of the references to finances were related to how the enterprise was financed. Whether an organisation operates in the private, public or not-for-profit sector is relevant in a contextual analysis as each, by their nature, has constraints and flexibilities that impact on the CEO's role and scope. It may be *de rigueur* to maximise shareholder value in the private sector but the concepts of profit and shareholders sit uneasily in the public and not-for-profit sectors for obvious reasons.

10.1.4 Sector/pubic sector/NHS

In the case of the NHS which is publicly funded from taxation, the UK government, through the DH, defines the roles and responsibilities of CEOs of local health care organisations by determining national policies, structures and organisational accountabilities. The key responsibility of a CEO in the NHS therefore is to translate national operating frameworks and policies into local implementation plans, which may sound straightforward but is rarely so, as Goodwin (2006) alluded to, due to the presence of local or organisational contextual factors. Having to operate within a national framework also constrains what CEOs can do, since budgets, rules and even prices are set

nationally. Being a free public service also has meant demand would always exceed affordability. As a consequence, strategic change in public services such as the NHS is often complicated and difficult to implement.

The NHS structure consists of a central core, the DH, an intermediate tier of regional offices called Strategic Health Authorities (SHAs), and some 400 local NHS organisations called NHS Trusts. Being free at the point of delivery meant the NHS has a number of unique contextual factors that do not apply to private firms, or even to other local public services. They include the ethos and history of local NHS services, expectations of local players and stakeholders, and emotional attachment of local communities to buildings and places used for care. Provision of care has to address issues of ethics, equity and equality. At the same time, NHS Trusts have to meet top down performance requirements and deliver complex goals that may be contingent upon stakeholder support within artificial time scales. The CEOs have to balance all these requirements while complying with regulations and dealing with interference from the management tier above (Goodwin, 2006).

NHS Trusts interface with the public by providing healthcare services to local communities. Like other nationally organized public services, local Trusts have to align the interests of the DH with those of local stakeholders and players. So NHS CEOs need to have good contextual intelligence when engaging with local politicians, stakeholders and pressure groups, especially if their beliefs and expectations were at odds with the government. The strong central controls exerted on NHS bodies create two potential adverse consequences of operating in politically driven environments. The first is a tendency towards centralisation including strong central controls inside organisations. The second is a fear of failure leading to inaction, as it is often safer not to act than act and be proven wrong. It is not surprising that Goodwin (2006) advised NHS CEOs to devote greater energy to managing the interface between the organisation and the political process. In other words, NHS leaders need to make sense of their contexts and transact with these environmental elements in order to survive.

10.1.5 The organisation

The organisation itself could be regarded as a contextual landscape and a fitness assessment of the internal organisational environment should form part of any contextual analysis. The systematic review identified 11 organisational contextual sub-factors: strategy, size, structure, systems, relationships, staff, adaptation and change, culture, organisational learning, top management team characteristics and operational efficiency. Some concepts overlapped, for example, adaptation and change could be categorised under culture, organisational learning or operational efficiency, depending on the changes involved; for this reason, they would not be appropriate as a standalone contextual factor. There were contextual factors which were enriched by the review, for example, temporal factors involving organisational history or memory, and communication which fall under information management and that in itself cuts across all the sub-factors.

It was notable that while all of the contextual factors had impacted on organisational performance in one way or another, there were no existing frameworks that had examined those factors systematically and in an inclusive manner. Off-the-shelf tools such as the 7 S framework (Waterman, Peters, & Phillips, 1988) cover some factors and may be useful for conducting quick but superficial organisational analysis. That may be sufficient for single loop learning but to achieve double loop learning (Bartunek et al., 1983) organisations need to be able to question their underlying assumptions and values and implement systems that can monitor and correct behaviours as well as determine what appropriate behaviours are. The 11 organisational contextual sub-factors provide an additional checklist for CEOs when conducting a contextual analysis of the internal organisation.

10.1.6 Decision making process

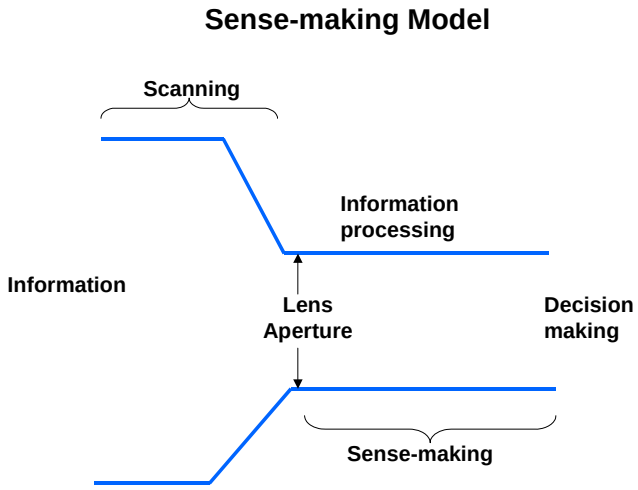
Decision making processes have been treated as a contextual factor on their own rather than being included under the context of organisational systems. This is because strategic decisions have to deal with many competing interests including those of parties outside the organisation. What, when, where and how

decisions are taken, and by whom, both influence and are influenced by decision making processes. In most cases, managing the strategic decision making process is part of the CEO's decision making context, and in order to manage the process, he or she would have to take account of relevant contextual factors. In large complex organisations like NHS Trusts, the real strategic decision making often takes place in forum or committees, so part of the CEO's responsibility will be to improve their organisation's decision making ability. By identifying the prevalent biases and dealing with the human factors of strategic decision making as well as shaping decision making processes should enable the CEO to create a productive decision making culture that would result in smarter strategic decisions.

It is not surprising that many of the factors identified above were consistent with Simon's (1957) bounded rationality model of decision making. The boundedness is particularly relevant for CEOs in the NHS who work in a highly politicised machine bureaucracy. Unclear goals that shift over time lead to people often searching for information and alternatives in a haphazard manner as well as opportunistically. Analysis of alternatives may be limited and decisions often reflect the use of standard operating procedures (*routines*) rather than systematic analysis, which reinforces the status quo. On the basis of evidence, the literature review identified three potential biases for CEOs when taking strategic decisions (Simon, 1997):

a) Existing strategy affects fields of vision; the strategic decision process satisfices instead of optimises, with strategic decision makers rarely engaged in comprehensive search, and discover their goals in the process of searching
b) Selective perception may limit options, as decisions follow the basic phases of problem identification, development and selection but as they cycle through the various stages, frequently repeating and following different paths in fits and starts
c) Current performance also affects strategic decisions as the complexity of the problem and the conflict among decision makers often affects the shape of the decision path

Figure 11 Sensemaking model of CEOs

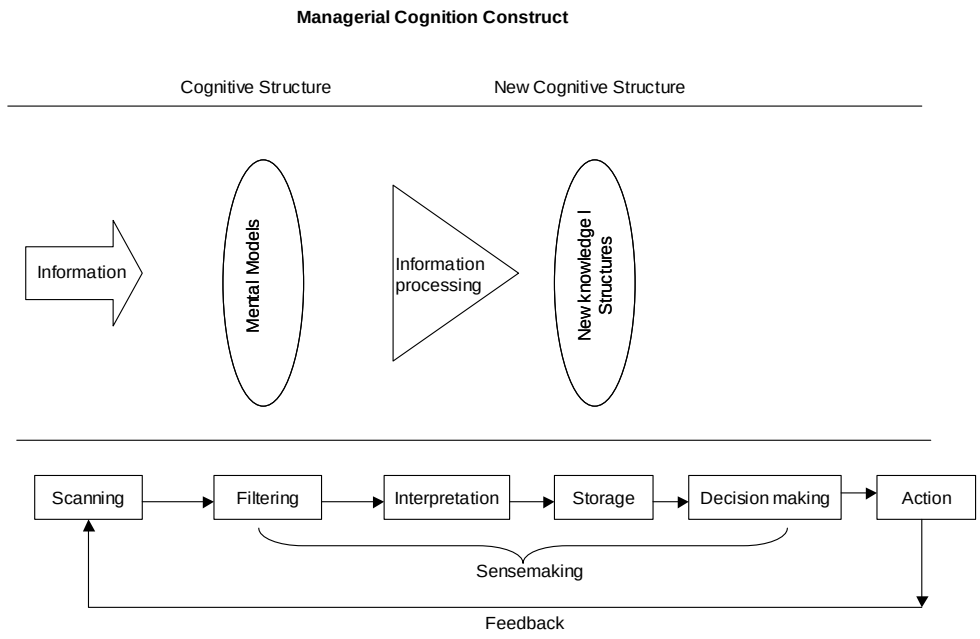


As mental models get exposed to new experiences and information, they change to incorporate the new insights, with new cognitive structures behaving like a wider and more flexible lens aperture (Figure 11). In an iterative sensemaking process, as individuals accumulate and extrapolate understandings and assumptions about the environment from experience or study, they revise their mental models to take account of more of the context, including accounting for actions post-hoc. This contextual rationality enables CEOs to be better informed as well as better prepared for taking strategic decisions. The principle is similar to the double loop learning model (Argyris and Shon, 1974) by which sustainable learning takes place after new (improved) cognitive maps were formed.

A managerial cognition model starts with systematic scanning of contextual factors followed by a sensemaking process before culminating in decision making as a precursor to action. The three steps are sequential, but actual time spent on each step could vary from seconds to days; sometimes all three could happen in quick succession as in an emergency, at other times it could be indefinite. The concept of contextual intelligence is based on developing a cognitive model of context that supports the CEO's sensemaking ability to improve strategic issue diagnosis. As the managerial cognition model is based

on skills that are developable, organisations can develop this competence in executives by providing a combination of contextual knowledge and experiential opportunities. A diagram of the managerial cognition model based on evidence from Corner et al. (1994), Weick (1995) and Gioia and Mehra (1996) is shown in Figure 12.

Figure 12 Managerial cognition model



10.1.7 Temporal

Time as a process or amount of time allowed and history are important contexts. This argues for the role of time to be explicitly incorporated into organisational decision making process.

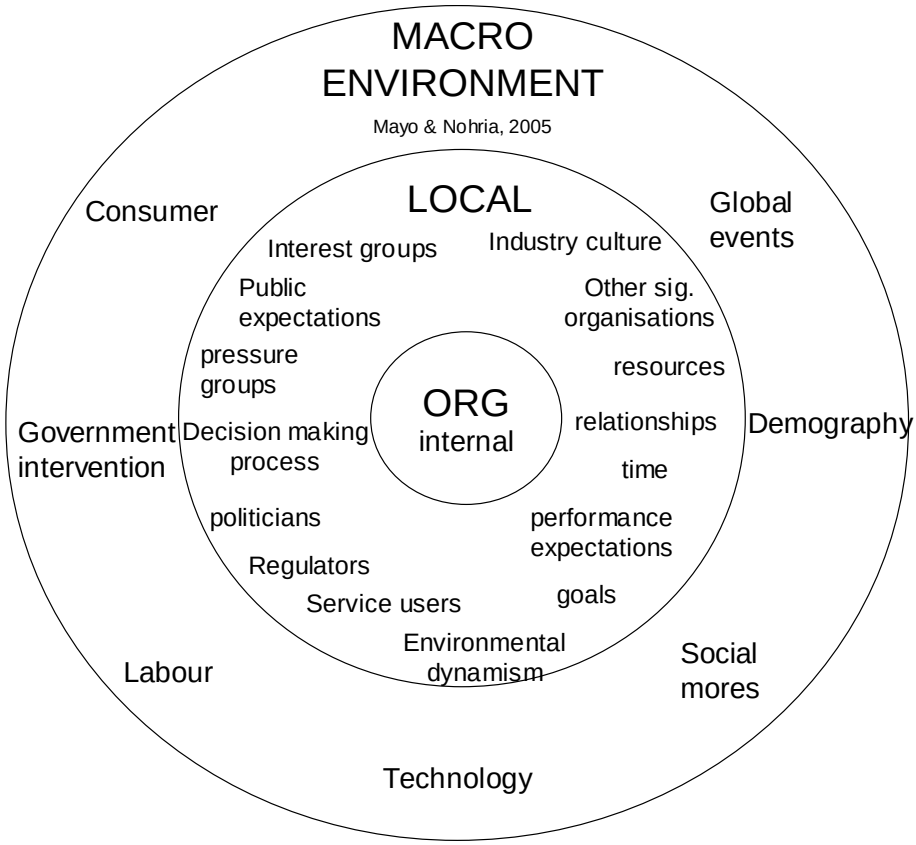
10.2 Modelling contextual factors

One of the main challenges in performing a contextual analysis is determining a reasonable organisational boundary. Because few organisations are closed systems, the decision about which environmental actors to include or to leave out can be arbitrary. Managers are often selective about where to draw their boundaries and therefore what they take into account. This poses two risks. One, they are prone to disregard information that appears outside the periphery of their construction of the context. Some of this information can be highly

valuable. Two, what they look out for and make sense of, will be influenced by their mental models. As dependence on mental models could constrain the quality of a contextual analysis, I have built a model of contextual factors that extended Mayo and Nohria's model, based on findings from the systematic review. The model has three concentric circles, radiating out from the CEO in the centre. In order to show all of the labels of contextual factors, they have been presented in two separate diagrams. The first shows the contextual factors operating inside of the organisational boundary (Figure 13). The second shows the contextual details of the two outer circles (Figure 14), each representing the local environmental and macro contexts respectively.

Figure 13 Internal organisation contextual factors

Figure 14 The (external) local and macro contextual factors



10.3 Process of contextual intelligence

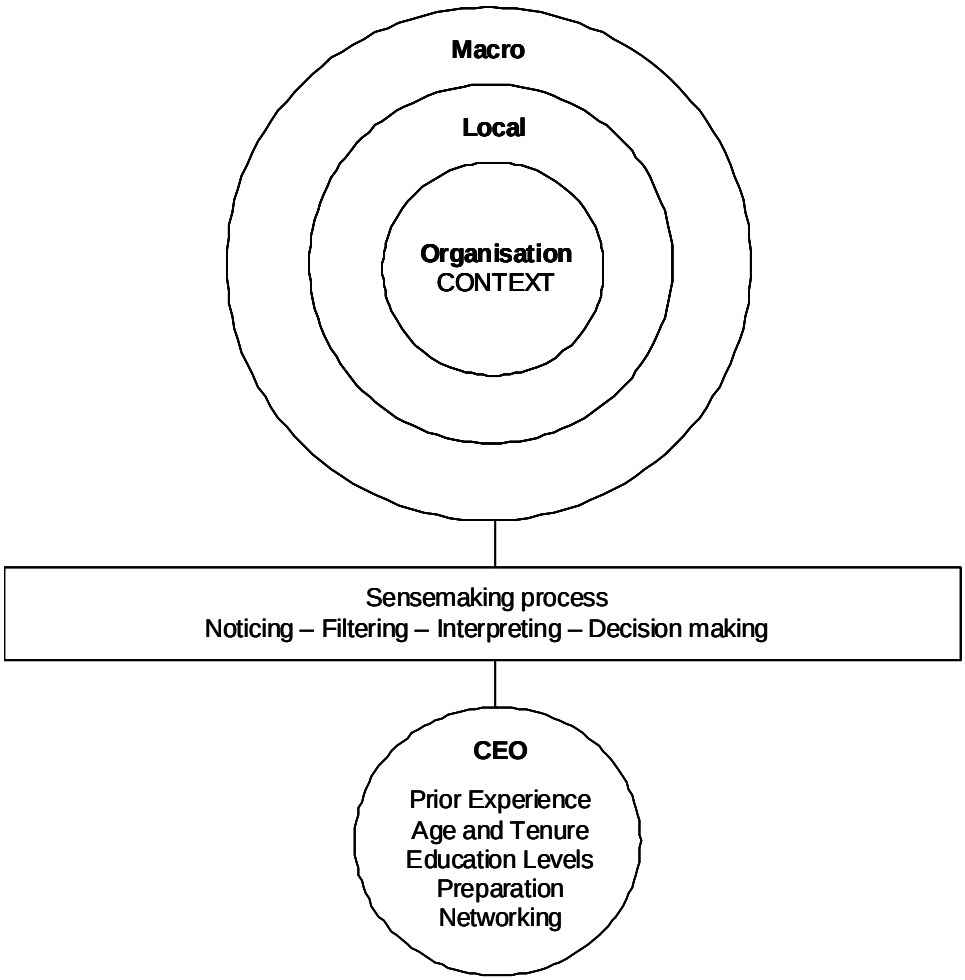
As individuals cannot imagine all possibilities, they adopt mental models that not only operate as the basis for the evaluation of choice alternatives, but more importantly, determine the cognitive space allowed for alternatives to be considered in any given decision problem. Just as the CEOs' beliefs or mental models were shaped by the different experiences and events earlier in their careers, it is proposed that contextual intelligence could be developed by expanding an actor's cognitive space, which could be achieved by altering individuals' mental models through training and development, broadening their work or life experiences and helping them to develop new insights through

raised level of self awareness. It is possible that terms such as “narrow-minded”, “tunnel vision” or parochial had arisen from a recognition that mental frames define the cognitive space used by decision makers and that they are developed through certain kinds of experience.

From the evidence gathered so far, the emerging model and process of contextual intelligence for CEOs appear to follow the pathway shown in Figure 15. (For details of elements within the concentric circles, please refer to Figure 13 and Figure 14) Mayo and Nohria (2005) described executive sense making as an “evolving opportunity structure” and attributed sensemaking to helping CEOs work out what their context was telling them, and what they needed to do to make the most of their environment. Building on Mayo and Nohria’s contextual model of leadership, the literature based model of contextual intelligence shows that, for a CEO, there are internal and external organisational contextual factors that are likely to affect his/her personal success, and therefore, the success of his/her organisation. For CEOs of public sector organisations, the local context plays a particularly important role. In addition, the personal contextual factors of the CEO may themselves be markers or predictors of likelihood of success, due to their influence on mental model and cognitive space developments. The sensemaking concept has been deconstructed to its elements of noticing/scanning, filtering, interpreting information and decision making.

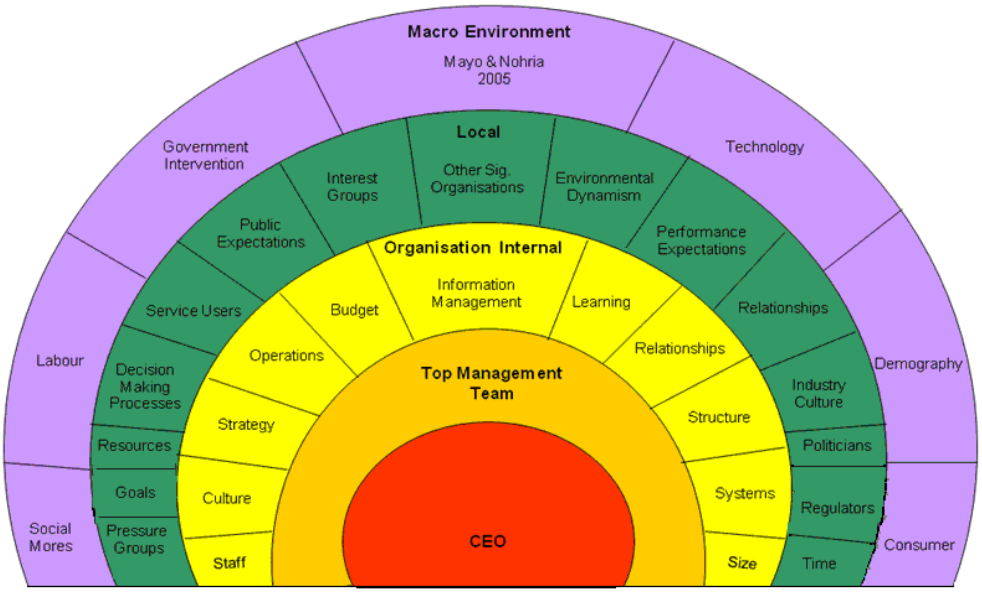
As a result of conducting the systematic review, an operational definition of contextual intelligence has been developed to describe the construct. CEOs who are contextually intelligent could be expected to define their strategic decision making context at three levels, namely the internal organisation, the local environment, and the macro economy, and at their sub-levels; demonstrate “ contextual intelligence” by systematically taking account of all relevant contextual factors in strategic decision making; demonstrate good information processing and sensemaking capabilities; have self awareness about their personal context; and able to make strategic decisions in a variety of different contexts.

Figure 15 Outline of the contextual intelligence process



The personal qualities of CEOs as possible contributors to contextual intelligence development were an interesting finding. However it is unclear how they impact on strategic decision making. Based on the contextual factors identified in the CEOs' operating environment, a literature based model of contextual intelligence is produced in Figure 16.

Figure 16 Literature based model of CEO contextual intelligence



11 CONCLUSION

The theory of contextual intelligence was first mooted by Sternberg (1988) as an executive capability, and Mayo and Nohria (2005) used the term in their historical review to describe business leaders who acted strategically in respond to prevailing macro level contextual factors. Surprisingly, there appears to have been no empirical research into the concept, despite a growing number of studies linking contextual factors to senior leader performance. The systematic literature review has drawn the following conclusions in response to the questions set out in paragraph 7.6.

First, a CEO needs to consider a number of key dimensions of contexts in strategic decision making. The dimensions of context for a CEO are his personal context, factors in the internal organisation, factors in the local economy, and macro-level factors at the national, or in some cases, global levels. Second, while the literature based model is expected to be generic for all CEOs, there are aspects of the NHS context that are relevant to a CEO operating in the NHS. These CEOs face particular constraints due to national policies, shifting goals, funding availability, power of the professions, stakeholder expectations including political interference. The results show 10 contextual factors that are particularly relevant to the NHS context. Third, by exploring the underlying concepts and theories of contextual intelligence, the literature review enabled the process of executive sensemaking to be captured. Fourth, the review enabled the formulation of the relationship between context, sensemaking and decision making, as shown in Figure 12. Fifth, as a result of a lack of empirical evidence, the impact of contextual intelligence on CEO and organisational performance cannot be confirmed.

The systematic review has resulted in the development of a literature based model of contextual intelligence which shows that CEOs need to consider different contextual factors when taking different types of strategic decisions. With public sector leaders such as CEOs of NHS Trusts, their main focus had been the local context, as most aspects of strategic decision making were about managing inter-personal and inter-organisational relationships and meeting the

competing expectations of different stakeholders. The literature based model revised and extended Mayo and Nohria's (2005) dimensions of context and deconstructed their "sense making" box to take account of prospective sensemaking. In a cycle of frequent renewals, contextual intelligence appears to guide managers in how they interpret the world and act on the information presented to them, enabling the actors to gain new insights that lead to further development of contextual intelligence.

The next step in the process of addressing the overarching research question of " how contextual intelligence influences PCT CEO strategic decision making in the English NHS" is to explore the derived contextual intelligence model in an empirical investigation.

Appendix B

Table summarising all of the included studies (119 studies)

Author	Data used in study	Date	Place of study	Summary of empirical findings
Adner Helfat	Review of annual reports of 30 companies in the petroleum industry	2003	USA	Use ANOVA to examine the effect of differences in managerial decisions on corporate performance. Found dynamic managerial capabilities in the form of human capital, social capital and managerial cognition to be linked to managerial decisions, and therefore firm performance.
Albright	n/a	2004	USA	A theoretical piece on environmental scanning
Alimo-Metcalfe Lawler	Postal survey of 44 private and public sector organisations – 30 questionnaires	2000	UK	When asked to identify factors influencing their organisations' approaches to leadership development, market place and shareholder value were rated over people issues.
Analoui Karami	Postal survey of CEOs of SMEs in the electrical and electronics industry – 132 question-naires	1999	UK	Direct correlation between increased environmental scanning, CEO strategic awareness and performance of SMEs (using non parametric correlation matrix, $p < 0.01$)

Barnett Pratt	n/a	2000	USA	Theorising a new conceptual model of organisational change "autogenic crises", used by top managers to prepare their organisations for future crises
Bartunek	Case study of a restructuring decision in a Religious Order	1979	USA	The process of change in interpretive schemas ("mindsets") is in reciprocal relationships with changes in structure. This relationship is not direct but is mediated by the actions of members and their emotional reactions to change. How the environment is interpreted by members also affects the type of change that takes place
Bartunek, Gordon Weathersby	n/a	1983	USA	A theoretical paper exploring Weick's notion of complicated understanding and linking it to other concepts including cognition and adult development
Baum Wally	Postal survey of CEOs of industrial companies - 318 questionnaires	2003	USA	Fast decision making is linked to improved firm performance but may produce bad decisions and bad performance if comprehensive information gathering is sacrificed to gain speed.

Beekun Ginn	Postal survey of hospital CEOs - 58 questionnaires	1993	USA	Use a Likert-scale to examine the relationship between CEO self assessments and Likert scale responses for two 5-year periods (1976 - 1980 and 1981-1985). Multiplexity was measured using network analysis. Found inter-organisational coupling patterns varied within two domains as a function of increasing environmental turbulence and strategy type
Bettis Prahalad	n/a	1995	USA	Theory development of the Dominant Logic
Blackler	Face to face Interviews with 25 NHS CEOs	2006	UK	Found the study of leadership in the public sector cannot be separated from the broader study of state institutions and that NHS CEOs have limited bureaucratic discretion
Blackler Kennedy	Face to face and telephone Interviews with 32 CEOs in NHS	2004	UK	Recognition by CEOs that their job was to deal with the everyday dilemmas and problems (rather than wishing them away) and this situation is not unique to the NHS

BluedornJohnson, Cartwright, Barringer	Literature review	1994	USA	Review of literature on strategic management and organisational context lead to six subsets: strategic leadership and upper echelons; scanning; inter-organisational relationships; institutional theory; organisational alignment; strategic control
Bourgeois Eisenhardt	Case studies of strategic decision making in 4 computer firms	1988	USA	Used hypothesis testing. In high velocity environments, successful firms were able to make major decisions carefully but quickly; and have a powerful, decisive CEO and powerful TMT
Broussine	Focus groups and one ot one telephone interviews - 36 CEOs of local councils	2000	UK	Five capacities were identified as central to a CEO's role: work with political dimensions; lead, change and develop the organisation; self awareness; develop external relationships; and focus on strategic and long term issues

Butler in mintzberg, Waters, Pettigrew Butler	Transcript of an exchange of view	1990	USA	Capturing Mintzberg and Waters' argument : in an organisation, the locus of decision making can be diffuse; exogenous events can trigger decisions; decisions are made within a context and help to influence the context for future decisions
Carpenter Golden	Management simulation based in food product industry – 20 managers and 78 MBA students	1997	USA	Measured three constructs- perceived managerial discretion, locus of control and perceived power – using statistical tests. Found individual differences, such as locus of control, influence the degree of discretion which predicts managerial power
Child	n/a	1997	UK	Theory about strategic choice in organisational action.
Clapham Schwenk	Content analysis of letter to shareholders in annual reports of 20 utility co's	1991	USA	Correlation tests on relationship between attributions and performance. Executives tended to take credit for good outcomes but to blame the environment for poor outcomes which may reflect cognitive bias. Found negative correlation between defensiveness and future earnings growth

Collinson Houden	Postal survey of SMEs – 30 questionnaires	2005	UK	Analysis of mental maps, correlation tests and use of Likert scales to identify factors influencing top managers' perceptions of spatial environment and patterns of internalisation.International experience and network relationships strongly influence managerial cognition and thereby internationalization decision-making.
Connor Becker	Survey of state managers attending their AGM – 161 questionnaires	2003	USA	Using the Rokeach Value Survey and Rowe decision style inventory, found personal values to affect decision making styles of public managers
Corner, Kinicki Keats	Literature review	1994	NZ	A conceptual model of strategic decision making that integrates organisational and individual level information processing perspectives

Daft, Sormunen Parks	Interviews with CEOs of SME manufacturing firms – 50 respondents	1988	USA	Tests for correlation between strategic uncertainty and CEO scanning behaviour. Found greater frequency of scanning and greater use of personal information sources when sector uncertainty was high; CEOs in high performing companies scanned more frequently and more broadly
Daniels, Johnson Chernatony	Semi-structured interviews of middle and senior managers in medium sized financial service firms – 32 participants	2002	UK	Use cognitive mapping methods to explore management cognition of competition. Institutional influences lead to convergence of mental models within middle managers across the industry. Task environment creates cognitive differences across organisations, especially amongst senior managers
Denison, Dutton, Khan Hart	Postal survey of CEOs in manufacturing technology firms – 320 questionnaires	1996	USA	Use factor analysis, correlation matrix and descriptive statistics to test hypotheses. Organisational context contributes to interpretation of strategic issues, significantly predicting the perception of threat and opportunity

Duhaime Schwenk	Selective citations of examples	1985	USA	Theorising four types of cognitive biases coming into play during decision making processes leading to corporate acquisitions or divestment decisions
Dutton	n/a	1993	USA	Theorising that strategic issue diagnosis for decision makers being affected by the organisational conditions, decision makers connections to a strategic issue, and characteristics of the issue – put decision makers on automatic in their interpretation of strategic issues
Dutton Duncan	n/a	1987	USA	Theorising that due to limited information processing capacity, an organisation's strategic planning process affects the set of strategic issues that capture decision makers' attention
Dutton Duncan	n/a	1987	USA	Conceptualising the process of strategic issue diagnosis creating momentum for change by linking to two contextual variables: the organisation's belief structure and its resources
Dutton, Fahey Narayan	n/a	1983	USA	Theorising a framework for strategic issue diagnosis in the process of strategic decision making

Dutton Jackson	n/a	1987	USA	A conceptual paper linking managerial cognition, strategic decision making and organisational action
Dutton, Walton Abrahamson	Interview strategic decision makers at the Port Authority -29 participants	1989	USA	Use Repertory Grid to identify the “meaning space” for strategic issues. Showed how framing of issues affects perception due to managerial cognition
Eisenhardt	Exemplar cases from computer industry	1992	USA	Fast decision makers look at real time information, focusing on the present; examine multiple simultaneous alternatives; seek expert advice; use conflict to reach a consensus; and integrate focal decision with other key decisions to achieve alignment with overall strategic direction
Eisenhardt Bourgeois	Interviews with CEOs and TMTs, questionnaire, and secondary source data – 8 firms in IT industry	1988	USA	Multiple case design. Results a) political behaviours arise from power centralisation and b) politics are not issue based but are organised into stable coalitions based on demographic characteristics such as age and office location, c) politics within TMT are associated with poor firm performance

Elsbach, Barr Hargadon	Literature review	2005	USA	Proposed a framework whereby specific cognitive schemas and specific contexts interact during sensemaking resulting in momentary perceptions called situated cognition
Euske	Literature review	2003	USA	Comparing the public, private and charity sector for differences and similarities in sectors
Fama	n/a	1980	USA	Using economics theory to deal with managerial incentive problems (“agency problems”) as a result of managers facing both the discipline and opportunities provided by markets for their services
Fiol	Case study of a large financial institution	1995	USA	Successful corporate innovation requires decision makers to develop a collective understanding by using communication frames to communicate the new reality
Fiol Huff	Literature review	1992	USA	Theorising a framework for classifying cognitive maps
Fiol O’Connor	Literature review	2003	USA	Interactions between mindfulness and the decision making context impact on managers’ ability to challenge bandwagon behaviours, hence affect decision outcomes

Garg, Walters Priem	Postal survey of CEOs of manufacturing firms – 105 questionnaires	2003	USA	Use descriptive analysis and correlation to test hypotheses. Recommend future scanning studies to include both internal and external environments of the firm when evaluating CEO scanning behaviour
Gavetti Leninthal	Computer simulations	2000	USA	Use Kauffman's NK landscape to model the degree to which alternative actions correlate with one another. Cognitive representation shown to be a powerful guide to search efforts. Changing actors' cognitive maps may be an act of adaptation but is offset by loss of tacit knowledge linked to prior recognition
Gavetti Leninthal	n/a	2001	USA	Theorising that the nature of the cognitive task and process of revision of beliefs likely to differ by level within a hierarchy
Gibbons O'Brien	Postal survey of CEOs of firms chosen randomly from directory – 92 questionnaires	2001	Ireland	Use factor analysis. Found negative link between socialisation (operationalised as exposure to variety of work experiences) and CEO commitment to status quo

Ginsberg Venkatraman	Postal survey of tax return preparation firms – 430 questionnaires	1995	USA	Structural equation analysis support taking a managerial cognition approach to 3 dimension of issue interpretation – urgency, understandability and manageability - as they enhance adaptive competencies
Gioia Manz	Literature review	1985	USA	Using scripts as a model for vicarious learning to link cognition and behaviour
Gioia Mehra	Book review	1996	USA	A critique of Weick's seminal text "sense making in organisations"
Gioia Poole	n/a	1984	USA	A conceptual framework on use of scripts in organisational behaviour, drawn from theory and research from other disciplines as well as the script notion
Gioia Thomas	Field notes, tapes and transcripts of interviews and meetings, action notes of task force and reflective recordings - an observational study in a university	1994	USA	Ethnographic analysis identified the main dimensions of sensemaking in a strategic change situation to be the guiding symbols and metaphors used, as the directionality if the the dominant change processes

Gioia Thomas	Case study - 30 in-depth interviews with TMT, internal documents. Findings then used to survey 311 executives from academia	1996	USA	Categorical analysis and Gestalt analyses. Found when facing strategic change, TMT members' perceptions of identity and image, especially desired future image, are key to the sensemaking process and serve as important links in members' issue interpretations
Greenwood Hinings	n/a	1988	USA	Theorising how organisational change and stability can be understood through the concepts of design types and tracks which are given meaning and coherence by underlying interpretive schemes
Gupta Govindarajan	Interview data from 16 senior managers and survey of general managers of SBUs from 8 Fortune 100 diversified firms – 58 questionnaires	1984	USA	Regression analysis suggests matching managerial characteristics with SBU strategy would increase likelihood of effective strategy implementation
Hambrick	Postal survey of CEOs and TMTs from 8 colleges, 6 hospitals and 6 insurance firms; Interview two executives from each industry	1981	USA	Frequency method was used to measure scanning variables against hierarchical levels and industry type. Results suggest no close or consistent relationship between scanning behaviour and either hierarchical levels or functional areas

Hambrick Mason	Literature review	1984	USA	The Upper Echelons theory states that organisational outcomes – strategic choices and performance levels – are partially predicted by managerial background characteristics
Hambrick Snow	Literature review	1977	USA	Theorising a contextual model of strategic decision making in organisations
Hambrick Finklestein Mooney	Literature review	2005	USA	Theorising a concept known as “executive job demands” to explain strategic decisions and leader behaviours
Harris	Literature review	1994	USA	Theorising individual sensemaking in organisation being based on mental dialogues between themselves and other contextually –relevant others as guided by their schemas for others
Harrison Boyle	Historical case study footwear industry	2005	UK	Business failure resulting from firm’s predominant mental model impacting on its learning capability
Hitt Ireland	Postal survey of top CEOs from all industries – 65 questionnaires	1991	USA	Use inter-correlation matrices to measure executives’ strategic decision making processes. Industry and executive characteristics are significant moderators ($p<0.01$) supporting the strategic choice perspective rational analytical approach

Hough White	Behavioural simulation - 172 managers from a Fortune 100 diversified technology firm; MBTI	1994	USA	Results indicate level of environmental dynamism combined with manager's functional position explains scanning behaviour
Jackson Dutton	Study 1 – administered questionnaire – 78 managers attending development programme Study 2 – reaction to posted stimulus material - 83 MBA alumni	1988	USA	Use statistical test. Study 1 identified the issue characteristics that managers associate with the concept of threat and opportunity Study 2 suggests presence of a threat bias leads managers to be more sensitive to issues associated with threats than to those associated with opportunities
Jenkins Johnson	Face to face interviews with owner manager of retail stores using laddering – 30 respondents	1997	UK	Causal maps elicited from discourses were compared to establish whether individual cognition is linked to business performance. No difference was found but subsequent inductive analysis identified a focus on relationships between specific concepts in the maps of high performers suggesting exploring the relationship between cognition and performance

Johnson Hoopes	Simulation game applying different parameters of sunk costs of changing strategy and observable competitor numbers	2003	USA	Modelling the dynamics of cognition and intra-industry structure shows a relationship between managerial cognition, the underlying nature of the industry (sunk costs) and evolution of industry structure
Kaplan Murray	23 year data - company annual reports patents filed, number of scientific publications - 15 largest drug companies	2003	UK and USA	Found recognition to be an important predictor of action, suggesting that cognition at the most senior level can help shape firms' response to discontinuities
Kiesler Sproull	Literature review	1982	USA	Conceptualizing managerial problem sensing, a necessary precondition for managerial activity directed toward organisational adaptation
Kumar, Subramanian Strandholm	Postal survey of CEOs in healthcare – 59 questionnaires	2001	USA	Statistical tests confirm significant moderating role of environmental scanning activities in competitive strategy and firm performance

Kuvaas	Postal survey of TMTs in newspaper industry – 162 questionnaires	2002	Norway	Use statistical tests. Results support behavioural decision making and social cognition perspective but question the organisational information processing prediction that assume active information processing equates to environmental vigilance
Lant Hewlin	Decision forms, information generated by the Markstrat simulation strategy game, questionnaire – 87 participants consisting of executives on development programmes and MBA students	2002	USA	Results point to cognitive schemas and team decision making structures focusing decision maker attention on different types of information for different categories of decisions
Lant, Milliken Batra	Content analysis of annual reports from firms in furniture and computer industries – 40 firms each	1992	USA	Descriptive statistic results indicate that poor past performance, environmental awareness, TMT heterogeneity and CEO turnover increase the likelihood of strategic re-orientation

Learmonth	Interviews with 16 CEOs in the NHS	2005	UK	Discourse analysis of distinguishing between words - management, administration and leadership – what the might represent and how they affect actions in the way they are used
Louis	Literature review	1980	USA	Theorising key features of newcomers' entry experiences and describing the sensemaking processes by which individuals coped with their entry experiences
Miller Friesen	Published data – 26 firms, postal survey of TMT– 10 questionnaires	1980	USA	Use statistical tests to analyze structural and strategy making variables over time. Found organizations to resist changing direction in strategy and structure.
Milliken	Postal survey of CEOs of liberal art colleges – 211 questionnaires	1990	USA	Use statistical tests and correlation. Results indicated perceived organizational and resource dependence characteristics significantly affected how CEOs interpreted environmental change
Mintzberg	Literature review	1979	Canada	Describes a pathway of strategy development
Mintzberg, Raisinghani Theoret	Field study of 25 strategic decision process; and literature review	1976	Canada	Describes patterns of a basic structure underlying all apparently "unstructured" processes

Mintzberg, Waters, Pettigrew Butler	Transcript of an exchange of views	1990	Canada	Key points to note in contextual analysis: interconnected levels of analysis; interconnectedness of past, present and future; importance of contexts and action; nature of causation about change
Monserrat	Postal survey of CEOs of SME from diversified industries – 233 questionnaires	2002	Spain	Use Likert scale to measure how managers make decisions and T-test to measure demographics. Found co-alignment between managerial characteristics and firm strategy contribute to organisational success
Nastanski	A Delphi process using multiple surveys in computer industry -20 questionnaires	2004	USA	Repeated round from Delphi. Active scanning is important to organisations operating in turbulent environment where future states are unpredictable
Nutt	78 case studies	1984	USA	Profiling decision-making processes uncovered variety of approaches and managers do not always use methods prescribed for good decision making. Most decision processes found to be solution centred, limit the number of alternatives considered and perpetuate the use of questionable tactics.

O'Reilly Roberts	Laboratory experiments	1974	USA	Processes of selective filtration which occur in organisational hierarchies indicate senders acted to filter different types of information depending on direction information was to be sent, and the senders' trust in the receiver
Oliver Roos	Case studies – a firm each from toy and high tech industries	2005	USA/ Netherlands	Profiling decision-making processes uncovered variety of approaches and managers do not always use methods prescribed for good decision making. Most decision processes found to be solution centred, limit the number of alternatives considered and perpetuate the use of questionable tactics.
Pettigrew	Single case study	1987	UK	Real strategic change requires crisis conditions, and by implications, senior executives pushing change in pre-crisis circumstances do not have sufficient leverage to break through the pattern of inertia in their organisation
Pettigrew in Mintzberg, Waters, Pettigrew Butler	Transcript of an exchange of views	1990	UK	Decision making need to be understood as a continuous process in context.

Pettigrew, Woodman Cameron	Literature review	2001	USA	Theorising future research studying organisational change and development should include time and history and to portray changes as continuous processes
Pfeffer Salacik	Postal survey of CEOs of hospitals – 57 questionnaires	1977	USA	Descriptive statistics and correlations were presented. Organisational contextual factors found to be related to characteristics of CEOs and CEO succession
Phillips	ethnographic interviews of cross section of staff from 12 (total) fine art museums and Californian wineries – 96 informants	1994	USA	Content analysis. Findings support existence of industry mindsets and recommend broadening research on industry based cognitive construct to include a wider range of cultural elements and wider set of industry participants
Porac Thomas	2 case studies of retail firms	1994	USA	How managerial cognitive structures using categorization help managers make sense of perceived competitive boundaries
Porac, Thomas Baden Fuller	Interviews with top managers from 6 Scottish knitwear firms. Secondary industry data	1989	UK	Qualitative analysis. Found industry structure both determines and is determined by managerial perceptions of the environment

Prahalad Bettis	Literature review	1986	USA	Theorising the concept of dominant logic to explain the connection between diversity and performance
Priem	Field study and survey of CEOs from manufacturing firms – 33 questionnaires	1994	USA	Descriptive statistics and correlations were presented. Executive judgements influence both organisational alignment and firm performance, supporting the strategic choice perspective
Priem Harrison	Literature review	1994	USA	Proposals for techniques for eliciting and analysing the strategic judgements of strategy makers
Rhodes Keogan	Interviews of CEOs from non profit housing associations – 25 participants	2005	Ireland	Qualitative analysis. Research suggest non profit strategy is affected by three external contexts: high regulation; impact of growth, and high HR visibility
Ring Perry	Literature review	1985	USA	Theorising implications of public vs private organisations on organisational behaviour and strategic choices
Samuelson, Galbraith McGuire	Historical published data	1985	USA	Statistical analysis. Top management performance has insignificant impact on organisational performance although new CEOs tend to be more risk adverse

Schwandt	Literature review	2005	USA	Theorising the conceptual orientations of sensemaking to adult learning and implication for conceptualisation of managerial work and development of managers
Schwenk	Literature review	1984	USA	Theorising possible cognitive simplification processes in strategic decision making
Schwenk	Literature review	1986	USA	Applying decision behavioural theory to model the process by which executives encourage commitment, by promoting specific cognitive heuristics and biases
Schwenk	Literature review	1988	USA	Proposes an integrative model of cognition in strategic decision making
Schwenk	Literature review	1995	USA	Modelling three different perspectives – cognitive, organisational and political – of strategic decision making to explain why organisations are resist strategic change
Seiling Hinrichs	n/a	2005	USA	Theorising mindfulness and constructive accountability as critical elements of effective sensemaking

Short Palmer	CEO annual shareholder letters in restaurant industry	2002	USA	Content analysis. CEOs use a wide variety of primarily internal referents to assess performance but those who integrate external referents tend to form larger and higher performing organisation
Short, Palmer Ketchen	Published performance data on 85 hospitals	2003	USA	Depending on what aspect of performance needing improvement, managers should focus their attention on either organisational resources or strategic group membership
Staw	Literature review	1981	USA	Theorising the concept of escalation of commitment and recommended a range of preventive actions
Staw, Sanderlands Dutton	Literature review	1981	USA	Multi-level analysis show a restriction in information processing and constriction of control when under threat – so called “threat rigidity effect”
Sternberg	Literature review	2003	USA	Conceptualizing the WICS –wisdom, creativity and intelligence – approach to leadership using stories
Sternberg Crigorenko	Literature reiew	2006	USA	Conceptualizing cultural intelligence and the importance of understanding intelligence in its cultural context

Swan	Literature review	1995	UK	describes the nature and importance of knowledge bases and cognitions for decisions about technological innovation
Stubbart	Literature review	1989	USA	Call for more explicit cognitive emphasis in strategic management research
Thomas McDaniel	Postal survey of hospital CEOs – 151 questionnaires Archival data from trade publications	1990	USA	Multivariate analysis and interpretations. Strategy and information processing structures of TMT affect how CEOs in different organisations interpret the same situation. If CEOs want this to change, they should manage their TMT's capacity to gather, process and convey information
Thomas, McDaniel Anderson	Postal survey of hospital CEOs – 162 questionnaires	1991	USA	Multivariate analysis. CEOs' interpretation of strategic issues, extent of whether a given strategic issue is perceived as controllable, is related to the existing hospital strategy and information processing structure
Thomas, Clark Gioia	Postal survey of hospital CEOs – 156 questionnaires	1993	USA	Path analyses based on case scenario method. Develop a model of strategic sensemaking and organisational performance that links scanning, interpretation, action and outcomes

Tucker, Cullen, Sinclair Wakeland	Single case study of a non-profit and simulation	2005	USA	Encourage non-profit leaders to use system dynamics modelling as decision making tools for options appraisal for strategic decisions
Tyler Steensma	Postal surveys of CEOs of technology firms – 101 questionnaires	1998	USA	Descriptive analysis and correlations. Top executives with a technical education or experience favour opportunities for potential technological alliances
Walsh	Literature review and synthesis	1995	USA	Identification of research implications to gain a better understanding of knowledge structure representation, development and use in organisations
Walters Priem	Survey and computerised judgement task data - CEOs of manufacturing firms – 42 questionnaires and data set	1999	USA	Descriptive analysis. CEO of highest performing firms matched certain aspects of external and internal scanning to business strategy
Walters, Jiang Klein	Postal survey of CEOs of small manufacturing firms - 116 questionnaires	2002	USA	Descriptive statistics. Internal information is just as important in analysis of new situations as is the external information

Wang Chan	Literature review	1995	UK	Propose that top management perception of strategic information processing in a turbulent environment is influenced by 4 contextual attributes – rewards and incentives, culture, structure of strategic planning process, and executive support systems
Weiner Mahoney	Secondary source data (Compustat) for 193 firms in manufacturing	1981	USA	Content analysis and descriptive statistics. A model of corporate performance as a function of environmental, organisational and leadership influences showing top leadership position of an organisation to be unimportant
Yukl Lepsinger	n/a	2006	USA	Organisational leaders should consider efficiency, adaptation and human resources as determinants of improvements in organisational effectiveness

CRANFIELD UNIVERSITY

SOM
DOCTOR OF BUSINESS ADMINISTRATION

DBA

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YI MIEN KOH

PROJECT 2:
CONTEXTUAL INTELLIGENCE AND CEO DECISION MAKING IN THE NHS

Supervisor: DR CATHERINE BAILEY
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This thesis is submitted in partial fulfilment of the requirements for the degree of DBA

12 INTRODUCTION

12.1 Statement of the issue

Recent studies of successful organisational leaders have reported the need for senior leaders to understand and take account of context when making strategic decisions (Thomas, 1988; Sternberg, 1988; Mayo and Nohria, 2005). A systematic review of the literature conducted in Project 1 has resulted in a literature based contextual intelligence model for chief executive officer (CEO) strategic decision making. What is unknown is that model, based on evidence from the corporate world, applies to CEOs working in the English National Health Service (NHS). The project will test the applicability of the literature based model by exploring the range of contextual factors Primary Care Trust (PCT) CEOs take into account when making substantive and organisationally significant decisions across different decision making contexts. The aims of Project 2 are two folds: one, to contribute to the understanding about the contextual intelligence concept in PCT CEO strategic decision making and two, to compare the contextual factors CEOs said they took into account against evidence from the literature.

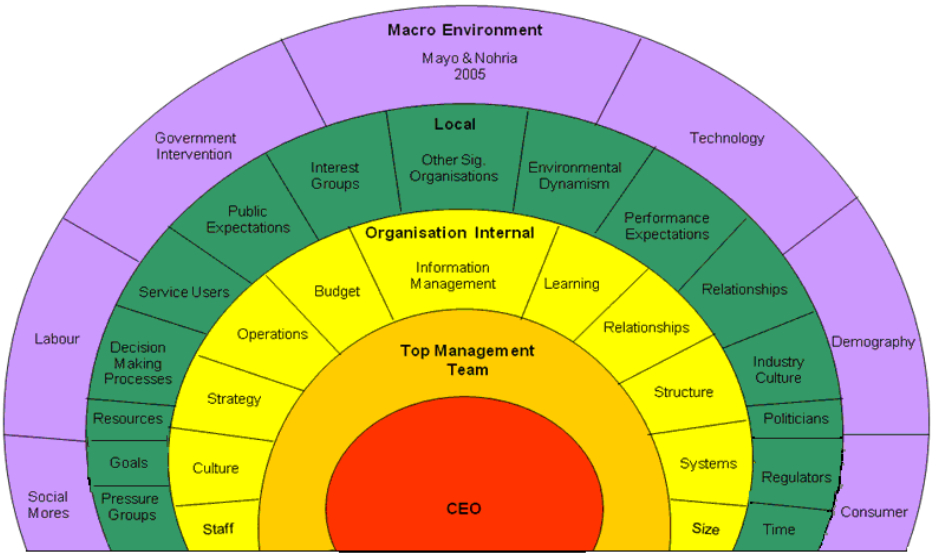
12.2 Background

Researchers of leadership and performance have long argued that contextual factors matter in relation to organisational performance (Lieberson O'Connor, 1972; Salancik Pfeffer, 1977; Samuelson et al., 1985; Weiner Mahoney, 1981), supported by studies showing how leaders have coped with or taken advantage of the key contingencies facing their organisations (Pettigrew 1987; Mayo Nohria, 2005). Yet the processes underlying how CEOs make sense of and respond to their environment are not well understood. Sternberg (1988) uses the term "contextual intelligence" to describe a leader who "learns and remembers and gains information from past mistakes and successes; has the ability to understand and interpret his environment, knows what's going on in the world" (p.244). Mayo and Nohria (2005) extended the concept with a leadership model of contextual intelligence based on an analysis of historical

data linking CEOs' sensitivity to macro-economic contextual factors and business success.

In order to understand what may constitutes contextual intelligence, it is necessary to, first, describe what the CEOs conceive of as their contexts, and second, to provide a plausible explanation as to how this conception influences strategic decision making. Drawing upon the systematic review findings, a conceptual model of CEO contextual intelligence was constructed as shown in Figure 17.

Figure 17 Literature based model of CEO contextual intelligence



This literature based model of contextual intelligence attempts to represent a CEO's contextual world in a series of hemispheres radiating outwards from the CEO in the middle and internal organisation to the external local and macro environments. Each hemisphere contains contextual factors that apply to that part of the CEO's social world. The ability to make sense of context and to apply this knowledge to strategic decisions is what constitutes contextual intelligence.

The literature based model of contextual factors has yet to be tested for its validity in practice as it was derived from studies in a broad range of management environments. Furthermore, with almost all of the published evidence coming from the corporate sector, its application to the public sector and in particular the NHS is unclear. A research study into how aspects of contextual factors influence strategic decision making occurs in the NHS would be helpful not only in identifying actions that could lead to better strategic decision making by senior leaders in the NHS but would also offer an opportunity to compare strategic decision making practices in the NHS with those in the corporate sector. Evidence about how CEOs in the NHS make strategic decisions would therefore contribute to leadership and decision-making theories by developing a practical understanding of strategic decision making practices in an organisationally critical role.

12.3 Statement of scope and aims

The research sets out to answer the following question:

What aspects of contextual intelligence are most important for PCT CEOs in the NHS?

In order to address this question, further eight sub questions were identified:

1. How do CEOs define their decision making context?
2. Is there a hierarchy among contextual factors? Do certain contextual factors have greater influence than others?
3. How do the contextual factors identified by the CEOs match the contextual intelligence model developed on the basis of the systematic review?
4. Are there common patterns of contextual factors and influence across CEOs?
5. Do the CEOs take different things into account when taking different kinds of strategic decisions?

6. If they do, is it possible to explain how the common approaches came about?

7. What are the differences between what CEOs say they do (theory) and what they actually do (practice)? (This tells us the extent to which CEOs enact their intentions.)

8. What other factors play a part in CEO decision making process?

In order to address these questions, the research was divided into two parts, Project 2 and Project 3. The first part, Project 2, is the subject of this report and is based on the first round interviews with CEOs about their decision making practices with respect to different kinds of strategic decisions. The aims of Project 2 are to address questions 1, 2, 3, 4 and 5 (*theories of action*). The second part is reported in Project 3 and is based on the findings from a second round of interviews with CEOs based on their diary activities at a later point. The aims of Project 3 are to address questions 5 (theories in use), 6, 7 and 8 as well as issues that arise in Project 2.

12.4 Research strategy

The research strategy used in Project 2 is abduction. An abductive strategy was chosen because it enables theory to be generated from the accounts given by the CEOs of their social world. In Project 2, such accounts contain the concepts and meanings used by the CEOs to structure their contexts and therefore to direct their decisional behaviour. By moving from first order constructs (*actors' descriptions and accounts*) to second order constructs (*researcher's interpretations*) the approach allows the researcher to discover and describe the key concepts making up the CEOs' decision making context from an "insider" view, thereby retaining the integrity of the phenomena.

13 METHODOLOGY

13.1 Research methods

The research is carried out in two parts, the first part in Project 2 and the second part in Project 3. It adopted a multi-method approach with a number of key features:

a) Project 2 used qualitative, semi-structured interviews to elicit CEOs' understanding of what they perceived as their decision making contexts. Diary based interviews were conducted in Project 3 to gather data on CEOs' lived experience.

b) The research design was both prospective (Project 2) and retrospective (Project 3). Two interviews conducted two months apart in a public decision-making timeframe enable data to be collected from participants in a "before and after" way, to enable the testing of theory (Project 2) versus. practice (Project 3). A gap of two months between interviews was chosen as an appropriate time frame as it was deemed to be sufficient for strategic decisions to have progressed and to show which contextual factors have influenced that progress. As the CEOs were asked to keep a diary in the interim period, a longer time frame would run the risk of non-compliance.

c) In Project 2, the CEOs were presented with four strategic decision contexts, in order to identify differences in the contextual factors that have significant influence on CEOs when dealing with different kinds of strategic decisions.

d) One of the four strategic decision making contexts was a major policy edict from the Strategic Health Authority (SHA). As a common decision instigator, it would involve all CEOs making comparable decisions in parallel, thereby identifying any individual differences.

e) All of the CEOs kept a diary to provide an additional source of confirmatory evidence of decision making activity for Project 3.

Project 2 is a report about the first round of semi-structured interviews.

13.2 Data sources, types and forms

Data sources used in Project 2 are as follows:

a) **Study population**: As the main research question is about what aspects of contextual intelligence influence CEO strategic decision making in the NHS, all CEOs of PCTs operating in an SHA region were invited to take part. Only permanent appointments were invited to participate to avoid the risk of having different approaches to strategic decision making being affected by the interim status of the incumbent.

b) **Semi-structured interviews**: An interview protocol (Appendix C) provided a standard and semi structured approach to collect qualitative data on the theory and intentions of how the CEOs conceived of their strategic decision making context.

13.3 Criteria for choosing appropriate strategic decision

An early pilot of the interview protocol with two NHS CEOs revealed that some organisationally critical decisions do not necessarily involve CEOs. For example, neither of the two CEOs interviewed knew what their organisations were doing on the “18 weeks referral to treatment” target which was a top national priority, as they had delegated that responsibility to their Director of Operations. The pilot findings suggest that NHS CEOs may delegate some strategic decision making to their teams, especially those with a large element of implementation. I therefore decided that the choices of strategic decision context would focus on policy or strategic plans that the CEO would be held accountable for by their boards. I was aware from my own experience that, in practice, the terms strategies, policies and plans were used interchangeably in the NHS. These policies, strategies or plans would have to be designated as the responsibility of the CEO for which they would be answerable to their boards. It must also allow for individual differences in action.

Around the time of study design, the SHA launched a major regional health strategy (hereafter to be referred to as RHS) so it made sense for the strategy

to be a focal policy to test CEO strategic decision making approach. The RHS was published in July 2007 by the SHA and proposed two key changes:

a) centralisation of emergency services in fewer hospitals where evidence supports the case for critical mass (activity volume and availability of expert staff). This would see PCTs commissioning new services in fewer (mainly teaching) hospitals, with minimal impact on local hospital services due to the small number of patients affected by the change.

b) shifting services out of hospitals into a new type of community health centre called polyclinics that would provide outpatient and simple diagnostics in addition to routine primary care and community services. This localisation strategy would have a major impact on PCTs as each would have to develop local plans to reconfigure the provisions of health services in its area as well as invest in new facilities. Local hospitals could lose business as activity moves out of hospitals and GP practices would have to work in a federated model.

The potential gainers of the RHS would be large teaching hospitals while district general hospitals could lose up to 25% of their activities. The SHA had set a timetable for public consultation (a statutory requirement for major service changes) to be led jointly by all PCTs in the region. Each PCT was responsible for consulting their local population and every PCT Board was required to consider the responses received in a public board meeting to be held in an agreed week in May 2008.

13.4 Data collection process and methods

Twenty four of the 31 PCT CEOs in the region took part in the study. Seven CEOs were excluded due to vacancy (2), interim appointments (3), imminent departure (1) and me, the researcher. The CEOs were recruited through a face to face meeting or telephone call followed by a personal email from me (Appendix C) explaining the research context and commitments required (two face to face interviews, each lasting up to 90 minutes to be conducted in their offices or an alternative preferred location; and keeping an electronic diary for two months), and assuring them of confidentiality. Attached to the email was a

participation information sheet (Appendix D) and the research ethics approval form (Appendix F). Once email confirmations were received from the CEOs, their offices were contacted and interview dates arranged.

The interviews adopted a semi-structured approach following an interview protocol (Appendix E). I conducted all the interviews personally. With four exceptions, all interviews took place in individual CEO's offices. Each interview took up to 1.5 hours and was recorded. The interviews focused on the contextual factors the CEOs would take account of when responding to national policies, a major regional strategy (RHS) and local strategic plans. All CEOs were asked four standard questions:

1. What factors would they take into account generally when taking generic strategic decisions?
2. What factors would they take into account when responding to national policies?
3. What factors would they take into account in relation to implementing the RHS proposals for service centralisation?
4. What factors would they take into account in responding to the RHS polyclinic strategy in their local area?

13.5 Ethical issues

There was a risk that despite the straightforward nature of the interview questions, some respondents could find the experience uncomfortable. In accordance with good practice in social research, participants were provided with an information sheet (Appendix D) about the nature of the project, what was expected of them, how the research procedures may affect them and how anonymity would be assured. It also reassured them that the information provided would be treated in confidence and that they had the right to withdraw from the process at any stage. The study satisfied the ethical standards laid down by Cranfield University Research Ethics Committee (Appendix G).

13.6 Data reduction process

The data reduction process involved a detailed line by line examination of the raw transcripts, a process known as microanalysis, using NVivo 8, a computer software package developed by QSR International for qualitative data analysis. In total, 23 of the 24 transcripts were analysed in this way. One recording was of poor quality and although hand written notes were taken during the interview, the decision was taken to exclude the transcript to ensure consistency with the rest of the data sources. With microanalysis, the data were mined, and relevant texts in the form of single words, phrases, sentences or paragraphs highlighted and "tagged". The tagging process enabled me to label or name the text in the form of a code, hence the use of the term "coding". By categorising the data, coding facilitated data management and conceptualisation as the process linked data to concepts and back to supporting data (Richards and Moore, 2007).

Overall, the open coding process identified well over 200 codes or "concepts", each represented by a tree node. As the number of nodes grew, it created multiple levels or generations (it reached five levels at one point) from the top level parent nodes. By then, the data had become too unwieldy to handle and time was wasted scrolling up and down coding trees to look for the tree node that fitted the description. It soon became evident that several codes were really sub-categories, duplications or even overlaps, by the ways they were relating to each other. To organise the concepts into more manageable and sensible groupings, I created *a priori* codes based on contextual factors from the literature based model and where applicable, parent tree nodes would be coded to these. This reductionist process led progressively to parent tree nodes coding the top level contextual factors and generational child nodes providing details of the phenomena such as when, where, why, who, how and with what consequences, thus giving each concept further clarification and specification.

13.7 Data analysis

Data analysis was carried out in three stages:

The first stage involved a systematic analysis of 23 of the interview transcripts (case files) with a view to testing the construct validity of the literature based contextual intelligence model. The aims were to examine the extent the theoretical framework applies to PCT CEOs and to identify any new contextual factor that had been missed in the systematic review. As I systematically went through the transcripts, relevant texts were coded based on my interpretation of the data and the emergent concept or phenomenon. Each code was assigned a tree node, with nodes progressively forming a hierarchy or "generations" under a top level parent node. Texts that did not show obvious connections to existing tree nodes were coded as free nodes.

For this stage, each transcript was analysed as a single response rather than as distinct responses to four separate questions. Whilst such an approach enabled the theoretical model to be tested, it would miss any potential differences in contextual factors associated with different kinds of strategic decision. With each of the four questions presenting a different strategic decision context, analysing the responses by question could help to clarify if CEOs took different contextual factors into account when dealing with different decision making contexts. This was the focus of the next stage of analysis.

The second stage of data analysis involved re-categorising the coded data from 12 case files by question. Only 12 files were coded this way as saturation was reached. Four coding systems, or trees, were set up in NVivo to represent the four decision making scenarios of *generic strategic decision, national policy, regional strategy (centralisation)*, and local plans (*polyclinic)*. Each tree had its own set of *a priori* codes (in the form of child nodes) based on the literature based model. Previously coded texts were retrieved and re-categorised according to the responses to questions. That is the main difference between stages 1 and 2; data analysis in stage 2 was scenario or context-based, while stage 1 was conceptually based.

The third and final stage in data analysis repeated the coding process used in Stage 2 to the CEO responses to Q1 ("*what factors do you take into account when taking generic strategic decisions?*") from the remaining 11 transcripts. By

taking a common approach to data analysis for the same question, a link was made between steps 1 and 2, enabling all 23 responses to Q1 to be analysed in a standard way**.**

13.8 Expected outcomes and benefits

The expected outcomes from adopting this analytical approach are as follow:

a) The first step of analysis involved systematic coding of 23 case files, treating each case file as a single response. The aim was to achieve a rapid assessment of the applicability of the literature based contextual intelligence model to PCT CEOs at a high level

b) The second stage of analysis was carried out on only 12 case files as saturation was achieved. This stage would show if PCT CEOs took different things into account when making different kinds of strategic decisions

c) The third stage of analysis extended stage 2 to the remaining 11 case files but only for responses to the Q1 which examined contextual factors in generic strategic decision making. This is to check for internal consistency between stages 1 and 2

d) If there were common patterns of contextual factors and influence across CEOs when taking strategic decisions, that might suggest the presence of an NHS mindset or mental model

Potential findings from data analysis should provide a clearer understanding of the common contextual factors PCT CEOs take into account and an elucidation and development of the proposed Contextual Intelligence model.

14 FINDINGS

14.1 Testing the literature based contextual intelligence model

The coding process enabled underpinning concepts to be identified, with the sub-factors explaining the make-up of each contextual factor. The findings are reported below, starting with the contextual factors closest to the CEO as represented in Figure 16.

14.1.1 Top Management Team

The contextual factor, Top Management Team (TMT), was referred to variously as the senior management team, top team, executive team or management team. For consistency, the term TMT was used throughout the research for any reference to individual directors or TMT. In total, 10 out of the 23 transcripts (10/23, 43%) referred to TMT, usually as sources of expertise, skills or managerial capacity, as shown in Table 14. While the focus on tasks and accountability was to be expected, some CEOs used their TMT or individual directors as sounding boards.

Table 14 Top Management Team (TMT) factors considered by PCT CEOs in strategic decision making

Functional expertise • Individuals skills • Deputising for CEO Tasks Accountability	Sounding board • testing ideas • brainstorming

Examples of quotes referring to TMT members are shown below

Functional expertise

We've got a strong public health director ….. and public health embedded in the values of the organisation. My directors, depending on whether the decision is in their domain, I would always take their advice.

CE Is

I have got a very reliable deputy chief executive in the Director of Finance and Information and for some issues, it is really helpful to be able to sort of have an informal word with him. He will always challenge me and offer a different perspective and that is really helpful in the early stages.

CE Br

Testing ideas and brainstorming

With the chief operating officer from our provider side, we sat there and we sort of said, there will be x and there will be y …... So we did brainstorming I suppose.

CEO Is

I do work very much with a team ….. who I trust, so their views would be fundamental.

CEO Ha

I would expect, in making those decisions therefore to have tested ….. with management team colleagues as to what their priorities are, and therefore what the context is for their decisions.

CEO Cr

14.1.2 Organisational internal factors

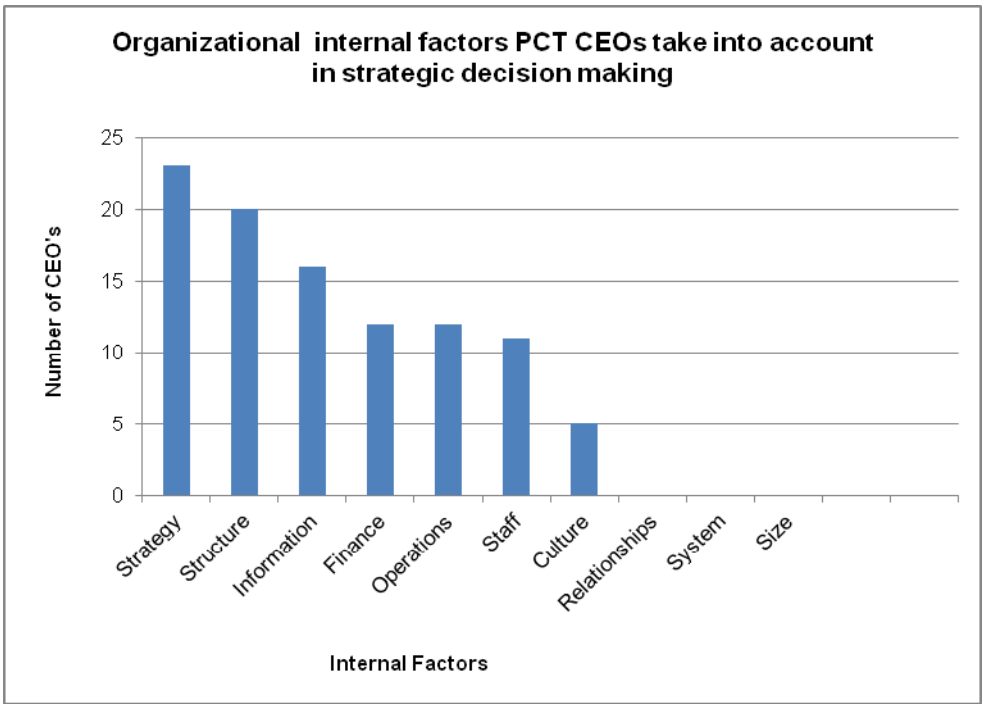
The results for the rest of organisational internal factors are set out in Table 15 and Figure 18. They show PCT CEOs identifying with a majority of the literature based contextual factors, albeit to different degrees.

Every CEO talked about **organisational strategy**, indicating this to be a critical factor in strategic decision making. In second place was structure, which was mentioned by 20 CEOs (20/23, 87%). The remaining factors, in order of citation frequency, were information, finance, operations and staff. A few factors, namely size, systems and relationships, were not mentioned by anyone. The next section will examine the contextual factors and their sub-factors (sub-categories) in detail.

Table 15 Organisational internal factors considered in CEO strategic decision making

Contextual factors	Number of CEOs *(%)*
Strategy	23 *(100)*
Structure	20 *(87)*
Information	16 *(70)*
Finance	12 *(52)*
Operations	12 *(52)*
Staff	11 *(48)*
Culture	5 *(22)*
Relationships	0
Systems	0
Size	0

Figure 18 Organisational internal factors considered in CEO strategic decision making



To understand the reasons for variations in frequency distribution of contextual factors, the coding trees of sub-categories were examined with a view to

identifying the explanatory factors underpinning each organisational internal factor (see Table 16 below.). The following notes were made with respect to contextual factors (which are represented by the parent tree node).

Table 16 Coding tree of <u>organisational internal factors</u> involved **in** PCT CEO **strategic decision making**

Strategy	**Information**
Coherence with national/regional policy	Hard (quantitative) evidence
Synergy	Published evidence
Flexibility	Best practice standards
Strategic fit	Existing data
Development process	Audit reports
Timetable	Qualitative insights
Openness	Expert views
Risk assessment	Consultation feedback
Impact analysis	Lessons from elsewhere
Strategy *vs* operations	Soft intelligence
Mapping risks	Talking to people
Assessing future needs	Seeking patient views
Negotiability	Modelling assumptions
Must do's	Observations
Compromises	
Fudges	**Finance**
Presentation	Affordability
Communication	Financial modelling
Local meaning	Value for money
Use of language	Risks
Vsioning	
Frequency	**Operations**
	Mobilisation
Structure	Performance
Engagement framework	Pilots
Group composition	Scale
Expert inputs	
Formal arrangements	**Staff**
Conflict of interest	Engagement
Organisation	Trade union
Leadership	Professional groups
Individual capability	Terms and conditions
Formal groupings	
Governance	**Culture**

Board	
Chairman	Values
NEDs	Climate
PEC Chair	Learning
Medical Director	
CEO	
Programme	
Programme boards	
Programme management	

14.1.2.1 Strategy

Organisational strategy was a critical factor guiding CEO decision making. Faced with top down policy requirements, the CEOs' first reactions were to seek strategic fit between policy and existing organisational strategy. If this were difficult, they would try to negotiate with the SHA or DH for local flexibilities. The CEOs described how they would operationalise the policies by establishing a process to engage stakeholders. A timetable will be set and the process might include a risk assessment with an impact analysis of trading off long versus short term needs, mapping risks and assessing future needs. The CEOs were in agreement about what counted as "must dos" or central diktats and if necessary they would try to present or "fudge" their local positions in legitimate ways to improve compliance. They would translate top down policies into meaningful and achievable local plans, which they do by using language that local stakeholders understood and communicating frequently.

14.1.2.2 Structure

The PCT CEOs appeared to take a broad view of structure, citing structural forms relating to engagement, organisation, governance, performance and programme management. They liked operating in a formal structure that involved the right people such as subject matter experts, and managed the conflicting interests of stakeholders. For this reason, programme management and decision making fora were popular. The CEOs would pay attention to leadership and individual capability at every level, from groups to organisations.

Having an effective governance structure was a high priority, and CEOs valued having a strong board with strong leadership with the ability to demonstrate accountability and legitimacy in strategic decision making.

14.1.2.3 Information

Three out of four CEOs said they would ask for evidence to inform their strategic decisions, with preferred information sources being formal publications ranging from DH reports, peer-reviewed journals to public audit reports. A few would also obtain advice and knowledge about best practices from subject matter experts, as well as source soft intelligence from talking to stakeholders, opinion formers, and other significant organisations such as the SHA or other PCTs. On occasions the PCTs may have to formally seek feedback from the public through formal consultations. Modelling was sometimes used to challenge prevailing assumptions and practices. The CEOs did not appear to use information systematically.

14.1.2.4 Finance

Half of the CEOs mentioned money issues, mainly to do with affordability and whether plans were value for money. There was little evidence of strategic financial acumen beyond financial modelling to mitigate risks.

14.1.2.5 Operations

The one in two CEOs who raised this was concerned about balancing implementation with maintaining performance, and said they would pilot changes before expanding on a larger scale.

14.1.2.6 Staff

Issues were about engaging with staff; dealing with a unionised multi professional workforce in the NHS and instilling a learning culture in the organisation.

14.1.2.7 Culture

Issues were about values, climate and culture within the PCTs.

In summary, all PCT CEOs espoused a determination to achieve alignment between organisational strategy and top down goals. They indicated they would try to influence their internal organisation to act in ways that would be advantageous for the PCT and its local population. There was a strong preference for formal structures and published quantitative evidence. As leaders of statutory organisations, the CEOs demonstrated that they had good knowledge of governance and accountability and would want to establish appropriate structures and communicating frequently with stakeholders. Just over half of all CEOs expressed concerns about finances and operations, which may reflect the financial situation of their PCTs at the time of interview. One in two CEOs cited staff engagement, including the building of a strong culture as part of policy implementation. Unsurprisingly, there was no mention of relationships, systems and size, which could be explained by CEOs being outward facing in relationship terms and are likely to delegate concerns about internal systems to the TMT. As there was no prescribed size for PCTs, which vary widely in the population covered, the size of the organisation was not a concern.

14.1.3 Local (external) contextual factors

Compared to internal organisational factors, PCT CEOs reportedly pay substantially more attention to local contextual factors external to their organisations, as shown in Table 17 and

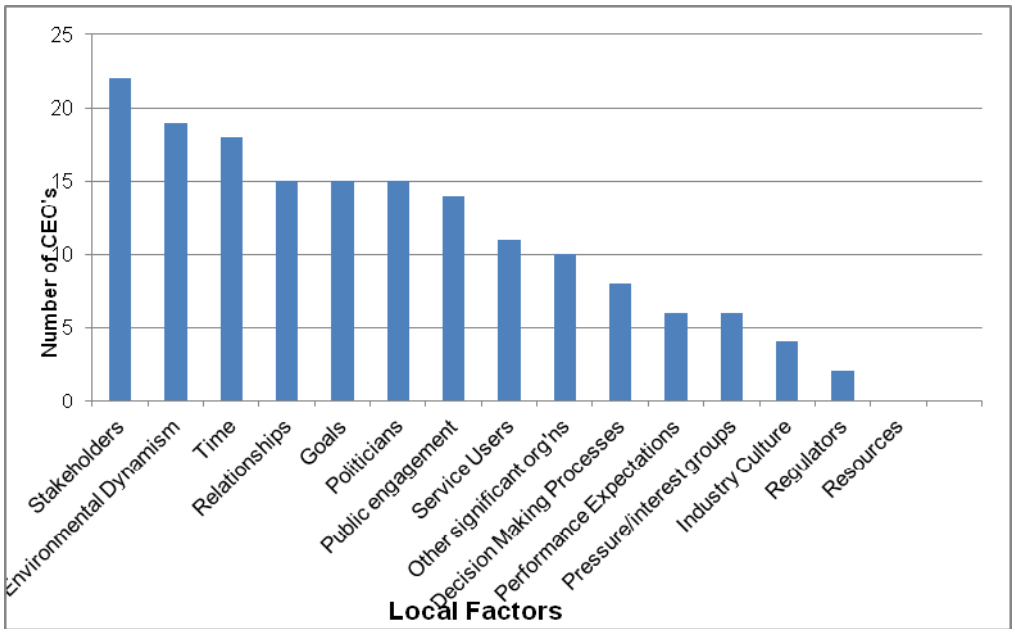
Figure 19. Of the first level factors, stakeholders topped the list, followed closely by goals and decision making process. The three contextual factors were cited by over 90% of CEOs, showing they may be critical contextual factors in PCT strategic decision making considerations. The next group of contextual factors cited by the majority of CEOs consists of, in descending frequency order, environmental dynamism, time, relationships, politicians and public engagement. The citation frequencies for this group indicate that such factors were likely to be important considerations depending on local circumstances. The final group of contextual factors is related to unique local contexts, as they

were cited by a minority of CEOs. (In both organisational internal and local contexts, no new contextual factor emerged from the analyses.)

Table 17 Local (external) contextual factors considered in CEO strategic decision making

Contextual factors	Number of CEOs *(%)*
Stakeholders	22 *(96)*
Goals	21*(91)*
Decision making process	21 *(91)*
Environmental Dynamism	19 *(83)*
Time	18 *(78)*
Relationships	15 *(65)*
Politicians	15 *(65)*
Public engagement	14 *(61)*
Service users	11*(48)*
Other significant organisations	10 *(43)*
Performance expectations	6 *(26)*
Interest or pressure groups	6 *(26)*
Industry culture	4 *(17)*
Regulators	2 *(9)*
Resources	0

Figure 19 Local contextual factors considered in CEO strategic decision making



A coding tree containing details of categories and sub-categories of PCT CEOs' local strategic decision making context is shown in Table 18.

Table 18 Coding scheme showing the categories and sub-categories of <u>local factors</u> informing PCT CEOs strategic decision making

Stakeholders	**Goals**
Stakeholder management	Origin or trigger
Identifying stakeholders (see list)	Top down requirement
Public	Local strategy
Signifiant organisations	Being opportunistic
NHS	Appropriateness
Non NHS	Right model of care
key post holders	Do-ability
Significant groups	Timeframe
Significant individuals	Alignment with strategy
Service users	Locally focussed
Politicians	Delivery
Conducting stakeholder analysis	Structure
Position	process
Interest	
Issues	Performance expectations**
Inner circle of influence	Clear specification
Engaging stakeholders	Targets
Taking soundings	Do minimum
Opportunity to raise concerns	Monitoring mechanisms

- Building links
- Building support

Managing stakeholders

- Managing expectations
- Managing relationships
- Managing reputation

List of stakeholders

Statutory (other sig organisations)*

Local council

- Local Strategic Partnerships
- **Politicians***
  - Mayor
  - Council leader
  - Ward councillors
  - OSC Chair
- Executives
  - CEO, DASS
- Social Services

NHS Trusts

Significant individuals

- Consultants
- CEO
- Medical Director

Issues

- Shared goal
- Financial problem
- Staff buy-in
- Relationship
- Range of service
- Access

Other PCTs

- Sector (sub-regional)
- Peers (other CEOs)

SHA

- Formal approach to policy
- View of sign individuals
- Department of Health
- GPs
- Organisations
  - LMC
  - PBC

Sanctions

Horison scanning

Decision making processes

Clarifying objectives

- Specifying outcomes

Demonstrating the problem

- Published evidence
- Expert views
- Lessons from elsewhere
- Independent validation

Developing a plan

- Mapping decision pathway
- Working backwards
- Having a Plan B
- Timetabling

Evaluating options

- Developing business case
- Appraising options
  - do-ability
  - Track record
- SWOT analysis

Mitigating actions

- Programme management

Negotiating outcomes

- Pragmatism
- Doing deals
- Trading off
- Compromising

Engaging stakeholders

- Conveying local meaning
- Getting buy-ins
- Early warning
- Communication

Relationships

Legitimising decisions

- Board
- Governance
  - processes
  - composition (members)
- Demonstrating accountability
- Demonstrating compliance

PEC
- Individuals
- LMC Chair
- PBC Chair
- Key local GPs

Issues
- Contractors
- Polyclinic anchor tenants
- business opportunities
- Closed shop

Non statutory

Clinical networks
Clinical reference groups
voluntary sector
politicians – MPs
Regulators*
- Monitor

Relationships (types)
Joint committees
Strategic Partnerships
Alliances
Cooperative
Collaborative
Joint working
Honest broker
Trading
Collective
Contractual

Public engagement*
Plan
- Communication plan
- Story telling

Methods
- Formal consultation

Multimedia
- Field work
- Talking head/ champion
- Formal events

Environmental dynamism
Space
- Location
- Geography

buildings
- of significance (usually hospitals)
- GP premises

Infrastructure
- Road
  - Access
  - Distance
  - Travel routes
  - travel times

Public transport
Socio- demography
- Population growth
- Deprivation
- Ethnicity

culture
Local economy
- healthcare market

Time (temporal)
Past
- Legacy
- History
- Track record

Measures
- Availability (hours/days)
- Timing
- Pace (speed)
- Momentum (rate)
- Period (duration or length)

Future
- Time scale
- Timetable
- Evolution

NHS (industry) culture
Staff afraid of making mistakes

Hard to reach groups	Impression management
Funding	Too many players
	Top down imposition
Service users*	Market immaturity
Patients	
Patient views	
Patients Forum	
GP patient groups	* stakeholder subgroups that are distinct conceptual groups
Local community	

The following section examines the major categories that define the external decision making context of PCT CEOs, starting with the most frequently cited concepts.

14.1.3.1 Stakeholders

The CEOs named several individual groups, while other times they may refer to stakeholders as a group. The list of stakeholders cited by CEOs vary from person to person but there are significant consistencies as to the most important, namely other significant organisations (and specific individuals within these organisations), the local council, both officers and councillors, and MPs. As PCTs are the local health authority, NHS Trusts, the SHA and GPs are significant players. The majority of PCT CEOs describe conducting stakeholder analysis to assess the positions of different stakeholders. They would use formal or informal stakeholder engagement processes to take soundings while giving stakeholders opportunities to raise concerns and to take part in decision making process and structures. Many use the term stakeholder management to dampen resistance and build support by managing expectations and positioning key stakeholders at key decision points in the decision making process.

14.1.3.2 Public engagement

The public interests in local NHS issues can be as service user, carer, community, taxpayer and citizen. PCTs have a statutory duty to consult the public on material strategic change, so public engagement is a specific activity.

14.1.3.3 Service users or patients

The NHS equivalent of customers in business. The government is encouraging NHS organisations to be much more focused on patient needs and to consult patients in redesigning services.

14.1.3.4 Goals

Goals are long term strategic directions for both the PCT as well as local health economy.

14.1.3.5 Performance expectation

This an the umbrella term used for coding references to measurable targets, standards or central requirements, as distinct from goals.

14.1.3.6 Decision making process

Decision making processes are used by CEOs to demonstrate governance and stakeholder engagement. They include actions and interactions, movements, sequence, and changes in response to changes in context or conditions.

14.1.3.7 Environmental dynamism

Environmental dynamism is an umbrella term used to cover references to issues in the local health economy. They included pace of change, spatial issues such as premises and infrastructure that need to be considered by the PCT in formulation of local strategies or plans. The main issues identified were space, in terms of location of properties and geography; buildings, especially hospitals of historical significance beloved of local communities and quality of GP premises; infrastructure mainly consisting of roads, with dimensions of ease of access, distance, travel routes and travel times; and public transport; and socio-demographic factors including community population profiles, and the local economy.

14.1.3.8 Time

Temporal factors including legacy, history, track record and memory would be influential. Also time measures such as availability, timing, pace, momentum

and period; and looking into the future in terms of timescale, timetable and evolution.

14.1.3.9 Relationships

The CEOs used different terms to describe their working relationships with stakeholders and other parties. The dimensions ranged from contracts and formal committees at one end, to alliances and collaborative at the other, with semi-formal arrangements such as joint working and strategic partnerships sitting somewhere in between.

14.1.3.10 NHS culture

The CEOs used phrases such as “staff fear making mistakes” which could be interpreted as having a blame culture, and a prevalence of impression management with impression counting more than results, too many “players” resulting in inefficiencies and bureaucracy, top down imposition revealing a command and control structure with little flexibility and market immaturity due to a lack of choice and competition and monopoly providers.

14.1.4 Macro level factors

Macro level factors were notably absent. Other than the one CEO who said he did not understand the impact of the economy, there was no other reference to macro level factors.

14.1.5 Summary

The results show that the literature based contextual intelligence model has some relevance to PCT CEO decision making practice in that at least half of the literature based contextual factors both within the organisation as well as externally in the local health economy were flagged up by a majority of CEOs as important considerations. Of the most frequently cited contextual factors, strategy and structure topped the organisational internal list while stakeholders, and goals and decision making processes emerged as critical local factors. Of the never cited contextual factors, surprising differences were one, the insignificance of organisational size in the NHS; two, CEOs’ lack of attention to

internal systems and relationships and three, CEOs' apparent limitation in seeking synergistic collaboration with non NHS resources. As a group, PCT CEOs appeared to take variable account of their context when taking strategic decisions. However, the findings did not adequately explain why the CEOs referenced certain contextual factors more than others. As the CEOs were asked four standard questions, each one presenting a different strategic decision context at the policy or strategy level, the next step is to analyse the CEOs' responses to each question independently.

14.2 Contextual factors in generic strategic decision making

This section presents the analysis of responses to Question 1. All 23 responses to Q1 were coded using the interpretive approach and the results shown in Table 19 and Table 20.

14.2.1 Top Management Team

Only five (22%) CEOs mentioned **TMT** in their responses, which relate to team problem solving, testing ideas, or individual contributions. One CEO gave two reasons. It was noted that 18 (78%) CEOs did not mention TMT in relation to generic strategies. This may be because they were asked for "what" rather than "whose views" would be taken into account, although this had not stopped the majority of CEOs from naming other individuals. Considering that TMTs form part of the PCT strategic apex, the finding suggests that most CEOs do not consider their TMT members as significant contributors to strategic decisions. This inference is somewhat consistent with the results in Table 19, which show CEOs tending to regard their TMT as functional experts who get tasks done. Earlier findings showed CEOs using TMTs as sounding boards; here they were engaged in problem solving and testing ideas, supporting CEO sense making, with the TMT using their expertise to help their boss to notice, filter and interpret the many competing contextual factors that shaped the strategic decision making context.

Table 19 Reasons for Top Management Team (TMT) influence on CEOs in strategic decision making

Reasons for TMT engagement	Number of CEOs
Team problem solving	2
Testing ideas	1
Sharing responsibility	1
Individual strengths or expertise	1

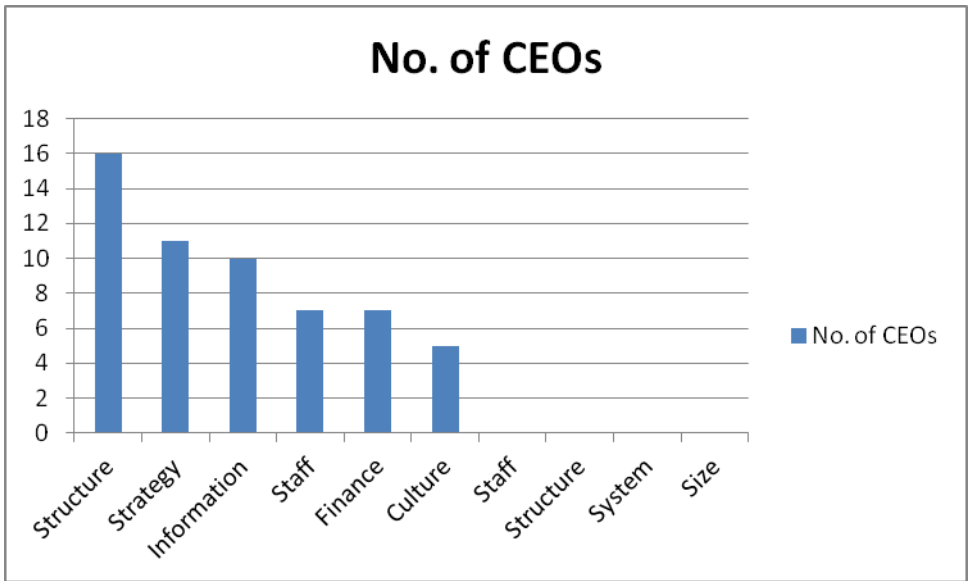
14.2.2 Organisational internal factors

The next set of results, summarised in Table 20 and presented as bar charts in Figure 20, shows the **organisational internal factors** CEOs said they took into account when taking generic strategic decisions.

Table 20 Organisational internal factors considered by CEOs in generic strategic decisions

Factors	No of CEOs *(%)*	Factors	No of CEOs *(%)*
structure	16 *(70)*	culture	5 *(22)*
strategy	11 *(48)*	operations	0
information	10 *(43)*	size	0
staff	7 *(30)*	relationship	0
finance	7 *(30)*	systems	0

Figure 20 Organisational internal factors considered by CEOs in generic strategic decisions



14.2.2.1 Structure

The most commonly cited were **structural** factors, with 70% (16/23) of CEOs referring to engagement, organisation, programme management, decision making and governance structures. It appears that CEOs liked having a framework and to operate within a structure when taking strategic decisions to give order, transparency and probity to their decision making processes, as shown in quote below.

I start by designing a process that enables work to be constructed, and then position key stakeholders either in individual work streams or at decision making points, or formally through a board or an executive.

If you take the sector work, we needed to find some way of bringing four acute trusts and five PCTs as boards together. What I designed there was a governance process, but quite consciously, I structured the work, organised it, put it on a critical path and all the usual stuff. You are doing big programme management, but then you draw up a list of actions – through that, developed a list of key stakeholders that needed to be engaged and then designed the processes for that engagement to occur.

We then needed to define the work streams that had to be undertaken so public engagement, clinical advice, business modelling and out of hospital care programmes in our whole sector, which are detailed programs in their own right, can take place. We then needed to be accountable to an executive that report to myself as the Senior Responsible Owner of the whole programme.

We can actually attempt to control some of the environment within which the work is going by engagement, but also that has a robustness of approach, so that when things go wrong and get rough, you have got the programme established in a way that it can go forward even if people are attacking it.

And the more work I have done as a chief executive, the more I think, particularly with very large programmes, the need for quite rigid structures within which the project unfolds. It is of critical importance to be able to record progress in the multiple and complex relationships, but perhaps more importantly, to provide a framework within which continuous engagement can occur.

CEO 3

14.2.2.2 Organisational strategy

Strategy was the next most popular, with 48% (11/23) of CEOs looking for strategic coherence or synergy with other local plans, especially where national and regional policies could be reframed to fit local contexts. Alignment between top down initiatives and local plans facilitate implementation and provide an

external stimulus to much needed change. Below is a quote from a CEO explaining why his PCT opened a new health centre in a particular location.

> *We as a team within the PCT do our best to try to relate what we do strategically, and then what we do practically, to the notion of "health benefit" for the borough. It just so happened ..... that we'd already identified the fact that there had probably been more proactive development in the north half ….. than in the south, and so we were already ..... thinking about the need for development in X (place). It is not coincidence therefore that it happened in X and not somewhere else. I suppose it goes back to "going after the do-able" doesn't it, that we sort of knew that would be well met.*
>
> *CEO 16*

14.2.2.3 Information management

The information management factor was cited by 43% (10/23) of CEOs in the form of research data, expert knowledge, quantitative analyses including modelling and benchmarking, published evidence and intelligence as shown by examples of quotes below. Information management focused on finding quantitative evidence to support decision making in deductive rather than inductive ways. There was a strong preference for numerical data as well as volume of data although few CEOs practised evidence based decision-making.

> *All the planning work was done on a huge amount of data and trajectories and when we brought in (consultants) they went through all the numbers and confirmed we had costed everything.*
>
> *CEO 23*

> *Depending on the decision, we totally have to have actual hard information. You look at the figures. In this particular example, you look at patient flows, you look at population forecast, you look at needs assessment. You also collect a fair amount of soft information along the way.*
>
> *CEO 8*

14.2.2.4 Staff

Employee related issues were cited by the 30% (7/23) of CEOs in relation to engagement or development events when taking strategic decisions as shown by quotes below.

> *We did workshop sessions with senior managers. We did staff briefings so the whole organisation understood the absolute critical importance of delivering this. We were creating this impetus to change, to move it on.*
>
> *CEO 23*

> *We need to do more to engage the team below directors ..... because sometimes they can contribute, you know. If we don't manage the information that comes from the thinking along the way, we miss some really good ideas.*
>
> *CEO 19*

14.2.2.5 Resources (finance)

The next category, resources, was identified by seven CEOs (30%). They were all about financial issues in relation to alignment with PCT strategy, risk management, and affordability as shown by quotes below.

> *We suffered dreadfully with the top slice, therefore I was quite influenced by that (experience). Whatever we do, it cannot risk us losing financial control, I couldn't pump prime it, I couldn't take risks - financial **risks**. We had to do it in a way that allowed us to keep that control.*
>
> *CEO 8*

> *Obviously we will be taking stock of **affordability**.*
>
> *CEO 16*

> *What we have had to struggle with is the desire to be focused on the here and now, around money versus the bigger strategic picture. We have found it difficult as many do in those circumstances to be playing both agendas.*
>
> *CEO 12*

14.2.2.6 Culture

Altogether, five out of 23 CEOs (22%) mentioned organisational **culture** issues, saying they wanted their organisation to be successful, to have the right values, valuing staff by providing a good work place, and becoming more financially aware. Examples of quotes from CEOs in relation to organisational culture are shown below.

> *Looking forward and that is about saying how do we begin to build a culture of ambition in the organisation about what we can achieve. How do we improve health outcomes, how do we demonstrate to our public, to our stake holders, to the board, that the investment that we are making now are improving outcomes, and that is a very different challenge.*
>
> *CEO 10*

> *You do need to run things back past your own values. You need to have some value sets about decision making. Which obviously you have to be about, if you do make decisions, you try to do it in an honest, transparent way and you take into account public sector values. ….. The point is, you have to make sure is that decision making is done in terms of agreed values. In all organisations there are agreed values in the organisation, but you also have your own personal values as well.*
>
> *CEO 2*

In summary, the findings describe the internal PCT actions involved in strategic decision making. The responses of PCT CEOs show a common approach to taking strategic decisions generally. Their key actions would involve designing structures and decision making processes for governance, to organise work, to engage staff and stakeholders, to keep track on progress and ultimately to take the strategic decision. The CEOs will want to ensure decisions are coherent with the PCT strategy, are evidence based and affordable.

14.2.3 Local contextual factors

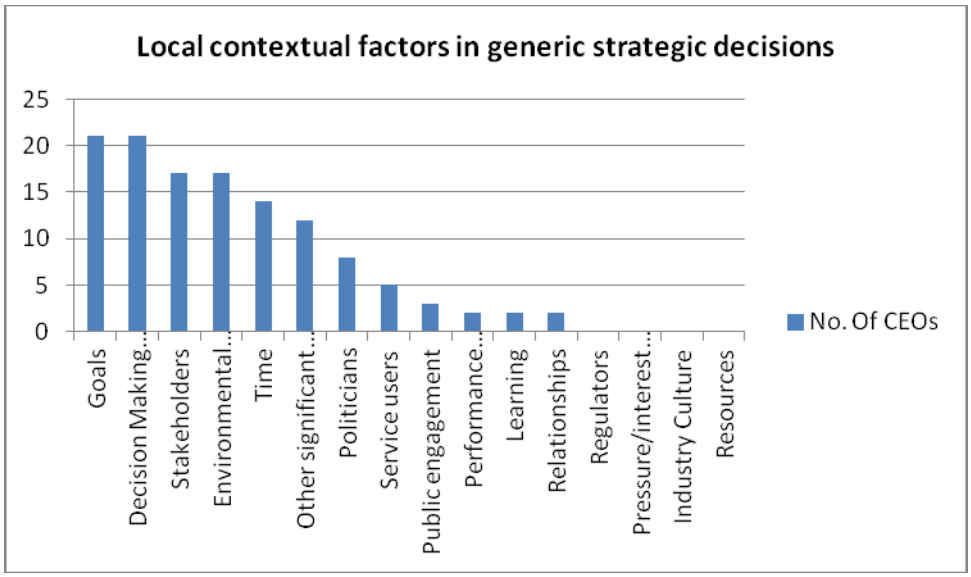
Table 21 and Figure 21 show the local factors CEOs said they took into account in **generic strategic decision making**. The local factors normally refer to

contextual factors in the local health economy. The health economy is normally defined as within the boundaries of the PCT catchment area but for supra PCT issues, the definition could extend to neighbouring PCT boundaries. They may therefore include regional factors but exclude national macro level factors. Compared to organisational internal factors, the vast majority of CEOs were likely to take external factors into account, as well as showing greater consistency in the factors that influenced their strategic decision making.

Table 21 Local factors CEOs took into account when taking generic strategic decisions

Factors	No of CEOs *(%)*	Factors	No of CEOs *(%)*
goals	21*(91)*	public engagement	3*(13)*
decision making processes	21*(91)*	performance expectations	2*(9)*
stakeholders	17*(74)*	learning	2*(9)*
environmental dynamism	17*(74)*	relationships	2*(9)*
time	14*(61)*	regulator	0
other significant organisations	12*(19)*		
politicians	8	pressure groups	0
service users	5	industry culture	0

Figure 21 Local factors CEOs took into account when taking generic strategic decisions



14.2.3.1 Goals

Of all of the local contextual factors, occupying joint top spots were **goals** and decision making process. They were mentioned by 21/23 (91%) of CEOs. It is no wonder that **goals** guide how PCT CEOs take strategic decisions. Examples of quotes from CEOs on how local goals influenced their decision making are shown below.

> *We got some priorities within the PCT that have been agreed at board level. Therefore, whatever the situation that presents itself that you had to take a decision on, you try and work through - how am I going to engineer this, so that it gets the best possible win against those priorities.*
>
> *CEO 8*

Top down requirements

> *In terms of a major change that would be imposed from above ..... I would want to have a discussion that says, what's this policy about? What are the pros and cons? What are the opportunities and what are the strengths and what does it mean for us in that local situation, obviously.*
>
> *CEO 19*

Achievability

I would expect to be testing factually both what our starting point is and talking with colleagues their judgment about what's reasonably achievable.

CEO 6

Triggers

To some extent it depends on where the original trigger for the strategic change comes from. My response might be quite different to something that lands from the DH ..... or that I observe in the organisation ..... or that a local stakeholder or a member of the board raises with me or comes up in a group discussion within the organisation.

CEO 10

Opportunistic

We have some quite powerful opportunities to bring those things together in joint commissioning arrangements ..... something the local authority would be willing to engage in.

CEO 12

Future impact

Hearing Bill Moyes (chairman of the regulator Monitor).....we have to have a much more sophisticated commissioning capability to really manage the commercial market and to drive improvement in a number of ways that isn't only through commercialisation.

CEO 20

Well, we were writing up our primary care strategy in draft before polyclinics, and we've got super health centres. So we launched our strategy ahead of (RHS) - there was, you know, a kind of eureka moment. I did think, oh fantastic, so I was a great supporter. But I kept thinking, wondering, whether he was going to water that down .....

CEO 11

It is not uncommon for CEOs to be faced with conflicting central demands and local goals. On these occasions, they said they would take into account a

number of factors: appropriateness of the new demands on local goals including do-ability within timeframes; importance of the trigger, taking into consideration synergy with local priorities and strategies; degree of local flexibility; being opportunistic and use national policies to push through local change, being anticipatory of future needs. In short, what is the problem the decision is trying to solve, and if the decision would support or compromise local or top down goals.

14.2.3.2 Decision making process

The same number (21/23) of CEOs talked about having decision making processes for taking key strategic decisions. As statutory organisations, PCTs must be able to demonstrate that due process had been followed. For reasons of corporate governance, transparency and sometimes mandatory arrangements, CEOs said they preferred to use formal decision making processes that usually follow a standard format with some common features (see Table 22 below).

Table 22 Key steps in decision making processes used by PCT CEOs in strategic decisions making

Features	No of CEOs (%)	Features	No of CEOs (%)
governance	20*(87)*	stakeholder engagement	16*(70)*
risk assessment	20*(87)*		
clear process	17*(74)*	clear objectives	10*(43)*
negotiation	17*(74)*	structure	10*(43)*

From the interviews with PCT CEOs, a coding tree of the terms and phrases used most frequently to describe strategic decision making processes is shown in Table 23.

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Table 23 Coding tree showing key features of strategic decision making process (cited by number of CEOs) based on terms and phrases used

Governance (20) Systems and process (20) Board (5) Risk assessment (20) Options appraisal (20) Do-ability (10) Threats (10) Opportunities (6) Expert views (4) Clear process (17) Decision pathway (16) Timeframe (4)	Negotiation (17) Compromises (11) Competing views(10) Stakeholder engagement (16) Framework for engagement (14) Buy-ins (10) Champion (6) Communication (4) Clear objectives (10) Structure (10) Program management (5)

Examples of quotes from CEOs on how they would approach **decision making processes** are shown below, with key concepts highlighted.

Governance

There needs to be clarity of objectives, clarity of process and above all, clarity of governance. Because when you've got multiple organisations collaborating, if you don't have good governance and structures you end up with bits of work being done, that people are not sighted on. You don't then formally sign them off, they don't hang together well. And above all, the PCT boards become completely disconnected from the critical decision.

CEO 3

We also had a program board for the Collaborative Commissioning Intentions which comprised Board Chairs, PEC Chairs and Chief Execs from five PCTs. So, we've got a strong governance piece, so that nobody could walk from it when it was difficult.

CEO 6

Accountability

Quite a lot of our partnership working is ..... single management with dual accountability, so we preserve quite a lot of the separate.

CEO 13

Risk assessment

The factors that I take into consideration are, I suppose, degrees of risk and opportunity and importance. And if it's sort of low risk, it's very important, then just get on and do it. If it's, you know, a higher risk, less important, I'm not ashamed of not doing anything. I'm quite happy to see what happens. I have created this formula, high risk, high importance, that's probably when I 'd write a paper, and I do take the leadership role, I suppose. The factors then would be around describing the risks, and how we're going to handle it.

CEO 13

There is also a thing about what might be discovered as collateral damage. There is no point getting a priority delivered, if the route by which you have done it caused such discontent and such unhappiness that it actually has a ripple effect onto other things that are your priorities.

CEO 8

Options appraisal

We have got four PCTs involved in the consultation. We have four hospital merger models with different consequences for (borough). Therefore there would be risks, both about which option is in favour but also, it is about, in a sense, our own position amongst those other PCTs and with local trusts. Do we form an alignment with the other PCTs? Do you form an alignment with the hospital trust, if you have got a good relationship? You look at patient flows, you look at activity flows, you look at population forecast, you look at needs assessment. You look at how, in the different options, they would play out for local population as well as the population of (region).

CEO 8

We write a paper to the board that explains and puts forward the proposal. We do have to be pretty explicit about what are the other ideas that we had thought about and why they are not right, or not right for now. So, the board would like to see options. They, like every board – actually won't have a genuine choice, so they don't like it if we work everything as it is appointed. That's when they start to be suspicious about the decision making process of the organisation.

CEO 14

Expert views

We've had an independent reviewer with expertise, you know, from one of the big national bodies to come in and review to make sure that our proposals are consistent with national policy, best practice and the evidence base.

It is about using the resources of the organisations better to ensure that the decisions are based on evidence, so that the decision is as good as possible, and that the different perspectives of people who know an issue really well are brought in.

CEO 6

Do-ability

It is no good saying the solution is all about closing X (hospital). If we closed X we can do all these marvellous things and here is the evidence that shows we don't need X. Frankly if you espouse a strategic objective that just is completely undeliverable then you are going to waste your own and everyone's time.

CEO 16

I would always prefer the high benefit, low risk, with low impact, and easy to achieve ones, but that doesn't mean you always choose the ones that are easy to achieve - but you need to understand the deliverability.

CEO 24

Opportunities

When a new idea comes, I am far more interested in thinking how I can make it happen than the barriers that stop it happening. While that is useful, I also notice ..... chief executives who talk about ..... risks, and how they spot all those, while I'm thinking about the opportunities.

CEO 19

I actually believe I've got an entirely independent business and I see opportunities that it could be providing paid-for services for our wealthy population.

CEO 14

Threats

I had the acute trust saying – no it won't, no it won't. I had (SHA) sort of axes hanging there above us like a dagger saying, well it's down to you and if you don't do it, you know heads will roll.

CEO 23

At the same time, finance was one factor, the other compounding factor was they were losing clinicians. So you know we were in danger actually of having unsafe services.

CEO 16

I think also you look at any potential political fallout, if it is going to knock-off the director suite - to what extent you think it is going to get the support of the team.

CEO 8

Stakeholder engagement

I work in a way that attempts to define the territory that the decision will impact upon, and then seek to identify very early in the process of developing the ideas, the plans. And to engage with those people who have a major stake in the issue, who have the potential to block, or indeed, who are potentially strong supporters.

CEO 3

It does lead to centralisation (of services) and it will be resisted. And we have to anticipate the resistance and deal with it

CEO 9

Paediatrics, AE and Obstetrics (centralisation) are the really big decisions. And the biggest problems are the emotions ..... very emotional for the local population.

CEO 17

Buy-ins

We decided what the answer was, and then we worked on who were the stakeholders that we had to make sure were signed up, and what was supposed to happen and what we have to do about it.

CEO 13

Framework for engagement

I then did several things, I formally reviewed the project and produced a board report, which basically said these are the reasons why you failed, and, if you take this on, this is the way it's going to be done.

I recast the arrangements so that PCTs took the leading role. And by creating new governance structures and project management structures, and got SHA on the programme board with me to ensure that everyone behaved properly.

And there is the other critical data about putting a framework around the things as you get co-design. Through co-design, you get a prospect of higher ownership. Not always, but by enabling people to influence the key decision, one, I think gets a better chance of getting a good decision, and two, also gains a critical mass of support for that decision.

CEO 3

Because then people own the framework and can move swiftly within the framework. When I have gone into new organisations that haven't had clarity around the framework, you are negotiating every decision on a one off basis.

CEO 6

Champion

He decided all of that, his name was C. He had been wanting to do it for about five years. He knew all the players, he knew all the facts, he knew everything inside out.

CEO 1

She is really good about thinking through what ..... will continue to give the board confidence even though the graphs from the data do not look right. She is very good about managing some of the internal politics at board level.

CEO 23

Negotiation

Where there is strong evidence on the back of demographics and local factors that you are different, then there should be some flexibility locally i.e. with your SHA, in terms of how you work these.

CEO 16

According to the chief executive ..... he has written to (SHA) to suggest a new model that might buy the local authorities out. The real reason they wanted a

PCT for their borough is because they couldn't get their hands on the money. If you give them the money anyway, you give them the element of the money that they have got some control over, you take away the argument.

CEO 11

I'm very much of the school of negotiating in more stages with the people for whom it is very important that we don't close down any of the options.

CEO 14

Compromises

We did have an issue quite recently about urological cancers where the decision of the council network board was to centralise at (trust X) but then (trust Y) were reluctant for that to happen. In the end we did force (Y) to agree to centralisation. We agreed a bit of a compromise on the centralisation which enabled them to do certain urological cancers which related to the kidneys. It is kidneys, so it is in relation to kidney transplants; there was a connection there which enabled them to do some, to continue to do some small amount of work at (hospital) which was quite important for them, in terms of their renal agenda.

CEO 2

Competing priorities

I would expect in making those decisions therefore to have tested with colleagues here in public health and in commissioning - the relevant parts of the commissioning team and with management team colleagues - what their priorities are, and therefore what the context is for their decisions.

CEO 6

We have three big issues as far as I am concerned at the moment – improving performance management to improve performance; Healthcare for (borough) strategy, and then quality and world class commissioning and what are we going to do about that.

CEO 18

Clear process

I would like to go through the process, depending on what the decision was, and how important it was. Obviously for less important decisions, we would scale that down and sometimes there were just internal and the board conversations.

CEO 5

The principle role of the chief executive in all of that is not only orchestrating the process, ensure all the work is designed properly and delivered properly. But it is holding a critical mass of issues or interests together - long enough to enable a decision to be made.

CEO 3

We got those processes right and we involved a lot of people in them ….. But if you were told by (SHA) to deliver X by date Y, and it means you are just not going to be able to get absolutely everybody on board - you hurry through an incomplete process to get there …... and hope you get away with it.

CEO 16

Pathway to decision

The next meeting which is 20th May, would be when we hope we'll get the "go ahead". We will then map out next year to externalisation. We are going to approach each service, decide where we are going to go. This needs six months. Basically we need to know what would go to planning for 1st of April next year.

CEO 14

We have come up with an option which enables us to build the building, move the GPs with a certain amount of expansion space, and then for five years bring an independent partner in to do a limited range of things which will complement, not compete, with the hospital. We believe that buys us time then to get our provider arm to be separate and to develop the market..

CEO 24

Structures

And by creating new governance structures and project management structures, and got SHA on the programme board with me to ensure that everyone behaves properly.

CEO 3

We had all the project management structures in place.

CEO 23

I am really concerned about putting programme management in, which is important.

CEO 18

Clear objectives

Ultimately it comes down to what we really need to achieve in terms of health outcomes and making a difference for our population. With all of the other pressures around - ..... a strategic plan for this..... to hit the trajectory for that – they should be by-products, rather than getting us blown off course. I have seen a lot of leaders get blown off course by doing that kind of "what has to be done today".

CEO 10

To move the focus of service away from secondary care and then to primary care - the driver for that is about what advantages would a patient see.

CEO 11

The findings show the contextual factors and concepts involved in strategic decision making processes identified by PCT CEOs. The most critical is governance, cited by 95% (20/21) of CEOs. Although only 12 CEOs actually used the term governance, all mentioned one or more of the mandatory arrangements or structures in place for corporate governance in the NHS, such as the board, committee structure, reservation of power to the board, line management, accountability, business planning, and procedural guidance for staff, and risk assurance. The semi structured interview situation did not encourage the CEOs to elaborate on their personal understanding of governance. Nonetheless, it appears that PCT CEOs hold common views of governance which are associated with systems of control.

Such control systems would identify and mitigate risks, hence the reference to risk assessment. For this reason, options appraisal is often an integral part of the business case process normally conducted in the NHS for strategic decisions. Structures such as programme management monitor progress and set out a clear decision pathway with time allowed for negotiations between interested parties. Engaging with stakeholders would be integral to the process to build support as well as to gain intelligence for better informed decisions

Significantly, some aspects of governance are missing, namely those that relate to service delivery, such as objectives, quality, safety and value for money

(another reason for having a business case); and ethical values such as transparency, so that objectives, timeframe and decision pathways are clear to stakeholders to encourage involvement. While these should, and might still be important issues for CEOs, the coding tree reveals the limitations of CEOs' conception of governance.

14.2.3.3 Stakeholders

Stakeholders were mentioned by three out of four CEOs (17/23, 74%). References to stakeholders can be grouped under *stakeholder analysis*, *stakeholder engagement,* and *stakeholders support*. Almost all CEOs (15/17, 88%) would carry out some form of stakeholder analysis, targeting specific groups of stakeholders. This is likely to be based on local knowledge and personal experience rather than from a systematic stakeholder analysis exercise. There appears to be a hierarchy among stakeholders, with council executives, politicians, hospitals and clinicians being consulted as a matter of course, or as expressed by two CEOs, there are inner and outer circles. A minority of CEOs talked about listening for the patient voice. Thirteen CEOs (13/17, 76%) would engage with stakeholders to gather intelligence, check out issues and positions of key groups or individuals including their acceptable parameters for negotiation. One in three CEOs (6/17, 35%) would actively manage stakeholders by taking actions such as building links, have facilitated meetings, set up collaborations, negotiate with key protagonists, or simply to manage expectations. Examples of relevant quotes are shown below

> ***Stakeholder analysis***
>
> *You've got to talk to people and find out where they are and what their issues are. Then there are always those issues about what they find acceptable and what they won't, but also how much they will run with things and how much they won't.*
>
> CEO 13
>
> *Taking into account of the views of the patients and practitioners, you clearly have to take into account the both positive and negative views.*

CEO 12

Needing to be aware of where the Mayor is going, what approach he is taking about transport development for example in relation to this hospital development because it needs better transport. *The other group that is pertinent and I think we struggle with, as much as everybody else, is the patient voice.*

CEO 24

Stakeholder engagement

The benefit of having spent so long on it and having gone through so many iterations with so much clinician involvement and so much forewarning of politicians and all of that, is that as much as any of these things can ever be relatively straightforward, it should be relatively straightforward to get through into implementation phase.

CEO 16

I talked to a lot of people. Listened to a lot of people, got to the heart of the GP community and found my way to about half a dozen putative leaders. This year we set up clinical roundtables - we had GPs, secondary care consultants from all the local hospitals, one commissioner and patients round the table.

CEO 1

I set up what we call strategic lock-ins ..... quarterly meetings involving about 15 senior leaders from across (borough) - PCT, the borough, acute trust, mental health trust, and the GP co-operative. We're able to test out aspects of policy at a very early stage.

CEO 15

Stakeholder support

All the issues are sort of stakeholder support which I guess play back to that first point about do-ability and the politics of it.

CEO 16

You don't need to have every GP behind you, but we need to have ..... two thirds behind it and by taking soundings, we found out about how far that we could take GPs with us on this. To be absolutely honest I think when this tanker started to turn, it wasn't because some of the other initiatives were happening, it was because we had got real engagement by GPs and the GPs not did want to see this fail.

CEO 24

If it did not have the broad support of the clinical leaders in the trusts concerned ..... if they were opposing, I want to know what was behind that, what was the clinical evidence here – were they really worried from a clinical point of view or was it an organisation worrying, which might be less concerning.

CEO 8

There are people that we very much have to take with us - councillors, board, patients ..... higher up, it's the chief executive, director of adult care whom we have to be very sure we are bringing with us. And particularly the chief executive of the borough who is on the NHS Management Board, so is a powerful character.

CEO 14

14.2.3.4 Environmental dynamism

The term is used to describe factors in the local health economy such as geography, place (location), premises, and infrastructure as well as local population factors. Three out of four CEOs (17/23, 74%) talked about environmental factors. Examples of CEO quotes are shown below. Geography was cited most often (12/17, 71%), typically in relation to place, communities, and administrative boundaries applied by other public services. Location of building is an important consideration, as they can influence how services cooperate and work together, as well as frequently forming the starting points for strategic developments. The quality of existing building stock, as in the case of substandard primary care premises, might influence investment decisions. All of these factors, alone or combined, could have a significant influence on service strategies.

geography

You can see from the map on the wall that we carved the borough into three ..... we work through ..... and are sort of staffed around three localities. Within each of the three localities, we see two neighbourhoods as they have got a degree of coherence to them ..... and they have got a decent match with the way that the council chunks the borough.

CEO 16

The council divided the borough into four neighbourhoods. And that's pretty geographical, so we may have something like four virtual hubs.

CEO 15

Environmental dynamism

In providers terms it is less than two miles away from a PFI hospital that we run which is struggling to cover its costs and has got spare capacity. So as a provider, the last thing we want to do is increase competition.

CEO 24

place

We are going to go into each of the local areas. Create the map for change and get sign off at the January board to then consult on these local areas.

CEO 11

If we have a situation where some of our residents have to walk past (hospital) on the way to a polyclinic, then that seems to be very stupid. .....nowhere over 80,000 population, I'll be mortified if we had three point polyclinics. So I think we'll probably have (hospital). We're doing major development in WC where there are sort of high level of need, and that is within WC and SB area - that could have a polyclinic as well, I think.

CEO 9

buildings

The general practice infrastructure is such that we have got 52 practices - 29 of whom are single handed and operating largely out of converted domestic

dwellings and 20 plus practices where there are only 2 doctors, and the balance are big practices.

CEO 12

There is land between them, and in hindsight ..... you would have integrated the practice with the community hospital. Well, what you have got now is, on the same site, a new PFI developed community hospital and a GP practice. You know although they are twenty yards away they might as well be two miles away.

CEO 2

14.2.3.5 Time

Temporal factors were mentioned by 61% (14/23) of CEOs, with timing (6/14, 43%) topping the list and the commonest reason for delay. A third (5/14, 36%) referred to time availability in two different contexts – reactive decisions where by the time available dictated subsequent actions, and proactive decisions to set aside time for planned activities such as mobilisation or engagement. Four CEOs (4/14, 28%) said they would use timelines to set out key decision points, milestones and deadlines, while the same number would use it to record evolution over time. Pace affect people's ability to cope with the speed of change. Examples of quotes from CEOs in relation to time factors are shown below.

Timing

He was moving to what we now call World Class Commissioning but I think it was a bit too early and he anticipated quite a long way ahead.

CEO 18

The Department of Health had a major push back ..... because it was very pretentious with our staff unions. There was a bit of fudge for a short period of time ..... before the policy came back.

CEO 5

The people from (RHS) keep on telling us to slow down and not to do things,

they haven't finished their blueprint yet and we will obviously make mistakes if we don't wait for it.

CEO 1

Available time

So it depends on how much time you've got for this decision.

CEO 13

If I had a lot more time I would have done things slightly differently, but we didn't have the time so they were done the way they were.

CEO 3

Timeline

The agreement has taken 15 months or so. In the future, with immediate effect for new practitioners, we will apply a set of quality expectations to any new service provider .....we will apply that to existing practices with the expectation that any shortcomings are responded to within 3 to 6 months.

CEO 12

Pace (speed)

Of course sometimes you are moving at a pace that makes it difficult. The temptation, when facing that kind of pressure, is to cut corners in the process even though you kind of know intellectually it is probably going to make it much more difficult down the line in terms of implementation.

CEO 16

And local PCT colleagues who are quite a little bit irritated with the pace..... they have pushed us to taking the time to think the issues through very carefully over the next six months

CEO 14

Evolution (change over time)

If you are prepared just to give it the time to bed in – you know, say, you have to put up with probably three or four meetings and quite a long time.

CEO 15

By the end of December, we were starting to see activity coming down ..... and by the end of the year, it had exceeded our expectations ..... but that period of three or four months was probably one of the most nervous periods I ever had in my career.

In fact the data was right - it was the length of time it took to kick in..

CEO 24

14.2.3.6 Other significant organisations

These are influential organisations, or key players within those organisations by virtue of their positional power. Half of all CEOs (12/23, 52%) named at least one other significant organisation in their responses, as shown in Table 24.

Based on the responses, the most influential organisations are the **local council,** which normally have several links with PCT strategy and operations, and **providers**, especially the local hospital. **GPs** are represented in three formal organisations: the Local Medical Committee (LMC) which is the local negotiating committee i.e. the union; the Professional Executive Committee (PEC), a subcommittee of the PCT Board, and practice-based commissioners (PBC) which are GP-commissioning structures. Other PCTs and the SHA form the rest of other significant organisations.

Table 24 Organisations (with key individuals shown in sub-categories) playing significant roles in PCT strategic decisions

Local authority (council) Joint commissioning Local Strategic Partnerships Politicians Mayor Council leader Cabinet members Councillors OSC chair Executives CEO Directors **Hospitals** Medical Consultants CEO Medical Director	**GPs** Local Medical Committee (union) Practice Based Commissioning (PBC) Professional Executive Committee (PEC) LMC Chair PBC Chair PEC Chair Local GP leaders **Other PCTs** **SHA**

Thirty per cent of CEOs (7/23, 30%) identified **politicians** as an important factor, as shown by the quotes below. Understanding the personal positions of councillors helps CEOs to build support.

> *The ruling party is the liberal democrats, they've been very important to this. And there is a couple of very key individuals we wouldn't normally think of - the two of them are married to each other - they are both councillors. One of the councillors, he also runs the church - he links into a lot of the others things ..... we've got to start working through some of those links.*
>
> *CEO 15*

> *Until very recently, the last local elections a couple of years ago, there was no overall majority. Now there is an overall conservative majority ..... slightly unusual and against expectations when they came to power. You actually can see some progress on strategic issues that previously was just going nowhere because it became much too political, too much noise.*

CEO 12

We actively sought the views of the council- the Leader of the Council.

CEO 24

14.2.3.7 Service users

One in five CEOs (5/23, 22%) expressed difficulty in engaging with patients or **service users**. This may be because such exercises are usually conducted for specific purposes; instead of as ongoing dialogues, PCTs have a duty to consult when proposing significant services changes.

I try to tune into patients' views about what is wrong. That is more difficult through all the traditional NHS mechanisms, but I try to wherever I can.

CEO 1

Patients do not always see the positives when you make a service change, as you well know. It is about being persuasive on the arguments and the best way to do that is having clinicians fronting them. But it is about coherence and clarity of the strategic direction and the why.

CEO 12

14.2.3.8 Organisational culture

References to culture were made by five CEOs (5/23, 22%). They described an unforgiving, command and control culture that generally rewards conformance, with power wielded by the centre. The safe option is to keep one's head down and not challenge the system. Resistance to change from staffs is not surprising, and in some PCTs, non executive directors have been brought in to challenge the culture. One CEO described his role as not really being free due to the constraints inherent within the system.

It's almost creating a climate of fear that you have to get it absolutely perfect. You are not to make any mistakes ..... creates an environment where change is far less likely to happen. If we sat down and think about these things, you'd think, well it would probably increase my workload several times over. If I get it wrong, I will be blamed and no one will support me on it. I believe I've seen some colleagues, not all of them by any means, made that calculation and

decide, I think I'll just keep my head down and ..... the organisation for a year or two .....give the impression of progress here and there.

CEO 9

I had the acute trust saying – no it won't, no it won't. I had (SHA) sort of axes hanging there above us like a dagger saying, well it's down to you and if you don't do it you know heads will roll.

CEO 24

And the decision of the chairman to deliberately bring in people who have got experience from outside the NHS. What we get from them is a real challenge about patient engagement around what are the alternatives. So they don't sort of think of an NHS person or of a NHS provider as a second though. When they ask us about a service ..... it is like ..... how do we tender this out or how do we compete ..... They may not understand what constraints are, what has been in the NHS ..... it's been my job to help them to understand, we can't be completely free.

CEO 14

14.2.4 Macro level factors

None of the CEOs mentioned macro level contextual factors such as the economy or social trends, or any of the other broader and more general factors. This may be due to the definitions of terms used to code for citations. For example, when CEOs talked about population issues, it was always about their local population characteristics. This applies even when CEOs referred to the supra-PCT population at a sub-regional or sector level, as the aggregated demography still formed the local context. Accordingly they are coded as "environmental dynamism" within local factors rather than under "demography" within macro environmental factors.

14.2.5 Summary

Section 14.2 presents a comprehensive list of contextual factors PCT CEOs said they took into account in strategic decision making generally. Although the number of contextual factors identified is large, they were all supported by

quotes from the CEOs. Unlike business leaders who focused on macro level factors (Mayo and Nohria, 2005), the PCT CEOs did not mention macro level factors and instead, identified contextual factors that were either in the PCT organisation itself or were within the local health economy although there were few references to the TMT. Based on the number of CEOs whose response included each of the contextual factor, the most influential contextual factors guiding PCT CEO strategic decision making generally appear to be local goals and decision making process, followed by stakeholders, environmental dynamism, structure and temporal factors. The results suggest PCT CEOs are likely to be focused on the goals of the local heath economy when they take strategic decisions. They will want to ensure there are appropriate decision making processes, engage with key external stakeholders, take account of what is out there in the local environment that may affect the strategic decision, and temporal factors.

14.3 Taking strategic decisions on national policies

All PCT CEOs were asked what factors they would take into account when dealing with national policies. The findings below come from 12 randomly selected interview transcripts. A summary of the findings is shown in Figure 22 and Figure 23. A breakdown by organisational internal factors taken into account by CEOs when responding to national policies is shown in Table 25.

14.3.1 Organisational internal factors

Figure 22 Organisational internal factors influencing CEO decisions on national policies show the distribution of organisational internal factors CEOs said they took into account when implementing national policies. The most frequently cited contextual factor was **structure** (9/12, 75%) for reasons of governance, especially the role of the board in providing legitimacy. **Strategy** was cited by two third of CEOs (8/12, 67%) in relation to strategic fit or synergy with local plans. **Information** factors (4/12, 34%) appear to focus on gap analysis, modelling of baselines and trajectories for implementation and expert advice of what worked. Last but not least were **financial** considerations, which tend to focus on costs and value for money.

Figure 22 Organisational internal factors influencing CEO decisions on national policies

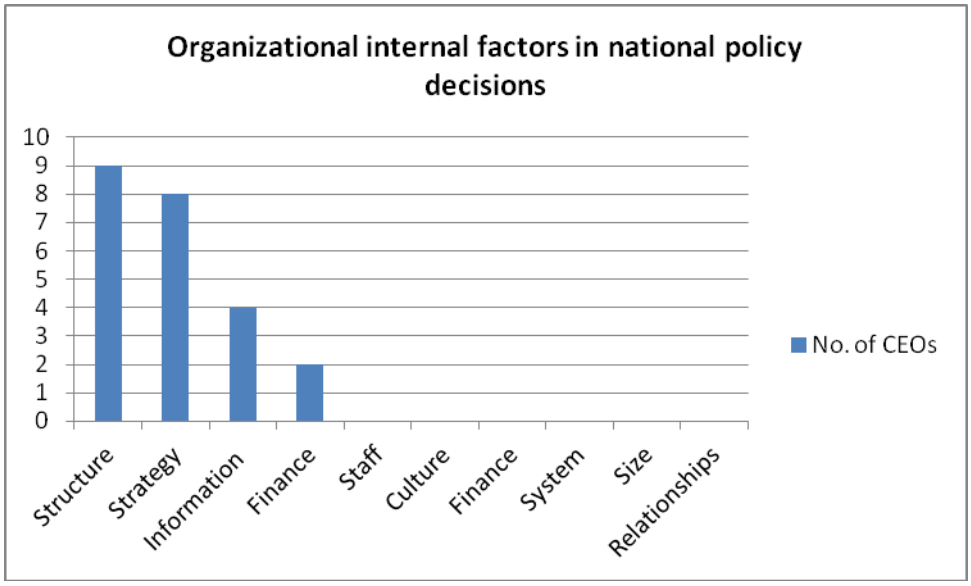


Table 25 Organisational internal factors CEOs took into account when responding to national policies

Factors	No of CEOs (%)	Factors	No of CEOs (%)
structure	9 (*75*)	culture	0
strategy	8 (*67*)	operations	0
information	4 (*34*)	system	0
finance	2 (*17*)	size	0
staff	0	relationship	0
time	0		

14.3.1.1 Structure

The top organisational internal factor for PCT CEOs in national policy strategic decision making is structure, as cited by three quarters (9/12) of responders. This is not surprising as structures form part of the corporate governance arrangements such as the board, the PEC, reservations of power to the board, processes to demonstrate accountability and setting directions, and risk

assurance. Quotations relating to structures and national policies are shown below.

> *We ensure that council members are linked into ..... through the partnership structure in the main, but we also have members and officers co-opted onto our PCT board and we have officers from the local authority as proper paid up members of PEC. We have a joint post on the PCT's PEC and also have a place for the local authority on our community health services governance board.*
>
> *CEO 20*

> *We call it a summit to achieve the implementation board. But basically, it's a trouble shooting board between the hospital and ourselves – to manage performance ..... on targets. Then it gets on to the management team meeting and then we put to the board in the monthly information for the board.*
>
> *CEO 17*

> *We had a crunch point with the board in January when I alerted them that (hospital) was at that point unlikely to meet the 18 weeks target. And the board kicked off. Give them surprises and they get upset. "But you told me in December we were on target and now you are telling me it isn't on target" and "we told you ..... should have been putting more in the private sector and you haven't done it". We had to listen and not treat them as critics as you must not disregard the board.*
>
> *CEO 14*

14.3.1.2 Organisational strategy

The next most common factor is organisational strategy. Two thirds (8/12, 67%) of PCT CEOs expressed concerns about the strategic fit between national policies and local plans. The CEOs said they would look for synergy wherever possible, and see central directives as opportunities to drive changes locally. Should the two interests be incongruent, the CEOs would resolve the conflict by making local adaptations or doing the minimum to be compliant. Examples of quotes from CEOs on balancing top down requirements with local strategy are shown below.

I am thinking what is it we are trying to achieve for (borough), what are our strategic objectives and how might those things that come from the centre help us to achieve those objectives, or not, as the case may be.

CEO 24

What we found difficult with national deliverables is that they are of necessity needing to address the major gains for the most vulnerable in society ……. We find it hard to consistently perform well purely because our population is above average in terms of health and well being.

CEO 20

I will be asking - what is the link with what we are already doing; what is the opportunity if it does not give us a lever that we have been looking for. For example ..... I jumped on that because it enabled us to deal with some of the issues in primary care that we have been struggling with.

CEO 18

14.3.1.3 Information

One in three CEOs (4/12, 34%) would ask for more **information** to inform their decision making. Examples given include conducting gap analysis, making sure that expert advice is available, ensuring data quality, and modelling assumptions. They would apply those insights to the information, so that they could be turned into knowledge and intelligence to inform strategic decisions. Quotes from CEOs on the use of information are shown below.

We would analyse the gaps and call in experts who are in the PCT. If they were somebody who has a lot of information or who could access them, we would bring them in for the discussion.

CEO 17

We struggled for a very long time with the poor quality of information systems and particularly patient clinical systems. They didn't have the systems which enabled them to create patient treatment list.

CEO 14

14.3.1.4 Finance

Financial consideration came up twice, both in relation to the cost of implementing a national policy, as seen in the quotes below.

> *The initiative is loss making even if it redirects (patients) from AE. So, the question is, does it really stack up when it is not even paying for itself?*
>
> *CEO 14*

> *We put money aside for it and as we got through the year.*
>
> *CEO 24*

As before, no one mentioned macro level factors.

14.3.1.5 Summary

The findings so far on how strategic decisions on national policies affect organisational internal factors draw the following preliminary conclusions. Local issues relating to national policies are usually about implementation. For the CEOs, “central diktats” or “must dos” are easily recognisable by their key performance indicators (KPIs) and central monitoring of performance. In such events, the policy would receive the full governance treatment including the CEOs’ personal attention and board scrutiny. With new policies, the CEOs would start by checking their PCT’s current performance levels, and if they needed to, or could, negotiate with the DH or SHA for different delivery terms. Information plays important roles to support this as well as the subsequent monitoring. The CEOs would look for strategic fit with existing plans to improve the efficiency of implementation. They would focus their organisation on the task at hand, including re-directing resources to the new priority.

14.3.2 Local contextual factors

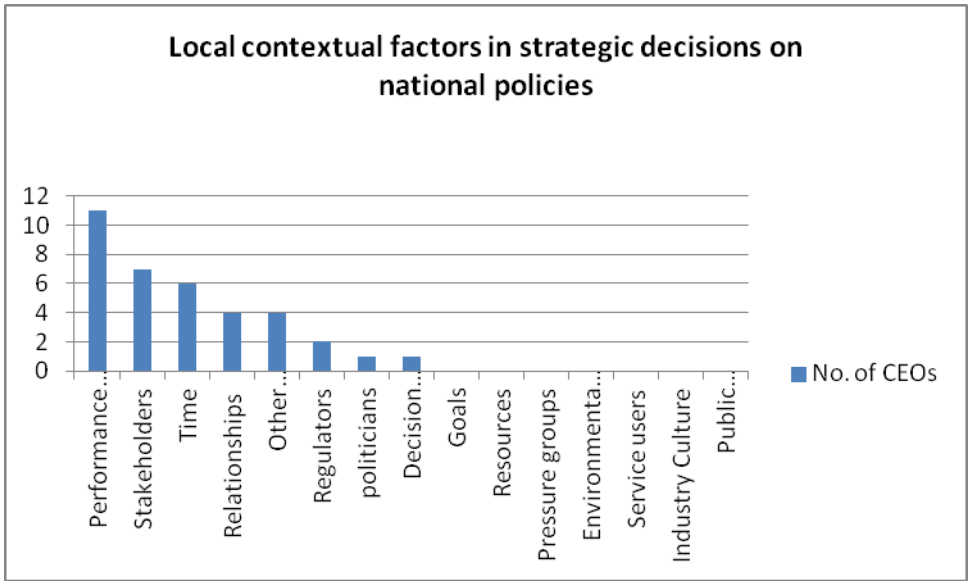
Table 26 and Figure 23 show the distribution of **local factors** CEOs said they took into account when implementing national policies. Compared to their earlier responses to generic strategic decision making, the findings are remarkable by the small number of local factors PCT CEOs would take into account overall.

Top among local factors was **performance expectations** or targets, as mentioned by 92% (11/12) of CEOs. Two thirds (8/12, 67%) would take account of **relationships**, and just over half (7/12, 58%) would consider **stakeholder** views. Two CEOs (2/12, 17%) would consider the requirements of **regulators**. Decision making processes and service user received one mention each. Interestingly, a number of external factors that CEOs in the business sector would normally take into account are missing from the responses.

Table 26 Local factors CEOs took into account when taking strategic decisions on national policies

Factors	No of CEOs *(%)*	Factors	No of CEOs (%)
performance expectations	11 *(92)*	goals	0
		resources	0
stakeholders	7 *(58)*	pressure groups	0
time	6 *(50)*	environmental dynamism	0
other significant organisations	4 *(34)*	service users	0
relationships	4 *(34)*	Industry culture	0
regulators	2*(17)*	public engagement	
politicians	1 *(8)*		0
decision making processes	1 *(8)*	goals	0

Figure 23 Distribution of local factors that CEOs would take into account in relation to national policies



14.3.2.1 Policy context

The importance of policy in guiding strategic decision making is raised here, to remind readers that policy is itself a context although the implications are brought by the PCT CEOs in performance expectations. The CEOs acknowledged that PCTs, being outposts of the DH are required to implement national policies, as illustrated by the quotes below.

> *I would expect that if something is very clearly a must do from the Department then you are wasting time and energy, and actually possibly delaying things if you do not. So, my advice to both myself and my board is, whether or not you agree, you just got to get on with it. You then have to decide how you execute, and that is clearly based on your analysis of the position.*
>
> *CEO 8*

> *So we had to handle it sensitively, really making it clear that this was evidence based. Re-drafting some of the documentation as being partnership documentation - that almost made officers lose the will to live. It was so heavily biased and really overlooked the health gain, but that is the challenge.*
>
> *CEO 20*

14.3.2.2 Performance expectations

National policies, in particular central diktats, usually have performance expectations set out in the form of targets or Key Performance Indicators (KPIs). As these are normally non negotiable, it is not surprising that PCT CEOs said they would prioritise KPIs for which they would be held accountable. They would seek clarification about the deliverables and their do-ability, and actively engage with relevant stakeholders who could help them achieve those targets and potentially ignore the rest. They would want to ensure compliance with regulations. Quotes giving examples of how CEOs deal with performance expectations or targets set in national policies are shown below.

> *If it is a target, it is a must do. And it goes into our performance management systems.*
>
> *CEO 18*

> *If there is a target and they are must dos, we just get on and do it. The trust has tried to argue with us on varying occasions it is a milestone and not a target. Well, as far as I am concerned, it is the target, and if you don't think it is a target, you'll be shot.*
>
> *CEO 15*

> *Take 18 weeks, it wasn't a negotiable target and a must do. People just got on and did it.*
>
> *CEO 21*

> *We took a view that the targets we had failed on the year before we had to address this year. We decided how much investment we could put in this year. We set up a project team that had internal project members and members from the major providers that we use. We set up regular reporting. We gave it a clear leadership at director and PEC chair level. We do monthly performance monitoring with our main provider so it was on the agenda every month. There was a structured process.*
>
> *CEO 24*

> *There is something about being absolutely clear what the starting position is, where we have to get to, was there a robust plan to start with and were the*

people charged with delivering it people who had a track record of getting on with it.

CEO 8

14.3.2.3 Stakeholders

With national policies, a major challenge for CEOs is to understand what they have to do to get a policy implemented locally. This is especially important for policies that require stakeholder support. Stakeholders are the second most often cited factor by CEOs (7/12, 58%), as engaging them demonstrates good governance as well as helping to gain support for a decision to be implemented. The CEOs said that simply imposing a diktat would lead to resistance from some stakeholders who would see it as taking away local autonomy. So they spend time anticipating, assessing potential risks, planning how to get support. The CEOs are likely to set up programme management structures and processes to involve stakeholders in the delivery of national policies. Examples of quotes from CEOs on stakeholder management and relationships in relation to national policies are shown below

I will want to know, what are the views of the GPs and executives, what is it they are likely to buy into? I'd also want to understand it from my main providers' perspective, so I know the difficulties. Not in detail, but I recognise that once you start sort of change systems like this, it is not an easy, straightforward thing to do.

CEO 5

If it is a target we can't meet by the PCT alone, we need to bring in the local authority or the acute trust. Each director would bring that (policy) into whatever relevant meetings they were attending. If it is to do with partnership with the local authorities, we would share it at partnership meetings. If it is to do with a secondary care target, it would be raised at the commissioning meetings with the director of commissioning and their counterparts. And we also have, at the moment, with the hospital, a fortnight the summit meeting between the top teams.

CEO 17

There was a lot of interactions with other PEC members and clinical leads in the mental health trust about whether we are going to do this, what are the options, and how might we deliver it.

CEO 24

14.3.2.4 Relationships

This may partly explain why relationships are important considerations for CEOs. References to relationships can be at one of more levels: personal between key executives, at organisational levels, in the forms of contractual relationship, joint working or partnership structures, as shown by the quotes from CEOs below.

Council members are linked in through the partnership structure in the main, but we also have members and officers co-opted onto our PCT board and we have officers from the local authority as proper paid up members of PEC. We also have a place for the local authority on our community health services governance board.

CEO 20

We are working principally with the (hospital) Foundation Trust, and with the (hospital) that we also host. What actually solved the problem was us working pretty closely with the trusts to do everything we could do to support.

EO 14

You either develop an adversarial behaviour …… or go down the relationship route.

CEO 8

14.3.2.5 Other significant organisations

The CEO quotes also refer to other significant organisations especially key local organisations such as the local hospitals, mental health trusts, councils and the SHA whose engagements are necessary for policy implementation.

14.3.2.6 Time

Temporal factors are important for reasons of timing, history in terms of what takes place before, and how the new policy relates to existing initiatives or

plans. It is also important to allow time for engagement prior to implementation. Examples of quotes from CEOs are shown below.

> *At the beginning of the year the board wanted to make a snap decision about what to do about provider services. I sort of put them off, or held them off, and said this wasn't the time to do that.*
>
> *CEO 24*

> *He was moving to what we now call World Class Commissioning but I think it was a bit too early and he anticipated quite a long way ahead.*
>
> *CEO 18*

> *In the seven years that we have been a PCT, we had two years in which we have had a deficit. First was in '04-'05 when the Health Authority at the time arbitrated in (trust)'s favour which left us with a deficit of £3.2m. We cleared that over two years and we got to a very small surplus by the end. Then they top sliced us as they did everybody, £13.5 million. We had a £6.3 million deficit at the end of '06-'07 as a consequence. Because we were in recovery anyway, that simply pushed us into more difficulty.*
>
> *CEO 12*

14.3.2.7 Regulators

Meeting regulatory requirements is another consideration for CEOs when implementing national policies. Examples of CEO quotes are shown below.

> *The thing that actually pushed the borough to engage with us on that was the fact that the performance review of X in the JAR (joint area review) wasn't great.*
>
> *CEO 8*

> *My starting assumption would be that if it is policy then we do it. There are at times benefits in considering whether you are doing it at the right speed or the right amount. For example we had debated quite a lot with (SHA) and the Department about the scale and the size of the crisis resolution teams because we still remain unconvinced that there is that demand, but we have never disputed that we'd do it. A Healthcare Commission review of mental health back*

in the back end of 2006 which reported in the second quarter of 2007 created a kind of external spur. If we hadn't been doing this, if you'd like, now we had to get on and address it.

CEO 24

14.3.2.8 Politicians and politics

Two CEOs mentioned **politicians** and **decision making process**, but these appear to be local issues, as shown by a quote below.

In a pretty conservative borough, you've also got to understand the politics of the ward councillors. We recently faced a situation where the work we were doing with young people in relation to sexual health became a political issue because the ward councillor was catholic and it was desperately difficult to get over that. Because local government is not and probably won't ever be the same as national government, by and large we are Liberal Democrat, so it's pretty anti labour but it will be as anti Tory when the Tories probably get in at some stage.

CEO 20

14.3.3 Summary

In summarising the relationship between national policies and local factors, the clear messages from the PCT CEOs are that "if it is national policy, just do it" – a phrase repeated throughout almost all the interviews. This applies especially to "diktats" or targets. For policies with strategic goals, the CEOs may decide to implement the policy at different speed to suit local circumstances. The important thing is to at least give the impression that the PCT is complying, even if it were "running on the spot" as described one CEO.

14.4 Implementing regional strategies

Figure 23 to Figure 26 examine the factors PCT CEOs said they took into account in implementing regional strategies that had differential impacts on PCTs. Strategic Health Authorities (SHAs) are the intermediate tier between Department of Health and PCTs. SHAs are responsible for strategic leadership, regional coordination and performance management of the NHS within their

geographical region. Around the time of the study design, SHA was consulting on a long term regional health strategy which would be referred to as “RHS”. RHS had two key policy initiatives. One, centralisation of specialist hospital services onto fewer sites and two, shifting care out of hospital into community health centres called polyclinics. The former would have minimal impact on PCTs as the proposals to centralise only affect hospitals and a very small number of patients. The polyclinic policy, in contrast, would have a significant impact on PCTs as implementation requires investments in new infrastructure and changing the way services would be provided in the local health economy.

RHS centralisation policy

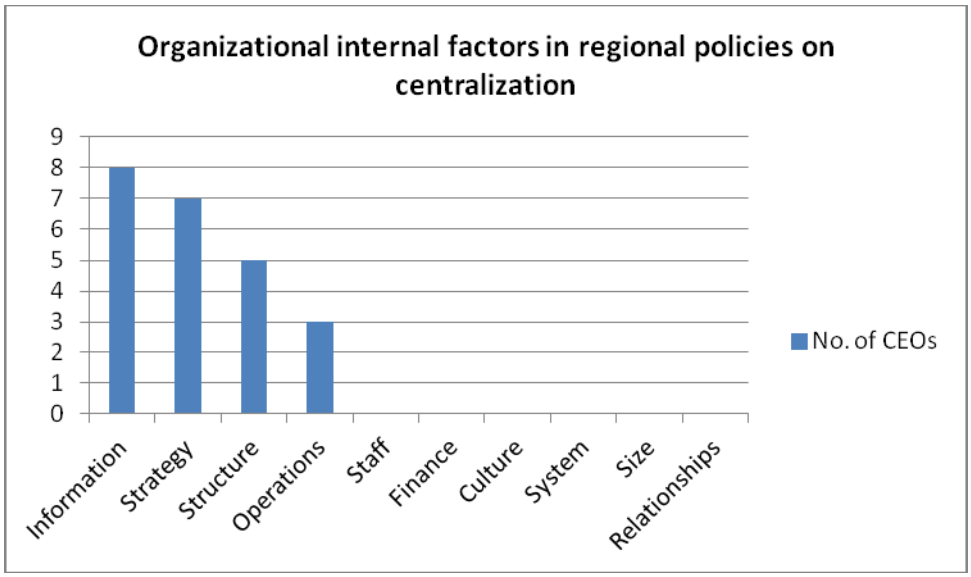
14.4.1 Organisational internal factors

Because the SHA strategic proposals for centralisation did not have a major impact on PCTs directly, CEO engagement of their own organisation was low and was related to three main areas: one, ensuring there was evidence, particularly from experts, to publicly support the case for change; two, that the regional plans were compatible with local strategies; and three, that appropriate structures were in place to take those decisions. Table 27 and Figure 24 show the organisational internal factors CEOs indicated they would take into account when having to implement RHS centralisation policy

Table 27 Organisational internal factors influencing CEO decision making on regional centralisation policies

Factors	No of CEOs *(%)*	Factors	No of CEOs *(%)*
information	8 *(67)*	culture	0
strategy	7 *(58)*	time	0
structure	4 *(34)*	system	0
operations	1 *(13)*	size	0
staff	0	relationship	0
finance	0		

Figure 24 Organisational internal factors influencing CEO decision making on centralisation policies



14.4.1.1 Information

Overall, very few organisational internal factors were mentioned by CEOs when dealing with policies that did not impact directly on PCTs. The top factor cited by three quarters of CEOs (8/12, 67%) was information, usually to support the case for change. The types of information that would be sought included published research data, expert views, practitioner views, user views as well as unpublished experiential evidence from places that had implemented those changes. Only one CEO said he would seek user views. Another expressed scepticism about giving too much weight to clinical views due to vested interests of different professional groups and subgroups. One CEO argued that clinical practice was ahead of published evidence. Overall, published evidence and expert advice carried the most weight in influencing CEO strategic decision making when it came to centralising services. Examples of quotes from CEOs are shown below.

> *I do not think we can avoid, and should not avoid, appreciating the evidence in relation to improving and driving up service quality, and that evidence comes from experts in the field.*
>
> *CEO 20*

I would want to hear out the most important factors that clinicians and users consider in relation to reaching a decision about what is important for the hospital of choice. We can tell them how many more people are alive in northeast now as a result of ambulances taking heart attacks to 24/7 heart attack centres instead of the local AE - that's a very powerful and compelling case for change. So having that evidence base and the story help reassure people, and gives me a strong starting point for centralisation.

CEO 19

The evidence base is moving so quickly and in some cases, I think the evidence base is behind.

CEO 5

I do not think we should listen too hard to clinicians. There are too many vested interests.

CEO 18

14.4.2 Organisational strategy

The next commonest factor, organisational strategy, was cited by seven out of 12 CEOs (58%) in response to the centralisation plans.

Adaptation and compromises

Our strategy has been to pilot a hub and spoke arrangement. The question is whether that is fudging the very thing that we are trying to do.

CEO 20

We may have to unpick decisions if people challenge them, and that may require some compromises, such as moving at a slower pace. At the end of the day, making changes in a multi- agency multi-professional community is usually about some sort of compromise.

CEO 5

Managing transition

At the moment, it looks like, as a hospital, (trust) is pretty secure. I am clear services will continue there, but they are going to have to change. They just

can't carry on doing exactly what they are doing, the way they've always done it. They now have to consolidate down to what they are good at, like maternity. But if they were to lose paediatrics, that's going to affect what I can do with maternity, so there are some issues.

CEO 15

I think it is right to design around what works, but that's it. Things like community services, if decentralised on a PCT basis, would threaten our collaboration with adult care and that would threaten our whole organisation. So, that is quite difficult, and we need to find a way to be collaborative without breaking that up.

CEO 21

I do believe in general in (RHS). (City) has to get on and be seen to be making some changes and having some early wins. But I don't think that we should try to do everything at once, otherwise we will end up with an awful mess.

CEO 5

As with national policies but with less of an imperative, the CEOs would try to adapt the regional strategy with a view to achieve synergy with local PCT plans. Some talked of making compromises, or "fudges", while for others, it was a matter of presentation. Several CEOs expressed concerns about the impact of centralisation, especially the domino effects on the viability of other services due to inter-dependency between services. As commissioning accessible safe services was fundamental to PCT strategy, the CEOs indicated they would take mitigating actions to manage the transition risks.

14.4.2.1 Structures

The third most common factor, structure, was cited by a third of CEOs (4/12, 34%) mainly in relation to governance and decision making. Examples of quotes are shown below.

I would expect the case to be fully discussed and debated, first with directors, and then the board.

CEO 5

The board has a responsibility to ensure that it actually knows and understands the risks.

CEO 20

That only a minority considered internal structural factors to matter in centralisation decisions could mean either the majority of CEOs treated those decisions as givens (like national policies) and so did not feel the need to put them through internal processes, or that they regarded the decisions to centralise to apply to hospitals and therefore were irrelevant to PCTs. One PCT CEO commented that the professional backgrounds of non executive directors (NEDs) were not typical NHS service users, so instead of thinking of consulting NHS providers in the first instance on matters affecting provision, their responses would be "to go to the market", reflecting their world view. This may be an isolated event, but the impact of NEDS' backgrounds on strategic decisions is worth further exploration.

14.4.2.2 Other factors

Last but not least, operationalising policies were mentioned by one CEO in relation to the centralisation of maternity services.

Our PEC chair, who is a midwife, set up a maternity choice program after she couldn't explain to me how we gave mums choice in maternity despite showing me all those strategy documents. Since we set that project up, every mom is now meeting a midwife who advises her on where to have her baby.

CEO 1

14.4.3 Local contextual factors

As was usual with any strategic change proposals, PCTs have to formally consult on the RHS centralisation policy, which might explain the local factors they said they would take into account in Figure 25.

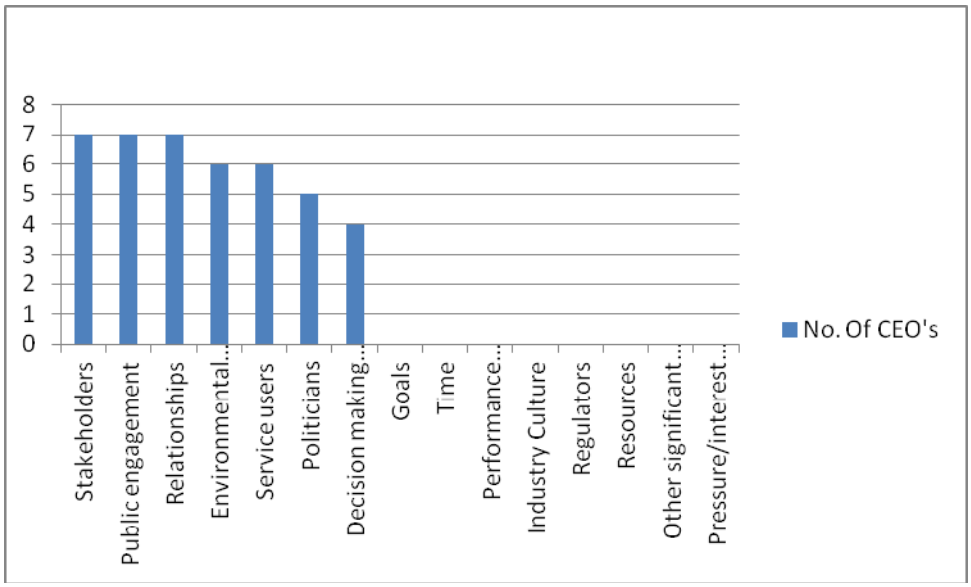
Support from stakeholders could come in different forms: positive support in the form of expressed support from local stakeholders such as service users, voluntary sector, clinicians, and the Overview and Scrutiny Committee (OSC), neutral or negative support from disenfranchised parties, in particular local

opinion formers. The CEOs would translate regional policies into local implementation plans, taking into consideration the positions of stakeholders, environmental factors of geography and existing infrastructure as well as the views of users and the public. They would build on their relationships, engage stakeholders and put the decision through formal decision making processes such as public consultation and OSC. The local factors that CEOs would focus on in strategic change decisions are set out in Table 28 and Figure 25.

Table 28 Local factors CEOs took into account when taking strategic decisions on centralisation policies

Factors	No of CEOs (%)	Factors	No of CEOs (%)
Other sig organisations	7 *(58)*	stakeholders	3
public engagement	7 *(58)*	performance expectations	0
relationships	7 *(58)*		
environmental dynamism	6 *(50)*	regulators	0
		pressure groups	0
service users	6 *(50)*	goals	0
politicians	5 *(42)*		
decision making processes	4 *(34)*	industry culture	0
		time	0

Figure 25 Local contextual factors taken into account by PCT CEOs when implementing centralisation policies



No critical factors stood out among CEOs and even the top three factors, **other significant organisations**, **relationships**, and **public engagement**, were only cited by seven out of 12 CEOs (58%). This was not a surprise as the centralisation proposals, although significant, would not have a major direct impact on PCTs. Understandably the CEOs focused on managing stakeholders and consulting the public. The other factors, environmental dynamism, service users, politicians and decision making processes, all related to implementing the proposals. Some contextual factors overlapped with others, for example, other significant organisations can be considered a subset of stakeholders, and there would always be an element of relationships. All factors will now be examined in turn.

14.4.3.1 Other significant organisations

Specific references to organisation, group or individual were coded to the named organisation, based on key words matching existing factors being coded to those factors. Otherwise, they would be categorised under “stakeholders”. The seven CEOs (7/12, 58%) who talked about consulting stakeholders

included three who remarked about stakeholders in general but all seven referred to at least one significant other organisation, including key individuals in those organisations. A selection of CEO quotes relating to centralisation is shown below, grouped under key stakeholder categories.

General statements about stakeholders

Of all the stakeholders really, clearly we'll have to take into account patients views, our clients' views, the views of our staff, our board, our partners, the council.

CEO 21

Well obviously we are listening to the professionals, the experts and what the research is saying around outcomes, and what public health is saying around that. We are also listening to our community about their concerns, and our local authority about their concerns around centralisation. We are talking to our acute trust as well ….. and thinking about how to engage with our GPs, our politicians and ….. of course we are talking with our neighbouring PCTs.

CEO 23

We need to listen to local people, the board, local authorities - those three groups know about what is right locally and we need to understand that. I do not think we should listen too hard to clinicians - there are too many vested interests.

CEO 18

***Acute trusts** (cited by 5 CEOs)*

We are talking to our acute trust about the impact that would have on the viability of the trust. Obviously, whilst we want to have specialist services, we also want to have a viable hospital.

CEO 23

The staff here had been very engaged in developing stroke pathways with (teaching trust). There's a lot of buy in and a lot of professional clinical engagement, which is good.

CEO 21

There's something about the implications for our local hospitals. If and once we centralise the range of services and decentralise the rest to polyclinics, what's left for the local hospitals?

CEO 19

***Local authorities** (cited by 5 CEOs)*

We need to listen to the local authorities.

CEO 18

We are also listening to our local authority about their concerns around centralisation. For me the signs that we were successful were the comments from our Overview and Scrutiny Committee backing (RHS). They said they felt that the case had been made for specialist services and specialist centres.

CEO 24

There is a need to properly consult with Health Overview and Scrutiny Committee, and that work is informed by our partnership structure with the local authority. We used the adult and older peoples' joint commissioning group to feed into that work on stroke.

CEO 20

There are only six or seven councillors on the OSC panel and there is a massive agenda. Not just ours, it is also what the trust is doing, and the mental health trust, and the borough itself. We are overloaded, but we are relying on some formal mechanisms, because clearly if we don't consult and we make decisions, they can object.

CEO 15

Neighbouring PCTs (cited by 3 CEOs)

To make it work, of course we are talking with our neighbouring PCTs.

CEO 23

There were sector wide discussions to be had.

CEO 19

***SHA** (cited by two CEOs)*

I do not think you can ignore the (city)'s strategic leadership – (SHA's) strategic leadership.

CEO 20

The quotes show PCT CEOs relating to stakeholders in three ways. First, they identified the characteristics of people or organisations considered to be stakeholders in this issue. Second, the distinction between "stakeholders" as a generic group, and the different stakeholder groups, overlaps. Third, for obvious reasons, the most important stakeholders, or primary stakeholders, appeared to be the council and the local hospitals followed by neighbouring PCTs, which is not surprising as centralisation impacts beyond PCT boundaries, and requires PCTs to work together. The SHA was cited mainly for its strategic oversight role across the region.

14.4.3.2 Relationships

The role of relationships in service centralisation had many forms, with references to pathways or networks and partnerships, as shown in the quote below.

In a place like (city), centralisation is absolutely the right thing to do provided we get the links right, and get the pathways right. The way people are fed in, if they don't, you know, come off the streets – the specialist centres need to be properly connected and the pathways need to be clear, otherwise you will lose the advantage of having the centralisation.

CEO 5

Something like stroke will be governed by a pathway…… which we need to do and then reflect it in our contractual procurement with the appropriate hospitals. The work on this has to be led by a partnership between managers and clinicians.

CEO 20

14.4.3.3 Public engagement

The focus on public engagement is not surprising as PCTs have a statutory duty to consult the public on proposals for changes in health services. Engaging

with the local community is part of that process. Quotations from CEOs in relation to public engagement are shown below.

> *We don't have a good enough system of, you know, ongoing engagements and involvements of the patients and public in the way we commission. It is pretty absent, I think, you know, it is weak around here. Our level of public engagement is definitely more reserved for the formal consultations.*
>
> *CEO 15*

> *I do not believe that you include the public in agreeing the position about where is the best place to run a stroke service. I don't believe that is appropriate. It is absolutely appropriate that we engage with the public about what factors we have taken into account in reaching our decisions about where the stroke services would be. And then to consult with the public about whether we reached the decision in the right way, and to seek their views about the obstacles of accessing a centralised service and what we can do to help them overcome those obstacles.*
>
> *CEO 19*

> *The question really, is taking the time to explain to people why this centralisation is absolutely, clinically evidenced and better for people. People will express difficulties – difficulty to getting to visit their relatives at this hospital. And it is not about saving money, we probably won't save money.*
>
> *CEO 14*

Unsurprisingly, most of the references to public engagement were in relation to community engagement or formal public consultation. It is noteworthy that the seven CEOs (7/12, 58%) who commented on this were from PCTs whose local hospitals would "lose" services to teaching hospitals under the proposals.

14.4.3.4 Environmental dynamism

One in two CEOs (6/12, 50%) highlighted the impact of centralisation on the local health economy. A selection of quotes from CEOs relating to environmental dynamism (see below) cover the following factors: premises, notably hospitals; population, location or geography of place; infrastructure such

as roads and transport. The main concerns were about what the proposal would mean for all hospitals, location of the centre, how patients would get there, and how the needs of the local population would be met.

premises

The work we have done in southwest ….. suggests that there isn't the capacity at the more distant centre for everybody with a stroke to be treated.

CEO 20

This straight argument about efficiency - about which hospitals can carry out what functions, and how many hospitals there should be in (city) in the future. The questions keep cropping up.

CEO 5

population

My role is to ensure that we have a properly informed commissioning cycle, where you go from understanding the background evidence from public health, taking views on the need, supply and demand issues on the population.

CEO 20

Geography

If you look at all of the trusts which are nearest to (town), I think they are pretty strong. The bigger issue would be if (Trust X) wasn't designated as a stroke centre, then our residents would have to go somewhere else..

CEO 15

I would want to be reassured that the geography of the specialist unit was appropriate.

CEO 5

Transport

For patient with stroke ….. we would commission the (area) Ambulance Service to take people in a particular fashion and direction. We may need to

commission a different type of emergency service for people who have had major trauma, for example, helicopter, to take them to a major trauma centre.

CEO 20

14.4.3.5 Service users

Five CEOs (5/12, 42%) said they would consult service users and patients, as shown by their quotes below. One CEO suggested using routine practice registers to engage patients. Two others would want to engage users or patients in decisions about the change. (Later analysis showed the two CEOs to be from PCTs likely to lose local services to regional centres, which would explain why they felt the need to consult local patient and user groups.) Reasons given for not consulting users included letting the evidence "speak for itself"; support from key stakeholders; SHA proposal likely to be a foregone conclusion; the proposal was favourable to the PCT; or engaging with patients and users was not important to the CEO personally.

Let's say we're going to have a centralised stroke service. What I would want is to hear out the most important factors that clinicians and users think about in relation to reaching a decision about which is the hospital of choice.

CEO 19

You cannot ignore what patients are saying about the kind of pathway they would actually find acceptable. Take stroke - our patients have said to us that they want ordinarily, as far as it is ever reasonable, to be able to access high quality stroke services locally, which, for them means at their DGH. It is only where that is impractical, unaffordable, all of those things, do they think it is reasonable that we should actually ask them to go to a more distant centre.

CEO 20

14.4.3.6 Politicians

Five CEOs out of 12 (42%) mentioned politicians or politics when discussing centralisation. They differentiated between MPs, MPs who were ministers, mayors, and local councillors. Councillors were regarded according to the power of their political roles, for example the mayor, council leader, cabinet

member or OSC chair. As before, CEOs who would engage with politicians were from PCTs where the local DGH was likely to lose services to specialist centres, so it was to be expected that they would want to prepare the politicians at the early stage for the change. A selection of quotes is shown below.

> *It is pan region, therefore, I would start to be thinking – who actually got a regional wide role. The mayor, for example, clearly has to play a role. And the regional assembly. And I think ….. the city's MPs. That and well, I would say probably the city MPs and the national politicians.*
>
> *CEO 20*

> *Once we get into that deeper level of debate actually, involving the public and councillors and patients,….. need to work with Overview and Scrutiny Committees.*
>
> *CEO 14*

14.4.3.7 Decision making processes

One in three CEOs (4/12, 33%) talked about having decision making processes. The issues were in two areas: one, having a decision making process that would incorporate relevant evidence including views of key stakeholders such as clinicians, and having a business case; and two, joint decision making with neighbouring PCTs. Centralisation of services require hospitals to co-operate across catchment areas, so it made sense for PCTs to work with their neighbours to jointly consult stakeholders. A Joint Committee of PCTs had been set up by the SHA to oversee the consultation across the region, which may explain why so few CEOs mentioned a local decision making process. Examples of quotes from CEOs relating to decision making process are shown below.

> *I would expect the case to be fully discussed and debated. I would first discuss with local clinicians, then have a wider discussion with the directors, and then go to board. By the time we go to the board, there will probably be, you know, a clinical advisory board case as well. So, I'll be looking for all of that evidence that they will bring.*
>
> *CEO 5*

But the difficult bit, which I don't see, is we have a group of PCTs who really got to grips with how the decisions will be made. If we make decisions about trauma, make decisions about stroke care, and effectively that leads on to saying some hospitals are large acute and some hospitals are locals, actually, how do we manage that process?

CEO 14

In summary, the above findings describe how PCT CEOs were likely to respond to a top down regional requirement that, although not of the same status as a national diktat, was still regarded as such. While the strategic proposal would not impact directly on their organisation, it would affect other NHS organisations and the delivery of health services in the local environment, which meant PCTs would have to formally consult the public. There was little resistance among CEOs as the proposed changes would improve the quality of patient care and therefore aligned with PCT strategic goals. The CEOs' involvement was largely confined to leading the local public consultation process, including engaging with key stakeholder groups, and to obtain formal board approval.

14.5 Implementing local plans (RHS polyclinic strategy)

In contrast to the centralisation strategy, the RHS polyclinic strategy required PCTs to develop their own local plans in response, so the strategy had significant direct local impact and will affect local plans. PCT CEOs would be expected to be more sensitive to local contextual factors when taking strategic decisions on local plans.

14.5.1 Organisational internal factors

14.5.1.1 Top Management Team

There were in total just two CEO references to **TMT** in relation to polyclinics; both on task leadership as to who is going to lead. As it became apparent that this would be a major change programme, the CEOs made new appointments to lead the work.

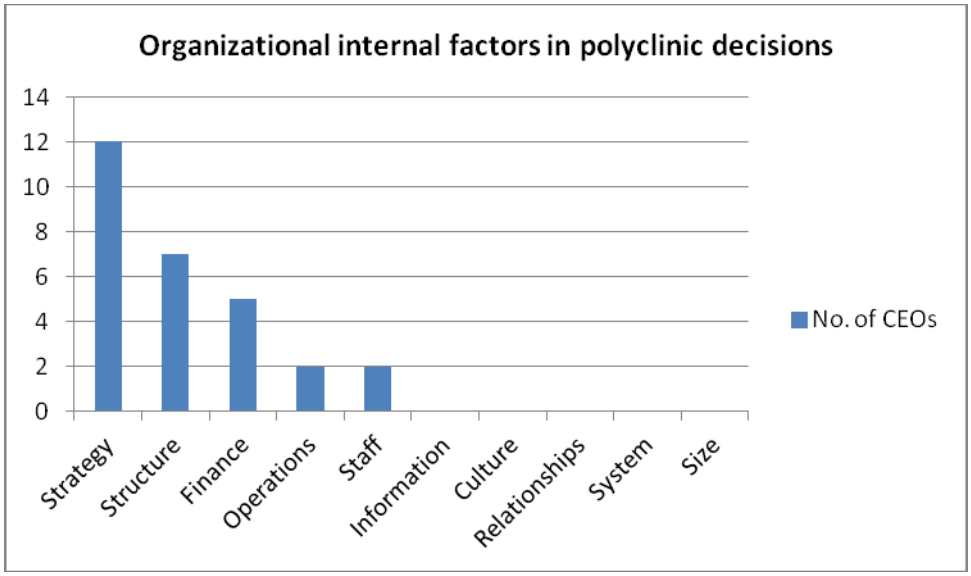
Table 29 and Figure 26 show the organisational internal factors CEOs said they would take account of when deciding on their response to the regional polyclinic

strategy. Overall, the most commonly cited factors were related to **strategy** and **structure**, followed by **time** and **financial factors**, which is not surprising as the polyclinic strategy had significant resource implications requiring board approval and will take time to implement.

Table 29 Organisational internal factors influencing CEO strategic decision making on polyclinic strategy

Factors	No of CEOs (%)	Factors	No of CEOs (%)
strategy	12 *(100)*	culture	0
structure	7 *(58)*	information	0
finance	5 *(42)*	size	0
staff	2 *(20)*	relationships	0
operations	2 *(20)*	systems	0

Figure 26 Organisational internal factors influencing CEO strategic decision making on polyclinic strategy



14.5.1.2 Strategy

The critical contextual factor, **strategy**, was mentioned by all of the 12 CEOs. The CEOs used the terms strategy, policy and plan interchangeably to describe

similar initiatives. Three quarters (9/12, 75%) saw the policy as an accelerator of change that PCTs had been planning for some time, so the PCTs should ride on the wave of the regional policy. For some CEOs, it provided an opportunity to change existing plans, with many saying that the strategy was pushing PCTs to be more bold and ambitious, both in the scale and pace of change. It helped that the SHA made some funding available to PCTs to support polyclinic development, and some PCTs took the opportunity to re-badge existing developments to access the financial support. A selection of quotes in relation to polyclinic strategy is shown below.

> *Well, polyclinics sort of fit very closely with our existing primary care strategy. We've already made significant investment in primary care facilities so we have got seven biggish buildings that are either brand new or they have had major refurbishments. In them they have got some GP services and some community services and some of them have got some sort of specialist services. More recently two of them have got independent sector diagnostics in them as well. So those things are sort of heading us in the direction of polyclinics so we are already drifting. Well not drifting, but we are already going in that direction. So what we've looked it is how does the concept of polyclinics help us to go faster, are there any things in the polyclinic model which are better than what we've been trying to do. So what we see is that polyclinics enable us to accelerate our primary care strategy and perhaps be a bit more radical than we wanted to be in the first place.*
>
> *CEO 23*

> *Most of us by and large buy into the principles around polyclinics in some shape or form and there is no major dispute about those and therefore we were already doing them and all this is doing is speeding it up and badge-ing it slightly differently.*
>
> *CEO 8*

> *What we've done is, essentially, say to (SHA) that we will remodel the service, and I anticipate that we will remodel inside, to try and make it a polyclinic. I think the polyclinic agenda fits fairly well with the strategy the PCT already had for a series of enhanced health centres like that….. That's why, as soon as this was mentioned, we realise it could be a vehicle for moving forward for us, and we hope, you know, we do expect that it will be.*

CEO 21

In terms of polyclinics, ….. it was so close to the strategy that we had already agreed.

CEO 19

Before I arrived, we are talking about summer '07, early '07, the PCT went for consultation on a primary care strategy. Don't be surprised, but in the borough, our single handed GPs are in really awful accommodation. And it's a matter of available buildings, available land and where whole borough is landlord. So, the PCT took a decision that, in order to redress health inequalities, the way to do it is through primary care, so you know, we got there before Darzi did.

And it has been in consultation, big consultation externally, with the GP community, and internally. They came up with a proposal for four clinics or centres and a number of practices, and we were going towards having local centres and those hubs then network with the rest of the practices. So, there is actually a plan for northeast, northwest, southeast and southwest health resource centres, and with borough-wide of networks around them. And some other practices are going into new premises.

So, that was our policy, so when polyclinics came out, we were irritated by the name, but the policy, you know, polyclinics, just confirms our direction of travel. And I think, in fact, it has confirmed that direction is right. It means that we will move faster, because, you know, there is (region) wide policy, and national policy around this. And also, I think some of the policy thinking and the thinking which emerged subsequently have broadened our horizons in terms of what we will put into the polyclinic.

CEO 5

14.5.1.3 Structure

The polyclinic model was synergistic with many PCTs' own strategy to transform primary care, especially in getting GPs to aggregate in larger modern practices. But the strategy extended this change by recommending that GPs operate from large modern health centres call polyclinics that were linked to practices in a hub and spoke model. As polyclinic development would be a significant local strategic decision, board support was important. Altogether

seven CEOs (7/12, 58%) referred to either boards or board members, in particular executive directors who would lead on polyclinic development. References to boards were linked to governance and accountability, while references to executive directors were about work delegation. A number of CEOs recruited new staff to lead the new work while others reassigned the roles within existing staff. Examples of quotes from CEOs are given below.

> *I had two informal discussions with the Chair, where this was very difficult information for her, because she is very closely identified with this project and then having done that, we then had an informal board briefing, although we had essentially made the decision. Then we had an informal briefing at the end of our board meeting in March, and that was really saying we have decided as a PCT executive that we need to change our tack on this, we need to drop the larger proposal rather than fight (SHA), we need to remodel it in the light of Darzi.*
>
> *CEO 21*

> *My director of clinical services retires at the end of July and we are recruiting now. Interview is next week for a chief operating officer and we are interested in somebody with very sharp business skills to essentially make collective decisions about where this (polyclinics) goes in the future.*
>
> *CEO 20*

> *We are about to appoint – should be a fortnight today – a Director of Healthcare Procurement and Performance. The interviews are set up*
>
> *CEO 12*

14.5.1.4 Finance

Financial or resource factors were mentioned by five of the 12 CEOs (5/12, 42%), in relation to affordability and how the capital investments would be funded. One CEO would use financial modelling, another talked about staff feeling unable to speak out about their concerns about value for money. Examples of quotes from CEOs on finance are shown below.

I do not think, if we replicate what happens in an acute hospital in a polyclinic, we will be able to afford this at all.

CEO 20

It was really around that – those issues about affordability and strategic fit.

CEO 21

There is evidence that around (region) that we have to be pretty careful, that some people have made very optimistic assumptions about finance about how much an urgent care centre will cost ….. Then we got to be really careful about balancing the money versus value to people. And an area that I don't think we do, you know, develop decision making based on cost-benefit analysis…… And of course the scheme has grown from a year ago before anyone thought of polyclinics.

CEO 14

14.5.1.5 Other factors

Two other factors that arose in the CEO interviews related to **operations** (2/12, 17%) and **staff** (2/12, 17%) as shown in the quotes from CEOs below. The reasons why only two CEOs mentioned operational factors may be partly due to the internal organisation of those PCTs. One had a large provider arm so may have been thinking about the operational impact of polyclinic implementation. The other reference was about the Professional Executive Committee (PEC) which has been coded under operations rather than *staff* due to PEC GPs not being PCT employees. In contrast, references to Assistant Directors was categorised under "staff".

Operational factors

We have the PEC which is meant to be the Commissioning Executive here but it does not work very well and we are just looking at that.

CEO 18

And the thoughts of how it will become an urgent care centre currently are that people going to the UCC for AE. We want to bring these three elements together - ambulatory AE and out of hours GPs and Minor Injuries, but with the GPs present all the time.

CEO 14

Staff factors

In the morning, we bring our Assistant Directors together with the Executive Directors and then in the afternoon we bring the GP members of the board together with Executive Directors. We feel the issues are of both operational and strategic importance in that time but we do an agenda in advance to let them know what we want planned. Pool our energies, if you know what I mean.

CEO 12

When the GPs move into the polyclinic ….. We have put quite a lot of effort into explaining exactly what we are doing ….. And obviously, the trust sees this as an opportunity at the moment, (to engage with) our own board, our own staff.

CEO 14

14.5.2 Local contextual factors

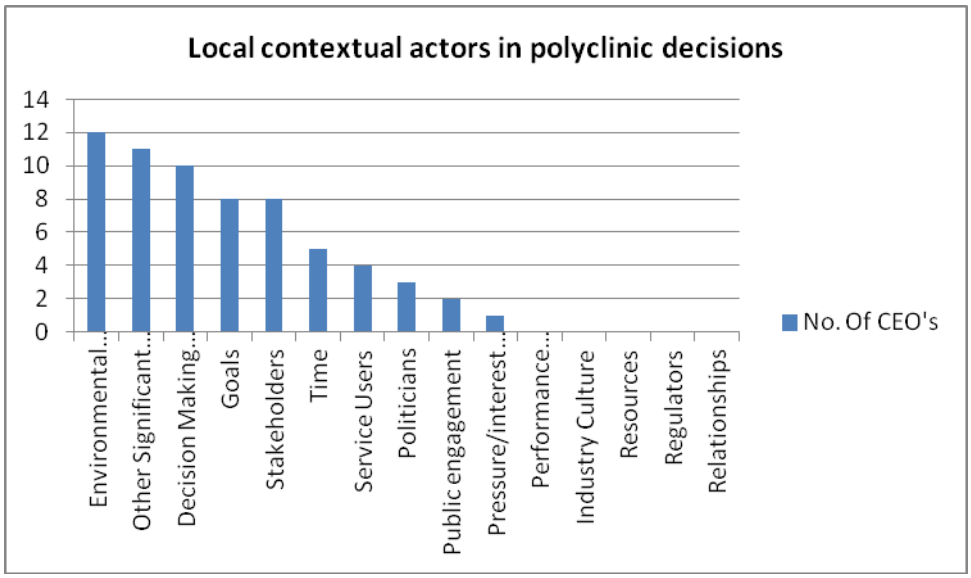
For polyclinics to fulfil their goals as NHS community services hubs, the development of the plans needs to engage with contextual factors in the local health economy Table 30 and

Figure 30 give a breakdown of the local factors that PCT CEOs said they would take into account in developing their local polyclinic strategy. There was a consensus on the key factors, such as environmental dynamism and other significant organisations, which were mentioned by all or almost all CEOs. Other important factors were decision making process and goals as were mentioned by a majority of CEOs. The remaining factors were connected to stakeholder management activities such as relationships and engagement.

Table 30 Local factors CEOs take into account when taking strategic decisions on polyclinic strategy

Factors	No of CEOs(%)	Factors	No of CEOs(%)
environmental dynamism	12 *(100)*	public engagement	2 *(17)*
other sig organisations	11*(92)*	relationships	2 *(17)*
decision making process	10 *(83)*	pressure groups	1 *(8)*
goals	8 *(67)*	performance expectations	0
stakeholders	8 *(67)*	industry culture	0
time	5 *(42)*	learning	0
service users	4 *(34*	regulator	
politicians	3*(25))*		

Table 31 Local factors CEOs take into account when taking strategic decisions on polyclinic strategy



14.5.2.1 Environmental dynamism

The SHA has set out specifications for buildings, catchment population and geography for polyclinics, so it is no wonder that environmental dynamism was mentioned by every CEO (12/12, 100%). But implementing the strategy

required PCTs to have a local plan. Two selected quotes from CEOs on dealing with complexity and pace of change in the environmental illustrate this point.

> *It was very strongly influenced by my not wanting to throw things up in the air. We have got a major community hospital development in the south of the borough that has got huge GP buy in, the sort that might be destabilised. I am very worried about that. We've got a big development, all combined with a swimming pool and a leisure centre in another part of the borough. Again we wanted to continue with that. We've got 15 GPs going into there, you know, with a whole range of things where we had already got major improvements. So I was really obsessed that we didn't derail all those. And then we have got other areas where actually I think the polyclinic concept would apply nicely. So it was about saying, that is our existing game plan, and this is how it fits, or how we could more fit into that, rather than, I have had an idea and now I am going to throw everything out the window that I was previously doing and bring in this new concept.*
>
> *CEO 8*

> *And so, it is being consulted. It's in consultation, big consultation externally with GP community and internally, they came up with a proposal for four clinics or centres and a number of practices as we are going towards as local centres and then those hubs network with the rest of the practices in the area. So, there is actually a plan for northeast, northwest, southeast and southwest within health resource centres, and borough wide networks around them. And some other practices are going into new premises. We don't have the buildings, unfortunately, and the first building is not going to come on stream until December '09 at the earliest. We have a LIFT (Local Investment Finance Trust) company and we are doing it through them. We have other practices, but with the network practices which are doing their own mix in the traditional build. But we have a lot of work going through the LIFT company in the next five years. And we're selling some of the land for residential housing.*
>
> *CEO 5*

Of the environmental factors that have major influence on polyclinics strategic decisions, the starting point seemed to be existing **buildings** notably hospital buildings or premises.

We've got this brand new big primary care centre in the under croft of the stand of the football stadium. ….. Then, the other one which I think we are going to have trouble with (SHA) but I think we are going to hold our ground on it, we've got two buildings, both of which are absolutely brand new. They are only about a mile from each other. Neither is big enough to have everything we want in a polyclinic hub but together they have got all the elements of a polyclinic hub.

And the reason that we can't is that one of them has got two GP practices in it, independent sector diagnostics and then a very large multi-agency children's special needs clinic. It is a really big building but it's got education staff, social services staff, health staff, and children's special needs. The only way we could make it into a polyclinic is to move all those people out, but they've only been in there two years and it was purpose built for them so we're not going to move them out.

Then the other building a mile down the road has got another large and growing GP practice, specialist dental services, whole range of outpatient outreach services, leg ulcer clinic, phlebotomy - a whole range of different things in it. So between those two buildings, we've got a really good vibrant hub and so we're going to go for hub and spoke model which builds on our existing buildings.

CEO 23

There is in south (region), X Community Hospital. X Community Hospital was part of Y and the PCT took it over a number of years ago. It is a Victorian hospital in the south of the borough. …..

CEO 21

The quote above highlights **location** or **sites**, which often for legacy reasons, accounted for the next most commonly considered environmental factor, as illustrated by the quote below.

Well it's on the old district general hospital site, so it's a huge site and we have an existing health centre with a small subset of those 15 GPs in at one end of the site.

CEO 8

We have to spend £15 million on renovating this site.

CEO 14

We have some obvious sites where we would expect to locate those (polyclinics) – one of them is here (X Hospital, place). The local population now is very wedded to the site. The second will probably be in (town centre). We do not have a site for that yet and we are in dialogue exploring a number of options for that, although we do occupy a site in (town) which is close enough to the town centre but it has an old Victorian former hospital on it. …..There is another much more central site in (town) that we have been looking at. Z is the final one and we think that would be likely to be on the former W Hospital site and we still occupy some of that site ourselves because have the Disablement Services Centre located there.

CEO 12

Linked to sites is the **geography** of the area, as well as existing **infrastructure**, as shown by selected quotes by CEOs below.

In deciding which way we went in terms of the health centre or the polyclinic, again we decided that the community hospital thing that we are doing in the south of the borough was so close to a polyclinic, in fact it's got all the elements in because that has got urgent care…… So what we did about that was, we presented information about the whole geographical area.

CEO 8

(Drew a map and pointing to pictures on the map) You've got the motorway coming up here, and this is kind of (town centre) down here, and you've got a big main road that comes down here and you've got the river down here and you've got another big main road down there. So…..the whole of this area is the X estate and behind it you've got Y Park and main road is just around there. So you've got main road which goes down here and the hospital, I've got my geography slightly wrong but the hospital is about there…… The way the road system works, there is one road that goes into the estate and then it kind of, it is one of those kind of tree things. So it's a classic how not to build an estate because you create that kind of doorway……It is a community and it is closed. I mean, if you shut that road, they would literally be shut in the estate. There is a little Sainsbury's that has opened here recently so there is an element of traffic right there, but not much. So if we put a walk in centre here, I think they will use it.

CEO 24

14.5.2.2 Public engagement

Engaging the public is an important consideration for PCTs, as each polyclinic had to serve a set catchment. The local plans therefore needed to take account of the socio-demography and health needs of local communities, as illustrated by the quote from a CEO below.

> *Just down the south west, there is hardly anything there. It is mainly brown field and this is where the population growth is – this is where all the regeneration will come …... That (pointing to an area on the map) is planned for a new facility and that is where new population will come so that could be polyclinic …... So then, it was a discussion about the existing population, which is mainly here. These communities - this is the area of our poorest practices - with most deprivations and limited access. Down here, and over here, is a similar story.*
>
> *In places like Hertfordshire, there is probably limited health gain left …... But here, there is low incidence of cancer in the population which I think is mainly because the youngest population in the country but very high mortality rate because of poor prevention and cultural issues that presents late although a lot of that is poor identification in primary care.*
>
> *CEO 18*

14.5.2.3 Other significant organisations

As a group, this factor was cited by all bar one CEO (11/12, 92%), with **GPs** (9/11, 82%), the **local council** (7/11, 64%) and **NHS hospitals** or acute trusts (3/11, 27%) most commonly cited. GPs were central to the delivery of polyclinics in their different roles as primary care provider, commissioner of secondary care and polyclinic anchor tenants. GPs were also influential with patients and the public. Some GPs saw polyclinics as providing opportunities to expand their business in provision. The local council had a number of key roles to play: providing support from local politicians representing the democratic constituency; as planning authority for approval of development proposals; as potential landlords of polyclinics; providing the statutory function of the Overview and Scrutiny Committee (OSC) to scrutinise proposed changes in health services; and support synergy by co-location of health and council

services. Hospitals would also need to engage as a significant proportion of their outpatient business may have to relocate due to changes in care pathways. The examples of quotes from CEOs in relation to other significant organisations are shown below.

> *We've got 15* ***GPs*** *going into there, you know, a whole range of things where we had already got major improvements. We had some GPs who would move from the existing health centre into there, and we'd encourage others who were in difficult premises to come in.*
>
> *CEO 8*

> *I am now having a dialogue with the LMC (Local Medical Committee).*
>
> *CEO 18*

> *Our PBC consortium has got big ideas about elderly care, having their own geriatric consultant and completely changing the focus of our day hospital……Our GPs are quite encouraged by the possibility of developing some teaching practices, as they don't have the space to do that now. They don't have the space to do minor procedures. They'll have that advantage of working from the biggest centre.*
>
> *CEO 14*

> *In the work on polyclinic we have to do proper pathway work with acute* ***hospitals****. We certainly shifted work into the community hospital already pretty substantially for patients with diabetes.*
>
> *CEO 20*

> *Obviously we've also got the* ***local authority****, discussions with them as to what will they be prepared to sign up to. So, a lot of work with Overview and Scrutiny Committee and with the Director of adult services. We do not want to be pushing a model that actually our local authority is not going to support.*
>
> *CEO 24*

> *We have four schemes at the moment where we are discussing land with the borough council planners…… I use those channels to unblock any issues and just to make sure that, you know, they've got the top person there and that*

those decisions all to go to cabinet at the appropriate time and then on planning committee. …..The borough is very committed to making life significantly better for the local people. And we do quite a lot through our strategic partnerships with the borough council as well and I sit on their key strategic groups

CEO 5

14.5.2.4 Decision making process

PCTs have to be able to demonstrate that they had consulted on significant service changes and that these have the support of key stakeholders. A common approach to achieving stakeholder support was to start engaging stakeholders before and as part of the formal processes. Not surprisingly, decision making process was mentioned by more than four out of five CEOs (10/12, 83%). The initial stages may involve taking soundings from key stakeholders, planning and preparing the business case (including verifying if there were a business case), and checking and assessing the likelihood of success. This planning period could be time consuming. As polyclinics would be major capital developments, the business cases would need to be approved by the SHA, so it was important to ensure that any local proposals had SHA support. The CEOs indicated that their PCT would try to "tick the box" in order to comply with SHA specifications. But where it would be difficult to do so, they would "dress up" or re-badge the developments so that they would be acceptable. A selection of quotes from CEOs relating to decision making processes is shown below.

Informal process

Basically the project is too big and it was committing our future revenue I thought in a way. We did get this informal feedback in a conversation in the corridor from their (SHA) nasty crew, but never mind. …..So what I am saying here is that we got a choice. We can carry on saying we want this business case that's already been put off and have a fight about it. Or we can change our proposals and ask if we want a polyclinic. What was planned was a bit like a polyclinic, you just didn't have the word you know.

CEO 21

Formal decision making process

We've really got to make sure we build a proper business case for that and we are really careful about optimism bias.

CEO 14

One of things that I have used as a tool here to help refine and to take the vision into reality is the simulation exercises, which for me, is really a powerful tool and engages a much wider group of people.

CEO 19

I suppose you are beginning to feel that we are almost, in style, incredibly inclusive and that it can take, sometimes, a long time to get somewhere, but we don't then generally have an argument when it comes to implementation, but you have got to have a fairly big capacity to handle things that were you not taking decisions by directing. If you take decisions through your programme of engagement, it is a slower process and you have to end up achieving results through influencing, through consensus, through compromise.

CEO 20

14.5.2.5 Goals

While not directly cited, goals were referred to by two thirds of CEOs (8/12, 67%) in relation to developing the local plans in response to the polyclinics strategy. While it was the SHA's goal to have polyclinics in every PCT and therefore an objective for PCT CEOs, goals in this context refer to the goals of the local health economy although they usually align with PCT strategic goals, Not surprisingly, the PCT CEOs were counting on local GPs to drive this change and championing it to local stakeholders. The CEOs were mindful that in order to meet the SHA specifications, compromises may be necessary. Because of the goal's importance, some CEOs were leading it personally, to make sure that risks were mitigated and the objective could be achieved.

We have combined the in and out of hours, and the GPs think that probably what they will do is end up being almost a cooperative and deliver the GMS component of the polyclinic on a rotational basis. At the moment it is open 8.00 am to 10.00 pm seven days a week but is not bookable for primary care appointments, and that is the gap in the current setup. So it does require some thinking and how they buy into that ….. question being whether we should be paying twice for something that we are already paying for, in private.

CEO 20

We are in discussion with the GPs about what can go into the resource centres. So, there is a team very much managing the project and with key milestones, and I, in fact, am currently chairing the polyclinics program board, which I might not necessarily do under the other circumstances but I am doing that it as so much rests on me.

CEO 5

14.5.2.6 Stakeholders

As discussed earlier, stakeholders could be a coded as an umbrella term (noun) or by their component constituents (e.g. politicians, other significant organisations, public). As the systematic review had identified stakeholders both as a group as well as in individual groupings, the same categories were kept for analysis. In total, two thirds of CEOs (8/12, 67%) referred to stakeholders as a single group, in contrast to the centralisation policy where the same proportion of CEOs named specific stakeholder groups. This may be due to a much longer list of stakeholders being involved in the local polyclinics plan, hence the use of the umbrella term. Examples of CEO quotes that relate to stakeholders in general are shown below.

We don't develop policy by going out to ask the public what they think ….. Every quarter there is a meeting that takes place involving about 15 senior leaders from across (borough). So we'll go, and the representatives of the organisations - from the PCT, the council, the acute trust, mental health trust, and GP Co-operative. You then get down to the very practical local level and discuss who is really going to make this happen.

CEO 21

You build up that kind of, over time, getting users, stakeholders, in gauging and shaping your strategic direction. The way to kind of reach decisions is through different ways of stakeholder engagement piece ….. to get the buy-in.

CEO 19

14.5.2.7 Time

Temporal factors were cited by just under half of CEOs (5/12, 42%). They were in relation to history and organisational memory, as well as allowing time for engagement during the planning phase.

> *The local population is very wedded to the site. Built in 1938, it was built by public subscription rather than being a property of NHS, therefore the current custodians and the borough still think that it is their hospital in effect when it should stay here.*
>
> *CEO 12*

> *If you take decisions through your program of engagement, it is a slower process ….. it can take, sometimes, a long time to get somewhere.*
>
> *CEO 20*

14.5.2.8 Service users

As care pathways will have to change to take account of polyclinics, a third of CEOs (4/12, 34%) said they would involve service users in their redesigns. Unlike the corporate sector where customer satisfaction is prioritised, patient views appear to not count as much as those of the stakeholders mentioned previously.

> *I would want to hear patient voice. I mean we have changed significantly the plans around B and NW during this year of consultation and that has been in response to the patient voice.*
>
> *CEO 24*

14.5.2.9 Politicians

Of the rest of the local contextual factors, the few comments made reflect local rather than general issues. Key opinion formers such as local politicians were mentioned by a quarter (3/12, 25%) of CEOs so may be specific to local issues.

> *I think it was driven by the desire of wanting to deliver a community hospital on the (town) site. (Town) does not need a community hospital. It seemed to me it was too politically driven by local issues. And it was very associated with the Chair and who is very political and wanted to deliver this. She lives down there,*

*she's – well, she's an ex-labour **politician**, has been in the labour party, it's a labour constituency.*

CEO 21

Our key partners in (borough) – I think I would say the borough council …... a number of the members have been influential, the ruling party being the Liberal Democrats, they've been very important to this.

CEO 15

14.5.2.10 Public engagement

The same number of CEOs (2/12, 34%) talked about engaging with the public. There was a single reference to pressure groups; in this particular case it was the voluntary sector which sometimes plays significant roles in community service provision.

It's the balance between leading and listening, but actually stubbornly walking in the opposite direction and ignoring completely the public voice is not very advisable. We have a clear understanding now of what our public want in that part of the borough. Because we actually need them to use and benefit from whatever it is we are designing and building - if they are saying "we really don't want that" ….. it is probably not the right way forward.

CEO 24

14.5.2.11 Relationships

Relationships were cited by two CEOs (2/12, 17%) as playing an important role in getting decisions agreed, as seen in the quote from a CEO who had an unsatisfactory relationship with the SHA, and another who chose to use a stakeholder for lobbying purposes.

We put pressure on (SHA) for some information. We then got a conference call with the Head of the Provider Agency, which he knew nothing about. It was booked, he knew nothing about it! A meeting was then arranged with the Director of Finance and Director of Strategy and MS. It was clear he had not done much arrangement. MS came in, it was during a gap in a meeting of the PCTs. Actually we had a conversation in the corridor for about 10 minutes and

then we got a letter of about two or three lines. So, I think that's what happened. So, that process wasn't completely unsatisfactory.

CEO 21

The LMC will support me in that because we don't want to do a polyclinic.

CEO 1

There was no mention of performance expectations, regulators or industry culture in relation to polyclinics.

14.5.3 Summary

In conclusion, unlike the centralisation strategy, the polyclinic strategy would have to be delivered locally, so had significant implications for PCT local plans. The introduction of polyclinics would affect every part of the local health system, which would explain why the CEOs were saying they would take into account many more contextual factors than for either the centralisation or national policies. Environmental dynamism was a critical factor in this regard. That was to be expected, as the polyclinic service model was prescriptive about catchment population, building size and space usages. Understandably, for such a major strategic decision, other significant organisations and decision making process featured high on the CEOs' contextual list – to ensure that key people and organisations work together to develop the plan, and that appropriate structures and processes were established to ensure governance. For PCTs whose existing local plans were similar to the polyclinic strategy, the strategy was a welcomed accelerator of change. For others they would try to rebadge existing developments. Finally, the PCT CEOs said they would want to involve all stakeholders to help shape the plans for implementation in the local health economy.

15 SUMMARY AND DISCUSSION

15.1 Summary

15.1.1 Generic strategic decision making

When taking generic strategic decisions, PCT CEOs said they would focus on the contextual factors needed for operationalisation. Of the organisational internal factors, strategy and structure were critical factors. Other important factors such as time, information, finance and staff were likely to be taken into account routinely, while operations, relationships and cultural factors may have local relevance but are not generalisable to all PCT CEOs. Of the local contextual factors, the CEOs would be most concerned about strategic fit between top down policies and existing local strategies or plans, and will seek synergy by linking any change to local goals

15.1.2 Decisions on national policies

Across the four different policy contexts, PCT CEOs would consider fewest contextual factors when taking strategic decisions on national policies. This is most likely because PCTs were expected or required to comply with national requirements, so there was no point wasting time deliberating which decision to take. This was noticeably so when dealing with key performance targets or national policy requirements, which were either tightly performance managed by the centre (the name the CEOs had for DH) or SHAs, or were assessed by the regulator in annual performance ratings. Usually it was both. The key national priorities or central diktats all had these features. It could be argued that the tight controls exerted on PCTs were not unreasonable as the NHS must be able to deliver a consistent and standard offering irrespective of local circumstances, especially on key national policy issues.

The majority of CEOs expressed taking a common approach to deciding how they dealt with national policies. Central diktats were possibly the easiest strategic decisions for PCT CEOs, as they were usually clearly defined. Stakeholders, especially parties central to delivery, knew they were non-negotiable so there would be less resistance and disaffections can be re-

attributed to the centre or as one CEO said “blame upstairs”. Implementation tended to adopt a “command and control” approach from the DH through the SHA, with reinforcement from regulation. Key national priorities can usually be traced back to the national medium or long term NHS strategy published by the DH, and which may start out as manifesto commitments. One of the longest serving CEOs talked about expecting to see something promised in a manifesto to emerge later as a “must do”. National priorities are normally set out by the DH in December for the following financial year in the annual Operating Framework, but new requirements could be introduce at any time. This may be in response to significant reports or events that have drawn public or media interests, such as Baby P or Stafford Hospital, and the government has to be seen to be taking appropriate actions.

Of the rest, the PCT CEOs indicated they would follow a routine to arrive at their decision. They would start by deciding on the degree of importance, and that often depended on the sanctions for non delivery and the performance management framework put in place to monitor progress i.e. the more serious the sanctions for failure and the more tightly a target will be monitored, the more weight it carries. If unsure, they would sound out the SHA or their peers. The CEOs would also assess the relative priority of the target against other national requirements, and whether it was do-able within the timeframe or available resources, or whether they could negotiate a more achievable milestone. They would consider the strategic fit with existing strategies or plans, and where possible, re-badge or adapt local plans to achieve synergy.

Implementing a new initiative is likely to have resource implications, so the CEOs would be thinking about governance arrangements and ways to achieve board ownership without board members feeling bounced into endorsing a top down decision. They would also be horizon scanning for forthcoming policies with the advantages or disadvantages of being ahead, and likely resistance to change. Depending on the nature of the deliverables, CEOs said they were likely to use formal decision making processes, as well as relationships, to garner stakeholder support. They may set up decision making structures to give

legitimacy to decisions, and to stop unpopular decisions unravelling. They were also likely to use tools such as programme management, options appraisal or gap analysis to support implementation.

15.1.3 Decisions on regional strategies

Compared to national policies and especially central diktats which are tightly monitored and regulated, regional strategies do not have the same status. Regional policies or strategies are not equivalent to national policies in terms of sanctions and central performance management, and are not normally regulated. Due to the regional focus, they may be less clear cut in terms of goals from a PCT perspective, with performance expectations more amenable to negotiation with the SHA. So, unless tightly managed by the SHA, CEOs may regard regional initiatives as optional relative to the national “must dos” and local priorities. But once it had been made clear that these regional policies were also mandatory, the CEOs would regard them in the same way as national diktats.

By their nature, regional strategies that make sense from an SHA perspective may not be of uniform relevance to PCTs due to PCTs’ differential local contexts, and unless a regional strategy can demonstrate clear local benefits or at the very least, no adverse local impact, PCT CEOs would find it hard to engage local stakeholders in regional plans. While such plans would not normally be regulated, strategic decisions of local importance would be subjected to scrutiny by the council’s OSC, whose members consist of local politicians. This formal process, as well as the duty to publicly consult on key strategic change, means CEOs had to ensure that due processes in consultation and engagement were followed, which required relationship building and an open and transparent decision making process. It also required PCTs to be able to demonstrate that they had taken into account the local contexts in arriving at their decisions. As regional policies can sometimes be problematic for CEOs, it was not surprising that of all of the contextual factors, the CEOs said they would prioritise, for most of the time, strategic and

information factors internally, to back up the rationale for these proposals, and on stakeholders and environmental factors externally.

There was a further issue of agency conflicts. As accountable officers, PCT CEOs are directly responsible to their boards for delivery of the organisation's strategic objectives, which by nature would include key national and regional requirements. But PCT CEOs are also accountable to the NHS CEO through the SHA CEO who, as "grandparent" in CEOs' annual appraisal process, has the final say. The SHA CEO has the power of hire and fire, as well as over opportunities for promotion. It is not unusual for PCT CEOs to have to ask their boards to take strategic decisions on regional policies that board members may feel uncertain about. To help the decision making process, the CEOs may set up decision making processes and governance structures that engage the board. These same structures are also used by CEOs to fend off the SHA when they disagree with central directives. This chiasm between central control and local accountability would account for why the CEOs heeded local factors than internal organisational factors when taking strategic decisions related to regional requirements.

15.1.4 Decisions on local plans (regional strategies with significant local impacts)

The CEOs' responses to regional polyclinic strategy is interesting from the perspective of understanding how regional strategies get developed and implemented at local PCT level. The SHA launched the polyclinic strategy as a sustainable solution to rising patient demand for care and prospective cuts in health service funding. The strategy was developed by an eminent doctor with the help of management consultants, on the assumption that health care provided outside of hospital would be substantially cheaper. The strategy development process examined international best practices and engaged stakeholders, in particular hospital consultants and patients, on how the patient journey can be improved. The plan was to shift services out of hospital settings to community health centre hubs called polyclinics that would provide a wide

range of services traditionally provided in hospital, as well as the primary care and community services.

For obvious reasons, the polyclinics concept was unpopular with local district general hospitals. Hospital managers saw it as an unnecessary upheaval to services, with possible loss of business in an over saturated provider market. Many criticised the projected cost savings as over optimistic, since overheads still had to be maintained. Overheads accounted for 20-30% of a hospital's non pay costs. Hospital consultants regarded working in the community as a downgrading in status, and believed decentralisation to polyclinics would increase costs. For polyclinics to be economically viable, there needed to be economies of scale, hence the requirements for catchment population and critically, for a large core of GPs to operate from the polyclinic. The latter was especially important as GPs are gateways into secondary care, and their involvement would be central to changing care pathways from hospital into the community.

The polyclinic concept was also viewed with some scepticism by PCTs but because it was being driven hard by the SHA, a majority of CEOs saw implementation as inevitable. It was a case of, if we have to do this, we might as well use the opportunity to achieve long awaited change locally. In the past decade, PCTs trying to modernise primary care practices have found it difficult as GPs are independent contractors to the NHS and the current national GP contract, which is life long, does not facilitate transformational change. Premises are a particular problem. There is a long history behind the development of British general practices that explains why the situation is as it is today.

From the inception of the NHS in 1948, despite various attempts to integrate GPs into the NHS, they have stayed as independent contractors. This has resulted in general practice not receiving the same degree of management or investment as hospitals. In some cities, there are still significant numbers of practices housed in sub standard premises that are owned by GPs themselves. There is also a cohort of GPs who came to this country in the 1970s from the

Indian subcontinent or East Africa who entered general practice because of limited opportunities in hospital medicine available then to non white doctors. Many independent contractors have invested their working life, as well as capital, in their practices which may explain the resistance to polyclinics.

Although considered by the general public to be part of the NHS frontline, GPs are private small businesses that contract with the PCT to provide primary care services to a defined local population who register with the practice. Every year, the general public rates GPs as the most trusted of all professional groups. This makes a command and control relationship between the PCT and GPs difficult to implement. So PCTs have to try different ways to get GPs to change. Managing relationships and trying to influence by appealing to their professionalism may achieve better cooperation but history shows that it is really only through contract management or financial incentives that substantial change can be achieved.

15.2 Implications of findings for strategic decision making in the NHS

Project 2 findings illustrate the challenges facing PCT CEOs in trying to lead and manage their local health system where progress depends on influence rather than authority. In PCT CEOs' world view, the parameters of their role means that their focus is local, and since the DH sets the rules and regulations as well as provides the funds by which the entire NHS operates hereby creating an internal health economy, there is no need for PCT CEOs to pay attention to macro level factors.

In terms of strategic decision making, formalising decision making process has several advantages: They include: clarification of desired outcomes; demonstration of the problem with an evidence base; production of a plan with timetable; robust evaluation of options, which may include carrying out options appraisal and developing a business case; identification of risks and taking early mitigating actions; demonstration of governance and accountability structure; provision of a structured approach for obtaining stakeholder support.

Engaging with the local community as part of the decision making process is especially important when implementing changes affecting hospital services, as history shows that local communities always support their local hospital and will resist what they perceive as threats to their local hospital. It is however of concern that only a minority of CEOs indicated they would pay attention to service users. Paying lip service to engagement and consultation would lead to the PCT missing out on the expert patient input that would result in better designed services.

The NHS has traditionally regarded itself as a scientific establishment in which objectivity is valued and where quantitative measures are regarded as more “true” than qualitative measures. Yet, despite the positivist culture that should encourage evidence based decision making, the majority of CEOs did not mention using information when taking strategic decisions. Not basing decision on evidence is likely to result in sub-optimum decisions

While some strategic decisions have little to do with staff, for example capital investments, in practice, there are few strategic decisions that would not require staff engagement. Sadly, the majority of CEOs would not have involved their staff in the strategic decision making process. NHS organisations need to consider engaging staff from the start of any strategic change process, before or at least concurrent with engaging external stakeholders, as it promotes staff support and provides opportunities to deal with the interests of different staff groups, notably doctors and nurses. PCT CEOs have to balance engaging staff early to get their buy in, withholding information that could potentially jeopardise the change before it gets off the ground.

It is surprising that financial factors were not mentioned more by the CEOs. While not all strategic decisions have resource implications, most strategic decisions tend to have some financial impact. It may be that PCT CEOs do not challenge top down requirements even if they have financial concerns, therefore making finance a less significant influence in strategic decision making, with associated financial risks. Another possible explanation could be that the interviews were carried out during a period of unprecedented funding growth in

the NHS (nationally, PCT allocations grew at an annual rate of 5.5-7% between 2007/08 and 2009/10), when money was less of a concern.

15.3 CEOs espoused decision-making context

The analysis and discussion above have identified several concepts in PCT CEO strategic decision making which are drawn together by responding to the research questions set in paragraph 12.3

15.3.1 How do PCT CEOs define their decision making context?

The findings show that PCT CEOs do not take a blanket approach to strategic decision making; instead, they define their decision making context by the degrees of freedom to respond. To enable CEOs to decide on the appropriate response, they will ask themselves, or other people, for answers to the following six questions (in priority order):

1. *Who is the edict from*?

   Policies from the DH, SHA, or regulators count the most, in descending order of priority.
2. *What is the goal or objective*?

   The CEO will seek to understand what the "problem" is that requires solving. For that, they will ask themselves two subsidiary questions: *One, is it a "must do"?* If the answer is yes, then universally, the CEOs will not waste time – they will just get on and "do it". If not, but the goal is aligned with PCT strategy, they would use the opportunity to step up the pace on local strategy plans. If no, and the goal does not support local strategy, they would then consider how to present things in such a way that would be acceptable to the centre. *Two, is there a target or KPI?* If yes, they will check information for levels of the current performance and decide whether to negotiate the baseline. If no, but is clear the requirement will be closely monitored, they will try to seek flexibility in terms of local interpretation to achieve synergy with local strategic goals.
3. *What is the timetable*?

If there is a deadline, is it “flexible” and is it negotiable? What are the milestones, for performance management purposes, to track progress. The issue here is to work out whether the goal is do-able within the timescale, and actions to be taken to mitigate the risks, for example a slower pace of change.

4. *Who needs to deliver this*?

   Included here is a sub-question on *who must be involved* for the goal to be achieved. This is where staffs, including the TMT, and stakeholders come into play. CEOs identify stakeholders by the impact the change will have on organisations or individuals. Internally, staff will start planning to operationalise the plans, under the executive leadership of TMT, who will also act as a sounding board for the CEO. The board will also need to be informed for governance purpose. Externally, the primary focus will be on organisations (so called “other significant organisations”) that will have to take actions, concentrating on key post holders whose support is crucial and might have to be won over. This includes GPs. The secondary focus will be on influential local groups, or individuals such as politicians. The final group are beneficiaries such as patients and the public.

5. *What needs to happen*?

   There are three sub-questions: *One, what are the dynamics in the local environment that are relevant?* This will involve an assessment of the local environmental factors such as space, geography, facilities, infrastructure, local demography and the local health economy. *Two, what are the resources required?* The main concern will be financial, mainly about affordability. *Three, how will the decision be taken?* This leads to the establishment of structures and processes to enable the work to be constructed, stakeholders to be positioned in work streams or key decision points, and formal decision making by the board.

6. *What would success look like?*

   Achievement of quantifiable results would be a clear demonstration of success. If the outcomes were less tangible, they would be judged according to their contribution to PCT strategic goals or objectives.

15.3.2 There is a hierarchy in contextual factors

Based on the findings, there appear to be three levels of contextual factors relevant to PCT CEO strategic decision making:

i) The first level consists of generic critical factors that are considered every time (or more than 90% of the time, in this study) the CEOs take a strategic decision, whatever the issue. The factors are: **organisational strategy**, internally within the PCT; and **stakeholders**, **goals**, and **decision making processes**, externally. Stakeholders also have differential status, which could be classified into three sub-groups. Primary stakeholders are usually statutory organisations such as the local council, NHS Trusts, GPs (as a professional group), and the SHA, who have key roles to play in implementation. Secondary stakeholders are those organisations or individuals with an interest in the outcome, such as GP trade unions, informal groups or networks, and politicians. Tertiary stakeholders are service users or patients and the public who are remote from the direct decision making process.

ii) The next level consists of factors the majority (that is, more than half) of CEOs would take into account when faced with the same scenario or issue. These factors are **structure**, **information**, **finance** and **operations**, internally; and **environmental dynamism**, **time**, **relationships**, **politicians** and **public engagement** locally.

iii) The third level factors are those that some CEOs will take account of but not others, due to unique local circumstances. The contextual factors are **TMT, staff** and **culture**, internally; and **patients** (service users) and **regulators** externally.

It is noted that none (or less than 10% of respondents) of the following contextual factors were mentioned by PCT CEOs: all macro economic factors; size, system, and relationships internally; and resources, pressure/interest groups and industry culture externally revealing the parochial nature of CEO strategic considerations.

15.3.3 Espoused behaviour *vs* literature based model

There is some degree of coherence between the literature based contextual intelligence model and the espoused decision making behaviour of PCT CEOs. Using the literature based model as a guide, one of the most significant observations was the complete lack of interest paid to macro economic factors by PCT CEOs. The CEOs paid differential attention to different contextual factors, and also consolidated the number of stand-alone contextual factors, by grouping (or merging) them or reducing them under an umbrella term. While the research did not identify new contextual factors, it did enable the contributions the TMT make to CEO decision making to be elucidated, including helping the CEO in the sense making process.

15.3.4 Patterns of contextual factors and influence across CEOs

A number of patterns are observed from the analysis, all of which would impact on the contextual factors that PCT CEOs would take into account in strategic decision making. First, the higher up the command chain the directive comes from, the less strategic and more operational would be the policy, and therefore the less need for strategic decisions by CEOs. Second, the higher up the origin of directive, the more likely it is to be accompanied by measurable targets, which also leaves less freedom for manoeuvre or negotiation, hence the “just get on with it” attitude of CEOs when dealing with central diktats. Third, the more strategic is the plan, the greater there is the need to engage with and consult local stakeholders, and to take into account local factors. Conversely, there is no need to consult stakeholders on central diktats. Fourth, the more contentious is the strategic decision, the greater is the need to be able to demonstrate governance and accountability, usually through formal decision making processes. Finally, the greater the anticipated resistance, the greater the need for formal decision making processes and structures.

15.3.5 Different factors matter in different kinds of decision

PCT CEOs indicated they would take different contextual factors into account when taking different kinds of strategic decision. Of all of the contextual factors, organisational strategy, stakeholders, goals, and decision making processes

appear to be generic critical factors which will be routinely considered in any strategic decision making. The rest of the contextual factors are situation dependent. With key national policies notably *diktats* and some regional policies, organisational strategy comes second to structure due to the focus then being on implementation, which involves engagement, operations, and governance. For other (non diktat) policies, because of organisational and executive accountability arrangements, the CEOs would usually try to comply; but where they felt it to be difficult to do so due to local circumstances or that the policy conflicts with the PCT strategic goals, they would use appropriate evidence to try to negotiate for changes in scope or pace. Regional policies that do not have significant direct local impact are regarded the same way. For regional policies with a significant local impact, CEOs would want to take advantage of the opportunity to expedite local strategy plans. The focus then would be on presentation, upwards to the SHA to show compliance, and outwards to local stakeholders to gain their support. Relevant contextual factors then would be about aligning strategic goals, managing key players and knowing about and dealing with relevant factors in the local environment, putting in place decision making processes to structure the work, to demonstrate governance and to lock in the strategic decisions.

15.4 The evolved contextual intelligence model for PCT CEOs

The contextual factors influencing PCT CEOs strategic decision making show different emphasis being placed on the contextual factors compared to the literature based model. The most obvious omission is the lack of reference to macro level factors. The other contextual factors that appear to play no or very minimal roles are interest and pressure groups, learning organisation, internal systems, organisational size and industry culture. In addition to individuals, groups and organisations being set out as discrete contextual factors in the literature based model, Project 2 introduces a new concept of stakeholders, as a group, as a contextual factor in PCT CEO strategic decision making. This has led to some refinements in the contextual intelligence model for PCT CEOs accordingly.

The results from Project 2 are shown in Figure 27-

Figure 30. Each one summarises the findings for a particular kind of strategic decision context, with the number of citations to each contextual factor included in the respective trapezium. Figure 27 shows the results for the generic strategic decision making context. Figure 28 shows the results for the contextual factors taken into account in strategic decision regarding national strategies. Figure 29 shows the results for the contextual factors taken into account in strategic decision regarding regional strategies with local impact.

Figure 30 shows the results for the contextual factors taken into account in strategic decision regarding regional strategies that have significant local impacts.

Figure 27 Significant contextual factors in generic strategic decision making

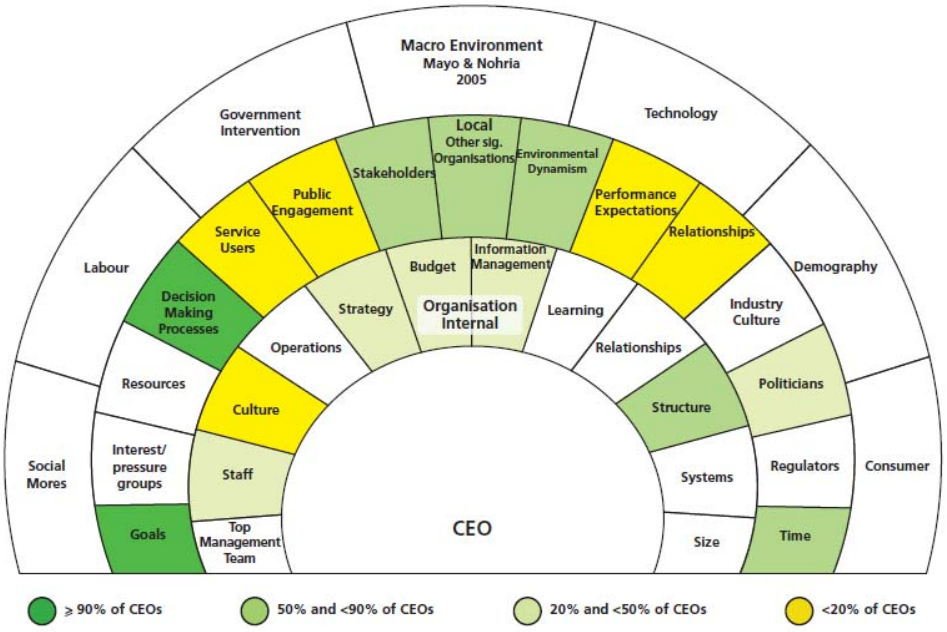


Figure 28 Significant factors of contextual intelligence in PCT CEO strategic decision making on national policies

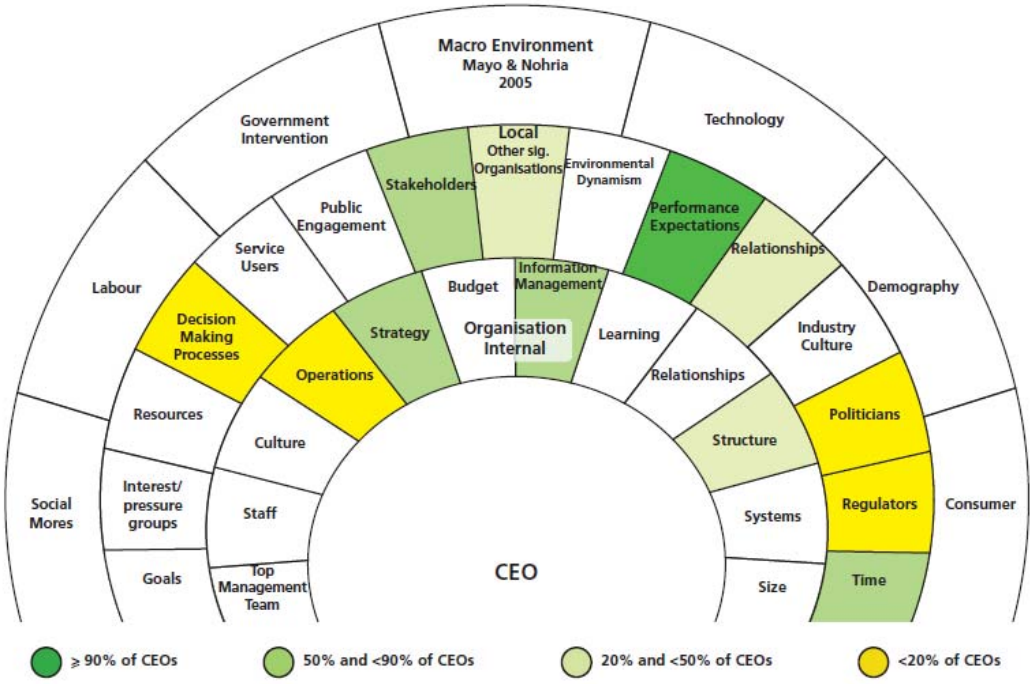


Figure 29 Significant factors of contextual intelligence in PCT CEO strategic decision making on regional strategies with little local impact

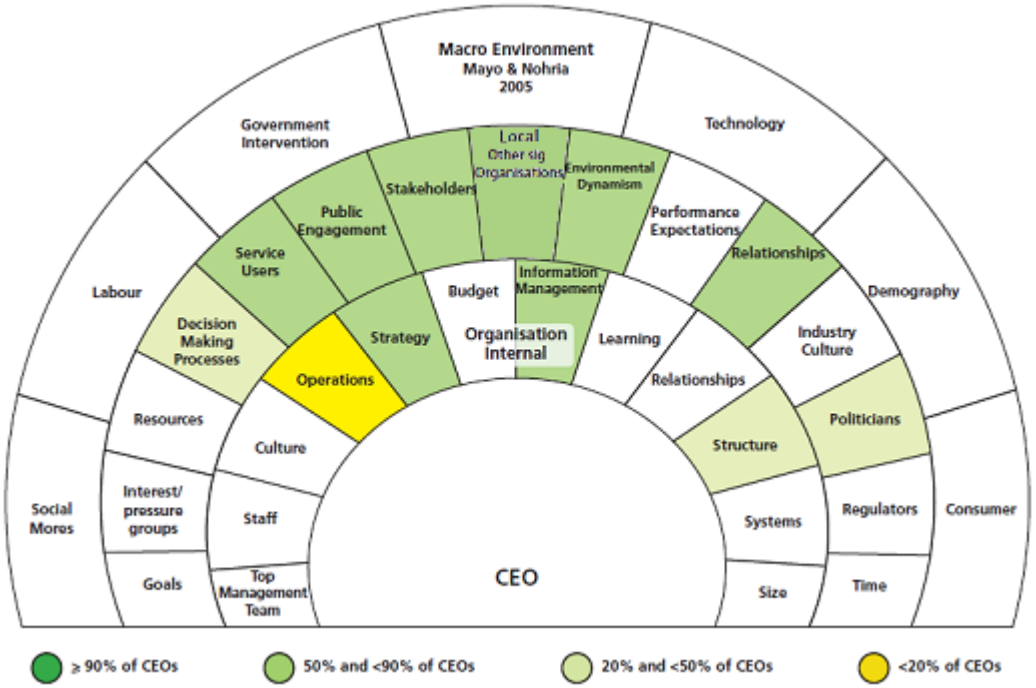
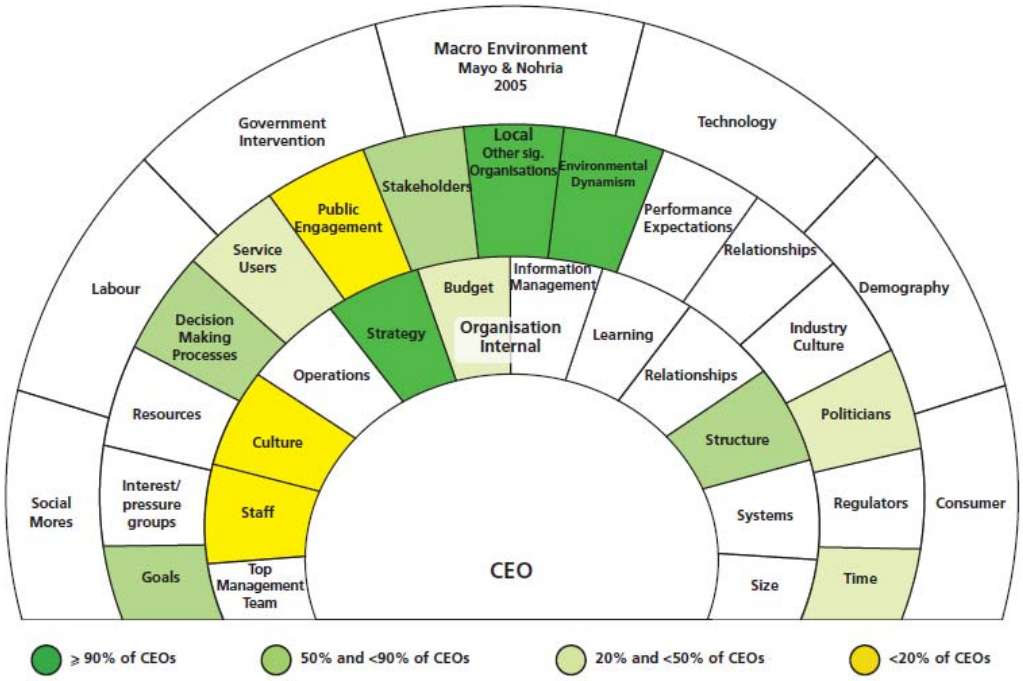


Figure 30 Significant factors of contextual intelligence in PCT CEO strategic decision making on local plans



All of the models vividly illustrate the bounded decision-making context of PCT CEOs, as defined by factors reportedly taken into account.

16 CONCLUSION

Project 2 findings provide a rich description of the environment that PCT CEOs have to work within and manage in the course of doing their jobs. It also illustrates the challenges facing PCT CEOs in trying to manage the local health system. In PCT CEOs' world view, the parameters of their role meant that their focus is local, and since the DH set the rules and regulations as well as provide the funds by which the entire NHS operates hereby creating an internal health economy, there is no need for PCT CEOs to pay attention to macro level factors. The pursuit of PCT strategic goals - to improve the health of the local population and commissioning effective health services that meet the needs of local people - appear to act as a moral compass guiding CEO actions. This ranges from having the appropriate processes for decision making, engaging with stakeholders, and, as a statutory organisation, to be able to demonstrate effective governance. There is no command chain below PCTs, so progress depends on influence rather than authority,

Compared to the literature based model of contextual intelligence, the findings show how PCT CEOs take strategic decisions, and how different contextual factors are taken into account depending on the presenting policy or strategic context, which also defines their decision making context. There is a hierarchy in contextual factors. While the contextual factors somewhat match the literature based model, the research reveals the irrelevance of macro level factors in PCT CEOs decision making in contrast to the corporate world where they are prime considerations. It also highlights the importance of stakeholders as a group, which is a new finding. Interest and pressure groups as well as the TMT appear to play negligible roles, in contrast to the corporate sector. The patterns of contextual factors and their influence in PCT CEO strategic decision makings confirm that PCT CEOs do take different things into account when taking different strategic decisions, resulting in a different contextual intelligence model.

While this project reveals the rich and elaborate decision-making context of the PCT CEO it is based on what CEOs said they would take into account. The

next step for the research will be to find out what these same CEOs actually took into account in these focal decisions. This is the focus of Project 3.

Appendix C

Letter to PCT CEOs for participation

Email letter to PCT CEOs confirming their participation in the research - sent following a telephone conversation about the research project.

Date

Dear

I am ever so grateful to you for agreeing to participate in my research project.

Background: I have been at the PCT for almost a year now. Before coming here, I was working towards a research degree on CEO and leadership, which I suspended after starting the job (which took over my life). I am now resuming my studies or at least trying to. There is no lessening in workload but I really should complete what I started and the university is threatening to kick me out if I don't progress. I should be most grateful for your help.

The research is a qualitative study looking at how PCT CEOs make decisions and the range of contextual factors they take into account in making key strategic decisions. As a participant, you are asked to give two interviews, each lasting up to an hour and a half, two months apart, and to keep a diary log (using your electronic diary, no additional work involved). I attach a 1.5 page briefing giving more information about participation in the project. The results should inform how the NHS could develop the quality of CEO decision making. I am the sole investigator, so will carry out the interviews and analysis myself, guided by my supervisor Dr Catherine Bailey. I will, of course, come to you and the interviews will take place in your office.

On a related issue, it would be nice to meet up informally as colleagues. I would love to hear about and learn from your achievements and progress in your PCT. If you were interested in outsourcing/procurement or hearing about what it was like to go through the FESC process, I would be delighted to share our experience in the PCT.

I will stop here. I will give you a call in the next few days to follow this up and to make arrangements for the first meeting. Many thanks.

Yours

Yi Mien

office direct tel:

mobile: 07956 115 773

Appendix D

Participant Information Sheet

Attachment 1

PARTICIPANT INFORMATION SHEET

Thank you very much for agreeing to help with my DBA research, which aims to explore the relationship between context and PCT CEO decision making. As part of the research design, I have developed this statement to provide you with further information about your participation in the project.

1. Nature of the project

This research is the second of three projects forming my DBA and has been designed to answer the research question: how does contextual intelligence influence NHS CEO decision making? Contextual intelligence (CI) is defined as paying attention to the information generated by the different contextual elements i.e. like spies get intelligence, and as a process within decision making rather than as a cognitive characteristic.

The question arose from the first project which consists of a systematic literature review of how leadership differences impact on organisational performance; it found that some performance variation can be accounted for by non-leadership factors, one of which is context. A contextual intelligence model which attempts to describe the relationship and impact of context was developed from that work. This project will explore the dimensions of context with respect to PCT chief executives and their impact on CEO decision making by collecting primary data.

2. Study design and method

The research method consists of qualitative, semi-structured interviews which have been chosen to tease out the theoretical model and to elicit participant's understanding of what you see as your decision making context, and the keeping of a diary to record significant events and insights.

3. Project timetable

The project is expected to take six months. Data collection period will take place April-June 2008, followed by data analyses in July-August. I hope to write up the findings in August and submit the final report to the University in September.

4. What is expected of you as a participant

You are asked to give two interviews, each taking up to an hour and a half, in your office (or an alternative preferred location). The first interview will take place at the beginning of April, and the second, two months later, in early June. The format for both is that of semi-structured interviews, meaning that you, as all participants, would be asked a similar set of open questions that address the research question.

You will be asked to provide basic personal background socio-demographic data to inform the data analysis based on a standard template. Standard information includes age and tenure (number of years as CEO), past experiences, functional background, significant development, and education levels. Alternatively you may wish to provide an up to date cv containing the information.

You will also be asked to keep a diary log in the period between the two interviews of factors that have influenced your decision making with regards to HfL. A standard diary template will be provided for recording your insights.

5. How the research procedures might affect you

Participating in a research activity takes up time and effort which I truly appreciate. The benefit of taking part is that you will contribute to help colleagues and others understand what and how actions might be taken to improve strategic decision making by CEOs.

You may feel uncomfortable sharing your insights, especially as the interviews will be taped, but I hope the assurance of confidentiality (below) will assuage this.

Once I have completed the final report and it has been approved by the University, I am very willing to send you a copy if you wish.

6. Assurance of confidentiality

The interview is entirely private and confidential. Everything that you say will be non attributable. Although the interviews will be taped, it is purely for transcription purposes. The recording will be erased once data has been transcribed and if you

wish, I should be glad to send you a copy of the transcripts of our interviews. This assurance is in line with the code of conduct for researchers of Cranfield University.

7. **Right to withdraw at any stage**

   You have the right to withdraw your participation at any time.

8. **Approval of the Cranfield Research Ethics Committee (CREC)**

   This project has been approved by the CREC as fully meeting the criteria for primary research. I will bring with me to our first meeting a copy of the letter of approval.

Thank you very much for your help.

Yi Mien

Appendix E

Interview Protocol

Thank you for agreeing to take part in my research project designed to contribute to understanding how decision making context influences PCT CEO decision making. This project is the second part of a (three part) DBA research project which aims to identify whether contextual intelligence (CI) (defined in this study as paying attention to the information generated by the different contextual elements i.e. like spies get intelligence) has an impact on how CEOs make decisions. The first part consists of a systematic literature review on CI and CEO performance. CI is defined as a process within decision making rather than as a cognitive characteristic.

You are one of the PCT CEOs in the region who have been invited to take part in the research. What I am asking you to do is to give two one hour interviews ***(I am making it an hour long for both interviews 1 and 2 to encourage sign-up)***, two months apart, and to keep a diary in the intervening period. I will provide a diary template for recording data.

I would like to ask you questions about how you make decisions with regard to implementing central policy. We understand that as PCT CEOs we often have to take many factors into account before arriving at a final position. Your answers will help me to understand the pattern of factors that you take into account. All CEOs will be asked the same questions. You will have the opportunity at the end of the research to see the results which we believe will be of value in understanding effective decision making in the NHS.

I would like to ask you about what you take into account when you are making important strategic decisions. To enable comparison of the aspects of context

that PCT CEOs take into consideration when making decisions, I have chosen a common decision instigator, namely *Regional Health Strategy*.

I will record your answers but assure you that that the interview will be recorded for data gathering purpose only and that data will be handled confidentially. No response will be attributed to any one individual or organisation. No one individual or organisation will be named and the data will be purely used for research purpose.

Interview questions

Question 1

Please think about that aspect of your role where you are involved in arriving at a decision for the PCT which has strategic significance. (This could be a decision about direction, changes to provision; service levels, policy implementation etc). In such situations can you describe what or who you generally take account of in arriving at the right decision?

(At the conclusion of the response – Are there any other factors that come into play?

Question 2

Can I ask you now about central DH policy implementation decisions? Can you describe what or who you generally seek to take account of in arriving at implementation decisions?

(At the conclusion) – Anything else?

Question 3

Can I ask you now about the current policy implementation decision around *Regional Health Strategy*. Let us first look at the “polyclinics” concept which has received a lot of attention.

So – in regard to the forming or taking decisions around **polyclinics**:-

- What do you expect to take into consideration
- What needs to be done to inform the decision
- How will you do so
- Why have you selected those particular factors
- Who do you expect to involve, in coming to a decision
- Of those people you have identified, whose voices would you pay more notice to than others
- What are you going to do to get these stakeholders' commitment?
- What do you plan to do to take forward the polyclinic agenda, if any

Question 4

Can I now ask you about the Centralisation agenda – the move to centralise specialist services in a small number of hospitals ……

Repeat the questions as above.

Question 5

Can I ask you to maintain a diary about key activities and conversations in the decision making process on *Regional Health Strategy* for the next two months. This would really help the data collection to ensure we don't miss out on significant influencers on your decision making process. I should be grateful if you could (please ask your secretary) to ensure that every activity (meeting, correspondence, internal or external) or conversations relating to *RHS* is entered into your electronic diary. When we have the second interview, we can then go through a print-out of the diary to check for completeness.

Question 6

I should also be grateful if you could complete this short questionnaire to provide purely factual information about your background to inform data analysis.

Appendix F

Proforma *(to be completed by CEOs after interview 1)*

Date of interview: ___ April 2008

PCT : _____

CEO Name: _____

Sex: male/female

Year of birth: _____

CEO experience (total no of years, including previous CEO roles): ____ years

Job title of the last post before appointed CEO (e.g. Director of Commissioning, Director of Finance etc):
_____

Management training and development (significant programmes/ courses attended) in last 10 years-
_____
_____
_____
_____
_____

Insights from significant experiences in last 10 years that has had an impact on how I approach strategic decision making now.
_____
_____
_____
_____
_____

Other significant events that may have influenced your development:
_____
_____
_____
_____
_____

Appendix G

Ethics Approval Form

ETHICAL APPROVAL FORM

Cranfield UNIVERSITY
School of Management

TITLE of the Research Project **Contextual Intelligence and CEO decision making** PROJECT 2

DELETE those which do **NOT** apply

Doctoral Project **DBA**

NAME of researcher(s) **OR** for anonymously submitted student material **EXAM NUMBER**
Yi Mien Koh

I certify that this is a true account of the research, and I have considered any ethical implications of the project
SIGNED Yi Mien Koh **DATE** 7.4.08

NAME of SUPERVISOR (for student research) **COURSE/ YEAR** **DATE**
Catherine Bailey

SUPERVISOR'S SIGNATURE (or Lead Researcher's in the case of **STAFF** research)

I certify that the project specified above conforms to the School of Managements' current ethical guidelines, and that the questions in this form have been answered and any ethical issues addressed **OR**
I certify that there are NO ethical implications whatsoever present in this study as the project is based on an analysis of publicly available secondary sources (if so, please indicate with a cross here ☐).

SIGNED Catherine Bailey **DATE** 12 May 2008

ETHICAL APPROVAL GRANTED / WITHELD

SIGNED **NAME** **DATE**

Introduction

- This form is designed to help you consider ethical aspects of your research, and to help the School of Management in providing advice and approval
- If you are using data that are not already in the public domain, or are obtaining data from people, then there may be ethical implications
- This form should be filled out by the researcher, and (in the case of non faculty work) counter-signed by the supervisor or member of faculty (additional comments for clarification can be added if necessary)
- This form is used in many contexts, so not all questions may apply to your research
- You may submit a paper or an electronic version (by email: for students via your supervisor who can forward it to the relevant Ethics Committee member)
- You may need to include this form with your research submission (eg for a grant, for marking etc)
- **IF** your research is based purely on publicly available secondary sources please sign and cross above, **ELSE,** If you consider that there are **NO ETHICAL IMPLICATIONS** to your research please answer **ALL** the questions and tick **BOX A, AND** then **provide a short summary** and sign, **OR,** If you consider that there **MAY BE ETHICAL ISSUES** raised by your proposed work then please fill out this form and tick **BOX B** and sign; **THEN** you will need to **provide further information**, which will lead to in-depth consideration by the School Ethics Committee
- Ethics and methodology are not the same; but they may be related; research design is not the focus of this process; that is a matter for supervision, professional judgement or peer review
- There is an **obligation** on the **lead researcher or supervisor** to bring to the attention of the Ethics Committee, or the University **any** ethical implications not covered by this checklist
- The School will keep a copy of this form and will collect data for monitoring purposes

		YES	NO	N/A
1	Will you describe your main research procedures to participants in advance, so that they are well informed about what to expect?	√		
2	Will this be done verbally and / or in writing, as appropriate, and will understanding be checked?	√		
3	Will you tell participants that their participation is voluntary?	√		
4	Have you addressed any relevant legal aspects of data collection and storage (eg those covered under Data Protection or Freedom of Information legislation)?	√		
5	Will you obtain informed consent for participation, in a recorded form? (eg a written form, consent as part of a recorded interview, or as electronically verifiable consent or similar)	√		
6	If the research is observational, and participants are in a context where they would not expect to be systematically observed, will you ask participants for their consent?			√
7	Is normal privacy, as usually interpreted by participants in that context, being respected?	√		
8	Will you tell participants that they may withdraw from the research at any time and for any reason?	√		
9	In questionnaire-based research, have you checked if a reliable and valid instrument already exists before creating one of your own?			√
10	Have you piloted any questionnaire or interview guide, to check for clarity and/ or possible offence?	√		
11	In questionnaires, or interviews, will you clearly give participants the option of omitting or declining questions they do not want to answer?	√		
12	Will you tell participants that their data will be treated with full confidentiality?	√		
13	Have appropriate precautions been taken with respect to commercially confidential or sensitive data (for example in relation to the organization's own codes or any regulatory codes)?	√		
14	Will data be rendered unidentifiable, and, if at all possible, will the sources of those data be able to verify that they are actually not identifiable?	√		
15	If individuals or organizations will be identified, or be identifiable, (e.g. in a case study) has fully informed prior consent for this been specifically obtained?			√
16	Will participants or organizations be informed whether the data may also be used for non-research purposes (e.g. summaries presented to sponsoring organizations, publications)?			√
17	Will you debrief participants (ie give them a brief explanation of the study)?	√		

*If you have ticked **NO** to any of **Q1-17,** but have ticked box A, **please give a full explanation.***

		YES	NO	N/A
18	Will your project involve deliberately withholding information from, deceiving or misleading participants (eg about the true purpose of the research or about the researcher)?		√	
19	Is the research of a sort where any formal agreement (eg the University's Tripartite agreement) is required for ethical, legal or contractual reasons?		√	
20	Is there a foreseeable risk of any participants experiencing either physical or psychological distress or discomfort?		√	
21	Are participants being subjected to risks greater than those which they would usually take in their normal lives?		√	
22	Are there any pre-existing conditions (eg medical conditions) that might put participants at increased risk during the project?		√	
23	Are there significant power differences present, or do dual or other complicating relationships exist? (e.g. the researcher is also a manager, director, has other perceived power, is romantically involved with a participant, works for a competitor etc.).		√ √	

*If you have ticked **YES** to any of **Q18 –23** you should normally **TICK BOX B;** if not, please give a full explanation on a separate sheet.*

			YES	NO	N/A
24	Do participants fall into any of the following groups? If you answer **YES** to **ANY** of these questions **TICK BOX B BELOW** ***Note*** *in some of these cases you may also need to obtain satisfactory Criminal Records Bureau clearance (or equivalent)*	Children (under 18 years of age)		√	
		People with learning or communication difficulties		√	
		Patients or people in care		√	
		People in custody		√	
		People engaged in illegal activities		√	

Please tick **EITHER BOX A** (*no ethical implications*) **OR BOX B** (*may have ethical implications*) **BELOW** and **PROVIDE THE DETAILS REQUIRED** in support of your application then **SIGN** the form.

A. I consider that this project has **NO SIGNIFICANT ETHICAL IMPLICATIONS**	**Yes** √	**No**	**N/A**

Please give a brief description of participants and procedure (methods, tests used etc) using **between 50 and 150 words**. Do please try and ensure that the ethics committee will have a good idea of your research as a result of reading this and will not need to ask for clarification or additional information.

All 28 PCT CEOs in London recruited face to face and followed up in writing with an information sheet (Attachment 1) inviting their participation.

All participants will be interviewed face to face twice, starting in April and in June, two months apart. The first interview is prospective – asking CEO what (in terms of contextual factors) and whose views they will take into account when they make decisions of strategic significance. They will be asked these questions in relations to 1) generic situation 2) central Department of Health diktat 3) Healthcare for London (HfL) policlinics proposal and 4) HfL centralization proposals. Please see attachment 2 for interview protocol.

The second interview will look back at what they actually did – espoused theory in practice. That is, they will be asked the same questions, but retrospectively.

In the intervening period, they will also keep a diary (usual electronic diary kept by the CEO). At the second interview, the CEO and I will go through the CEO's diary – which acts as a record of what actually took place. The evidence will be used to triangulate the interview data. Data collection period will be from 1 April – 30 May.

All PCT Boards have to take a decision in public on HfL proposals in the week 19-23 May, based on feedback from local public consultations. This week in May acts as a common stimulus and provides a further piece of evidence of strategic decision making by the CEO.

The interviews will be transcribed and analysed using nvivo.

This form (and any attachments) should be submitted to the Ethics Committee (see below).

B. I consider that this project **MAY HAVE ETHICAL IMPLICATIONS** that should be considered by the School Ethics Committee	**Yes**	**No**	**N/A**

Please provide all the further information listed below in a separate attachment.

1. Title of project.
2. Purpose of project and its academic rationale.
3. Brief description of methods and measurements.
4. Participants: recruitment methods, number, age, gender, exclusion/inclusion criteria.
5. Consent and participant information arrangements, debriefing.
   (Please attach intended information and consent forms).
6. A clear but concise statement of the ethical considerations raised by the project and how you intend to deal with them. You might also wish to explicitly argue why the need to carry out this research, in this way, overrides any ethical issues raised. A project may raise ethical considerations but still be judged to be an appropriate piece of research.
7. If there is a foreseeable risk of harm or distress you should also explain how you will ameliorate it, and if it endures, what steps you will take to minimise its impact, and what referral agencies are available to you.
8. Estimated start date and duration of project.

Additional Comments from the Supervisor (you may wish to clarify aspects of the procedure, state if this is a classroom based assignment, indicate other ethical approval that has already been obtained etc.)

A copy of this form should be submitted to the relevant member of the Ethics Committee for consideration, the Community representatives are:

Innovation & Process Management: **Professor Keith Goffin**
(Innovation, Operations, Project Management, IS)

Leadership & Organization Development: **Professor Kim Turnbull James**
(Organizational Studies, People, OB, HR, Praxis, General Management)

Policy Strategy and Performance: **Dr Ruth Bender**
(Strategy, Economics, Finance and accounting, Entrepreneurship / Enterprise)

Demand Chain Management: **Dr John Towriss**
(Marketing, Logistics, Supply Chain)

For MBA Projects: **Richard Kwiatkowski**
For PhD Projects: **Dr Colin Pilbeam**
For DBA Projects: **Professor Alan Harrison**

- Please keep a separate copy (as a precaution against loss) for your records
- If you send it by email please make the subject;
  Ethics Form: Your name: Your Course (Full title) if any: Date research is expected to begin

FINAL SECTION

I am familiar with the School Guidelines for ethical practices in research (and have discussed them with any other researchers involved in the project). I believe that this form accurately represents the research.

Signed.....Print Name.....Date.....

Signed.....Print Name.....Date.....

Signed.....Print Name.....Date.....

Signed.....Print Name.....Date.....

Signed.....Print Name.....Date.....

Signed.....Print Name.....Date.....

LEAD RESEARCHER OR SUPERVISOR

Signed.....**Print Name**.....**Date**.....

STATEMENT OF ETHICAL APPROVAL

This project has been considered on ethical grounds using agreed School procedures and is approved

Signed.....Print Name.....Date.....
(Chair Ethics Committee, or Community representative)

CRANFIELD UNIVERSITY

SOM
DOCTOR OF BUSINESS ADMINISTRATION

DBA

Academic Year 2010 - 2011

YI MIEN KOH

PROJECT 3
CONTEXTUAL INTELLIGENCE AND PCT CHIEF EXECUTIVE DECISIONAL BEHAVIOUR

Supervisor: DR CATHERINE BAILEY
FEBRUARY 2011

This thesis is submitted in partial fulfilment of the requirements for the degree of DBA

17 INTRODUCTION

17.1 Statement of the issue

PCT CEOs are responsible for taking strategic decisions that have not only short to medium term business implications but could have long term effects on the provision of healthcare for their local population. Research has shown that business leaders who are sensitive to context, what Sternberg (1988, p244) and Mayo and Nohria (2005) call “contextual intelligence”, are more likely to be associated with successful organisational outcomes. The aim of this study is to understand how contextual intelligence applies to PCT CEO strategic decision making in the NHS in practice. Project 3 is the second of a two part qualitative study to explore the decision making behaviours of PCT CEOs in terms of contextual factors they take into account in strategic decision making.

17.2 Findings from Project 2

The over-ridding research question for the executive doctorate is:

What aspects of contextual intelligence are important for PCT CEO strategic decision making?

To address this question, the research study is structured in two parts (Project 2 and Project 3). The first part, Project 2, addresses questions 1, 2, 3, 4 and 5 (theory) out of a set of eight questions. Twenty four PCT CEOs within an English health region were interviewed about the contextual factors they take into account when taking strategic decisions in general, and specifically in relation to national policies, regional strategies and local plans. (The terms “policies”, “strategies” and “plans” are used interchangeably in this research.) The questions Project 2 addresses are as follows:

1. How do PCT CEOs define their decision making contexts?
2. Do certain contextual factors have greater influence than others in PCT CEO strategic decision making?
3. How do the contextual factors identified by the CEOs match the literature based model?

4. Are there common patterns of contextual factors and influence across PCT CEOs in strategic decision making?

5. Do PCT CEOs take different things into account when making different kinds of decisions (theory)?

The results suggest that PCT CEOs define their strategic decision making contexts according to the following criteria: Originator of the policy (*who is the edict from?*); goals (*is it a "must do" and is there a target?*); time (*is it do-able within the timescale?*); stakeholders (*who needs to be involved?*); resources (*is it affordable?*) and structures and processes (*how will the decision be taken?*).

Compared to the literature based model, PCT CEOs do not take into account macro level factors when taking strategic decisions. Instead, they said they focused on a number of contextual factors within their organisation and in the local health economy. The contextual factors that a majority of PCT CEOs said they took into account in different strategic decision types are as follows.

a) For strategic decisions in general, organisational strategy, stakeholders, goals, and decision making, processes appear to be critical contextual factors that every PCT CEO said they routinely considered in any strategic decision making.
b) As the performance expectations of national policies are usually set centrally, CEO strategic decision making takes notice of these. With national policies notably *diktats* and some regional policies, strategy comes second to structure due to the focus on implementation, which also takes account of stakeholders and time.
c) National strategies without targets or performance monitoring mechanisms were not prioritised unless there was synergy or strategic fit with existing PCT plans. Then, they would be used to drive local plans.
d) PCT CEOs said they treated regional strategies in the same way as national policies. The contextual factors identified by a majority of PCT CEOs in this regard were information and strategy internally and other significant organisations, relationships, and public engagement externally.

e) All PCT CEOs said they would take account of organisational strategy and environmental dynamism when taking strategic decisions about local plans. A majority of CEOs talked about engaging other significant organisations, decision making processes, stakeholders, goals and structure.

Several patterns can be observed from the results with regards to contextual factors taken into account in PCT CEO strategic decision making. First, the higher up the command chain the directive comes from, the less strategic and more operational would be the policy, and therefore the less need for strategic decisions by CEOs. Second, the higher up the origin of the directive, the more likely it is to be accompanied by measurable targets, which also leaves less freedom for negotiation, hence the “just get on with it” attitude of CEOs when taking decisions on central diktats. Third, the more strategic the plan, the greater is the need to engage with and consult local stakeholders, and to take into account local factors. Conversely, there is no need to consult stakeholders on central diktats. Fourth, the more contentious the strategic decision, the greater is the need to be able to demonstrate governance and accountability, usually through formal decision making processes. Finally, the greater the anticipated resistance, the greater the need for formal decision making processes and structures.

In summary, there appears to be a relationship between contextual factors, PCT CEO strategic decision making and the degrees of freedom they have in policy response. In contrast to the literature based model, the contextual intelligence model as espoused by PCT CEOs shows fewer contextual factors being taken into account, and an absence of macro-level factors. The findings set the stage for Project 3 which aims to study the actual strategic decision making practices of PCT CEOs.

17.3 Statement of scope and aims for Project 3

Project 3 sets out to study the contextual factors that are actually taken into account by PCT CEOs in strategic decision making. The research has two aspects:

a) a retrospective analysis of actual decision making behaviours in relation to the three levels of strategic decisions previously explored in Project 2
b) an analysis of a key strategic decision making event involving all PCT CEOs that took place during the study period

A second-round of interviews was conducted with the same 24 CEOs based on their diaries covering a two month period. It seeks to answer questions 5, 6, 7 and 8 from the original set of eight research questions.

6. In practice, do PCT CEOs take different things into account when making different kinds of decisions?
7. If they do, is it possible to explain how the common approaches came about?
8. Are there any differences between what PCT CEOs say they do (theory) and what they actually do (practice)?
9. What other factors play a part in CEO strategic decision making process?

17.4 Making methodological choices

The ontological position in Project 3 is interpretivism. As the purpose of the social enquiry is to understand how strategic decisions are taken by PCT CEOs in the NHS, multiple sources of evidence are used to obtain different perspectives and observations of reality as socially constructed (construct validity) and given meaning by the subjects. This choice of methodology does however limit the generalisability of the findings outside of the NHS (external validity).

18 METHODS

18.1 Research strategy

The main research strategy used in this project is abduction. As Project 3 seeks to examine CEO decisional behaviour with a view to understanding how contextual intelligence influences strategic decision making, an abductive enquiry will draw on the concepts and meanings used by the CEOs (as social actors) and the activities in which they engage. As Blaikie (2000) explains, interpretivism takes the *meanings* and *interpretations*, the *motives* and *intentions* (the author's italics), which people use in their everyday lives, and which direct their behaviour.

For interpretivism, the social world *is* the world perceived and experienced by its members, from the inside, and the task of the social scientist is to discover and describe this "insider" view. The interpretive approach therefore seeks to discover why people do what they do by uncovering the largely tacit, mutual knowledge, and symbolic meanings, intentions and rules that guide their actions (Blaikie, 2000). Blaikie describes mutual knowledge as the background knowledge that is largely unarticulated yet is constantly being used and modified by social actors as they interact with each other in cycles of production and reproduction in the course of their lives together. According to Blaikie (2000, p176), the abductive strategy has many layers to it which can be summarised as follows:

Everyday concepts and meanings

provide the basis for

social action/interaction

about which

Social actors can give accounts

from which

Social scientific descriptions can be made

from which OR and understood in terms of

Social theories can be generated *Social theories or perspectives*

In other words, it is the process of moving from lay descriptions of social life, to technical descriptions of that social life, that the notion of abduction is applied.

18.2 Data sources, types and forms

The study population consists of the same 24 CEOs who participated in Project 2. Data sources are diaries and interviews with supplementary insights from participant observation. Data were collected personally by me, the author, from CEOs' electronic work diaries and one to one interviews. When an opportunity arose during the data collection period to study a key strategic decision making event involving all of the PCT CEOs in the region, I was able to take advantage of my position as a peer to observe, firsthand, how the strategic decision was taken. Apart from simple frequency counts, the data were qualitative throughout all stages of the research.

18.3 Data collection

18.3.1 Diary based interviews

In the first round of interviews (reported in Project 2), all 24 PCT CEOs agreed to keep an electronic diary for a period of two months - April to May 2008. The diary activities are taken to represent contextual factors the CEOs take account of in strategic decision making in relation to three different policy types – national, regional and local. National policies are requirements or guidance issued by the Department of Health (DH) or other national bodies that apply to the whole NHS. Regional strategies are issued by the Strategic Health Authority (SHA) for implementation within the region including sub-regional plans. Local plans are defined as those applying within the PCT or local authority boundaries. The second round of interviews took place in June to July 2008, mostly in individual CEO offices, although a few were held at venues chosen by the CEOs for convenience.

At the start of each interview, I re-iterated the aim of the study which is to explore the range of contextual factors PCT CEOs take into account when responding to national policies, regional strategies or local plans. Paper copies of work diaries covering two months of activity, showing the duration (time in

hours) and title of each activity, were provided by the CEOs. I had explained that, after we have gone through the diary, I would like to return to the 14-15 May, a key strategic decision making event where all of the PCT CEOs had attended, to hear of their experience of the two days. The diary analysis assumes that, by participating in an activity, it represents an opportunity for the CEO to take account of the contextual factor(s) surrounding the interaction.

All interviews followed a standard format. Each CEO talked through their diary in chronological order, explaining each entry from the perspective of who was present at the activity, why it took place and what happened. This was to enable me to understand what the CEO does in practice when taking strategic decisions and which factors play a part in their strategic decision making process. By themselves, the diary entries provide only a limited insight into why and with whom the CEOs had engaged in that activity. To obtain a more meaningful exposition of the activities, each diary entry was checked against the hand written notes taken at the time of the interview, as well as the interview transcripts. This corroboration of diary data with interview data improves data quality and provides further insights on the possible impact or influence of different contextual factors.

As far as possible, data were collected on the following points:

a) **What** was the activity i.e. meeting, telephone call, conference, social etc.
b) **Why** (reason) the event took place, i.e. **what** was the activity **for**, and noting if the agenda fell under national, regional, local policies or plans, or internal organisational matters. This provides an indication of not only the amount of time the CEO dedicates to particular strategic decisions but also allows the contextual considerations around those events to be examined in more detail.
c) **Who** was involved (who initiated the activity, who else was at the meeting, was the activity part of a formal structure or process).
d) **Why** the CEO participated in the activity and what s/he hoped to achieve from that event.

The interviews lasted between one and one and a half hours each. At the end of their accounts, the CEOs were asked to elaborate on their experience of the away day held on 14-15 May; at that point, I adopted a semi structured interview approach by asking a number of standard questions (see next section). At the end of each interview, I retained a paper copy of the electronic diary for subsequent analysis. Hand written notes were taken at each interview. All of the interviews were recorded and transcribed. The transcriptions were then verified against the hand written notes for accuracy. Both data sets were used to inform the coding of diary data, which were analysed using Microsoft Excel.

18.3.2 An in depth exploration of a critical decision making event

The 14-15 May was an important away day for PCT CEOs organised by the SHA. Lasting 24 hours (4pm to 4pm), the event, which took place in a city hotel, could be described as a “lock in”, as CEOs were asked to not communicate with work colleagues including their chairmen during this period that was spent in the company of SHA executives and management consultants. Unusually for such an important meeting, no agenda was sent in advance; instead a dossier, marked confidential, containing population and healthcare statistics for the region was couriered to each CEO’s office the evening before. On the day, the SHA CEO confirmed a desire to achieve consensus on the future configurations of PCTs in the region, an ambition long harboured by the SHA but had been resisted by PCTs.

The study of the away day as a strategic decision making event was opportunistic as it involved all PCT CEOs participating in a common strategic decision making exercise during the data collection period. The SHA proposal presented a fundamental organisational strategic decision for individual PCTs. Legally, the SHA has no power to mandate PCTs to merge or reconfigure, as by statute, only PCT boards can take that decision. Because of the size and geography of the region, any decision to merge PCTs would require the majority to agree. The entire decision making episode from beginning to end took place over a defined period, during which its purpose and outcomes were sufficiently

clear to all observers to enable them to give an account of what happened. For these reasons, the event offered a unique insight into actual strategic decision making practice of PCT CEOs and the contextual factors at play on a common real time decision.

To gather data on the away day event, I used a semi-structured interview style at the end of the diary-based interview and asked the following questions:

a) what they thought happened at the event.
b) whether their position (on PCT configurations) changed over the course of the two days, and the reasons.
c) the event achieved a collective decision to pursue reconfigurations of the 31 PCTs into regional sub-sectors. From their experience, how they thought it happened.
d) how they felt throughout the course of the event.

The CEOs' responses were recorded and transcribed in the same way as the diary based interviews.

18.4 Data handling and analysis

The process of data handling and analysis was carried out in two parts.

18.4.1 Part 1: Analysis of diary data and interview transcripts

Data from diaries, interview notes and transcripts were analysed in three sequential steps for every PCT CEO. For each diary entry:

a) The first step was to appraise the reason(s) given for the activity and assigning that activity to one of the three decision making contexts below (this is to enable later comparison with Project 2):
    - **national policies** (national requirements including performance targets set by the DH or other national governmental bodies)
    - **regional strategies** (actions required by the SHA, including sub-regional plans or supra-PCT activities led by the SHA)

- **local plans** (plans or strategies developed by individual PCT or the PCT in conjunction with its local partners within the borough).

b) The next step involves allocating the contextual factors involved in the activity to contextual factors within the two sub categories - **organisational internal** and **local** (external) **factors,** from the literature based model from Project 1. Had new contextual factors emerged, they would have been coded separately with new categories.

c) In the final step, a measure of time is allocated to each contextual factor, based on insights from diary data and interview transcripts.

In order to maximise the insights from the diary-based interview data, activity data were coded by frequency (count) of the factor(s) involved and time spent (hours) on those factors. The three categories of policies, each with two sub-categories of factors that are internal or external to the organisation, and their constituent contextual factors were plotted out on a Microsoft Excel spreadsheet. Each diary activity was entered onto the spreadsheet using the following protocol:

- Count – for every diary activity, each identified contextual factor would be allocated one count.
- Sum – time allocation (in units of 15 minutes/ 0.25 hour duration) was based on the my judgement of the time spent on that contextual factor from the CEO's descriptions of the activity. A minimum time unit of 15 minutes was set as the quickest activity in all the diaries. The approach assumes that as PCT CEOs are busy people with high pressured jobs, duration of exposure to contextual factors can be regarded as those factors having commensurable influence on their strategic decision making behaviour.

An example of how the coding rules operated: a two hour meeting with the SHA and other PCT CEOs on the regional health strategy (RHS) was coded under

the categories of “regional strategy” and “local factors” (as *local* refers to borough or supra-borough and smaller than a region) with quantitative time entries in the following cells: “other significant organisations” (1.0 hour), goals (0.5 hour) and decision making process (0.5 hour). This equates to three counts, one for each of the contextual factors listed, with the sum of the time allocated to each contextual factor adding up to two hours. Further details of the coding methods used are shown in Appendix H.

18.4.2 Part 2: Analysis of strategic decision making event

Narratives relating to the away day were extracted from all 24 interview transcripts and analysed using an interpretive approach. Using NViVo, relevant sections of the narratives were coded, with the codes representing concepts. Coding starts from a central theme of *strategic decision making* forming the core category. The core category is then linked to subcategories by means of relational concepts, such as the conditions in which the action took place, the strategies adopted for dealing with a phenomenon, and the outcome of the action. Through gaining access to multiple personal experience stories and accounts of the event, I built up a picture of the PCT CEOs’ strategic decision making context. Each CEO’s account of the event adds evidence to the central theme. From these, I was able to draw the concepts of strategic decision making context in the NHS setting to reveal the essential, recurring features of contextual intelligence in terms of PCT CEOs in the NHS.

Research involving direct observation of the powerful in the field is rare due to problems with access, but I was accepted and trusted by peers who were willing to support my research. Being an insider, I was sensitive to the nuances expressed by PCT CEOs which, besides helping interviews go smoothly, also facilitated data interpretation and analysis. My complete immersion in the social setting enabled me to share the respondents’ experiences by not merely observing what was happening but also feeling it. The research therefore has features of participant observation.

18.5 Issues in qualitative research

Qualitative research methods that enable me to get close to his or her subjects are known as ethnography. Ethnography is not a single method of collecting data; instead, it involves applying a range of approaches, the three main ones being observation, participation in the setting, and gathering reports from informants, to elucidate the subjective basis of people's behaviour. In practice, the choice of techniques is largely governed by the type of "social" role to be adopted in the "field". According to Gill and Johnson (2002), such decisions are usually taken in the context of a researcher's philosophical commitment to understanding the behaviour of subjects in their natural settings, through an inductive development of an empathetic understanding of those actors' rationalities.

The SHA-led meetings of PCT CEOs provided me with opportunities to directly observe while diary based interviews provided indirect observational data. The CEOs' participation in the research itself meant that observations were overt, as the majority, the permanent CEOs, were aware that I was researching CEO strategic decision making. No individual data were collected on non participants. The field roles I adopted have several advantages. The first is ecological validity. As I was already a member of their community, I was able to share the experiences of the CEOs, and could therefore check the truthfulness of their accounts. Second, being fully immersed in the culture of the NHS provided me with intimate knowledge of the CEOs' frame of reference which was essential for deciphering their everyday behaviour (Adler and Adler, 1994). Third, my "insider" status allowed access to powerful people who are notoriously difficult to observe and participant observation provides a viable way of discovering what is actually happening. Fourth, the fact that the social phenomena are being studied in their natural contexts arguably reduces subjects' reactivity to my presence and the data collection procedures.

Nonetheless, there are limitations to using ethnographic research. First, there is always a concern in field work that the researcher "goes native" and the risk is compounded in this case by me being a native. Any potential bias can be

minimised by my being conscious of her own frame of reference, and intentionally taking a dispassionate view of events as a researcher (Gill and Johnson, 2002). Second, no matter how close the researcher is to her subjects and how overt the observation, collecting data is intrusive, and I need to be reflexive. Hammersley and Atkinson (1994) advise overcoming reactivity by my monitoring their effects and bringing them under control where possible. They also suggest collecting different kinds of data to allow comparisons. Third, covert observation can create ethical problems in relation to non participants not recognising my participant observer status. I therefore had to be careful on what and how I report on the behaviour of the non PCT CEOs in that situation. Fourth, indirect observation in the form of reports from informants, including data from the away day can be prone to misinterpretation and ethnocentricity.

The semi structured interviews focusing on the CEOs' experiences of the away day enable me to "get close to the subjects" (Bryman, 1989). Once assurances have been given of confidentiality and anonymity, the interviewee usually is able to recount his or her story. Although the accounts are retrospective, the fact that the event was a critical strategic decision making event means that the subjects usually have good recall. By collecting and analysing multiple CEO stories, I can look for commonalities in themes to increase generalisability. In this situation, I adopted an ethnographic approach although she did not interview herself. A further advantage of the approach is enabling me to relate context, strategy and outcomes, to look for repetition of patterns and thus to build up a picture of tactics for handling similar situations in the future (Chell, 2004).

18.6 Expected outcomes and benefits

The combination of methods has the potential to increase the reliability of the emerging theoretical concepts and reduce the effect of the particular limitations of each method. Potential findings from analysing data in the ways as described should one, produce a clearer understanding of the contextual factors PCT CEOs take into account when taking strategic decisions; two, show the differences between what CEOs say they do (theory) and what they actually do (practice) when they have to take important strategic decisions; and three,

enable the elucidation of a conceptual model of contextual intelligence in the PCT CEO context.

19 FINDINGS

19.1 Results from diary and interview data

This section presents the analyses of diary and interview data. It examines the local and organisational internal contextual factors that are considered to have influenced PCT CEOs strategic decision making across three policy scenarios. For each scenario, results are shown, first, by "**counts**", which measures the frequency (number) of events CEOs had with the contextual factor over the two month data collection period, then by "**sum**", which measures the estimated total amount of time spent on that factor (in hourly units). A summary table of the average counts and time spent for the six scenarios is set out in Table 32. This shows significant differences between the time and frequency of attention paid to contextual factors across decision making scenarios. The following sections report the findings by counts and time in relation to each scenario.

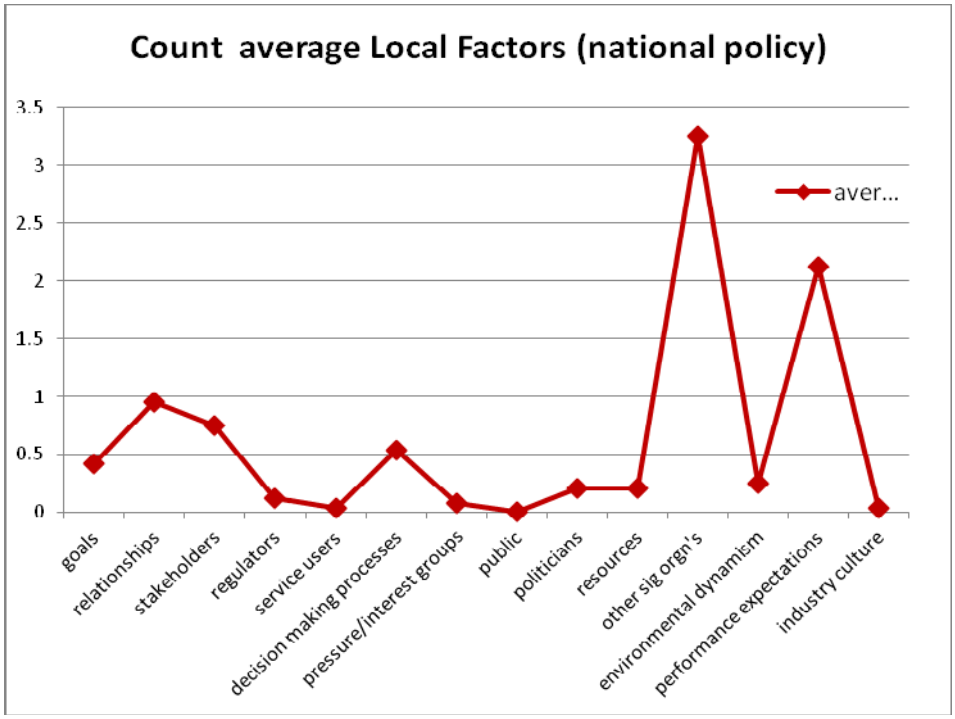
COUNTS (FREQUENCY OF OCCURRENCE)

19.1.1 Local contextual factors and national policies

Figure 31 shows the **local contextual factors** that CEOs took into account in dealing with **national policies**. Overall, PCT CEOs spent very little time on national policy matters, with average values for contextual factors hovering around zero. The findings are consistent with the pilot interviews conducted prior to the first round of interviews which showed CEOs delegating the implementation of national policies to their TMT and only get involved if performance is failing. Findings from Project 2 show national policies, especially the "must dos", to be well defined, with measurable goals and underpinned by a national performance management regime - features that facilitate delegation and monitoring. The two factors that stand out by a small margin are other significant organisations and performance expectations, showing that CEOs get involved when necessary. Then, the CEOs' efforts (which add up to an average of 5.38 encounters in the two month period) focused on interacting at the strategic level with organisations that play a major part in delivering the targets, or engaging with the SHA or in two cases, DH, on activities relating to

performance management. The results are not inconsistent with the CEOs' accounts of notable contextual factors reported in Project 2. Project 2 did not find any first level or critical factors (defined as having been flagged up by >90% of CEOs), but identified performance expectations, stakeholders and time as second level or major factors (defined as having been flagged up by 50-90% of CEOs) and goals, relationships and stakeholders as the third level factors (defined as having been flagged up by 10-<50% of CEOs) in CEO decision making relating to national policies.

Figure 31 Frequency of local contextual factors taken into account by PCT CEOs in relation to national policies



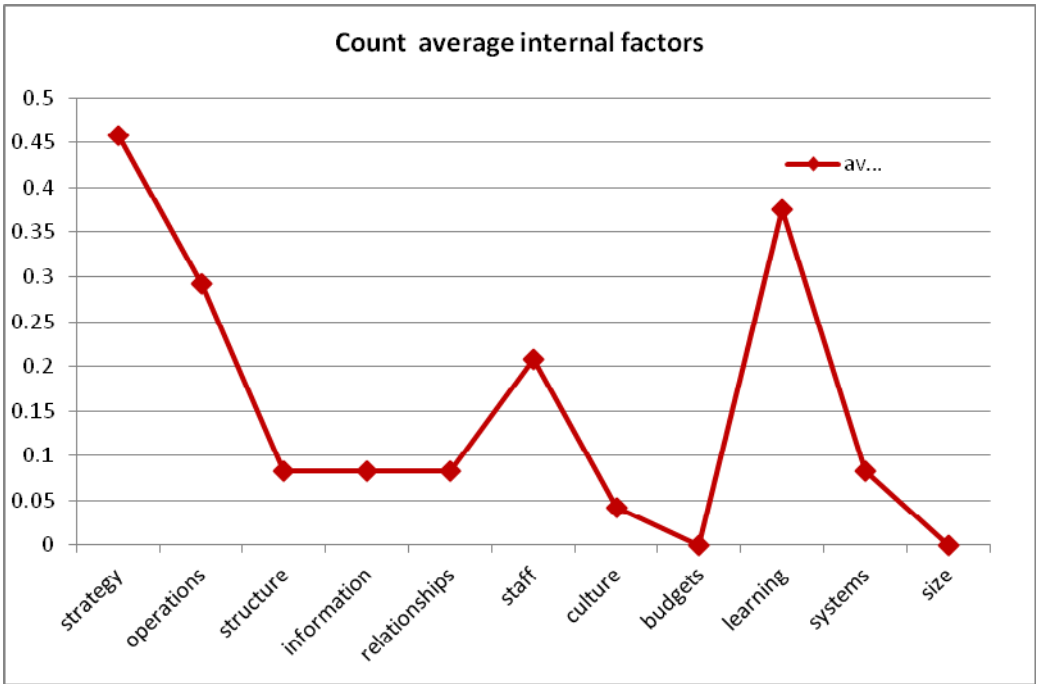
19.1.2 Organisational internal factors and national policies

Figure 32 shows the **organisational internal factors** that CEOs would take into account when implementing **national policies**

PCT CEOs hardly engaged directly with their internal organisation on matters relating to national policies, with the majority of such activities taking place between 0-1 event, although four contextual factors show up to 2.5 events, over

the nine week period. One possible reason for this may be delegation of responsibility for implementation to TMT, as before. The contextual factors CEOs are marginally more exposed to are strategy, organisational learning, and operations, which make sense considering that the CEO role is strategic, although there will be occasions when they need to be concerned about operational matters. The reference to learning related specifically to an SHA sponsored organisational development programme as part of a particular national policy which several PCT TMTs, including the PCT CEOS, took part in. The findings here are similar to Project 2 which reported no first level organisational internal factors but two second level contextual factors, namely structure and strategy and two third level contextual factors in information and finance.

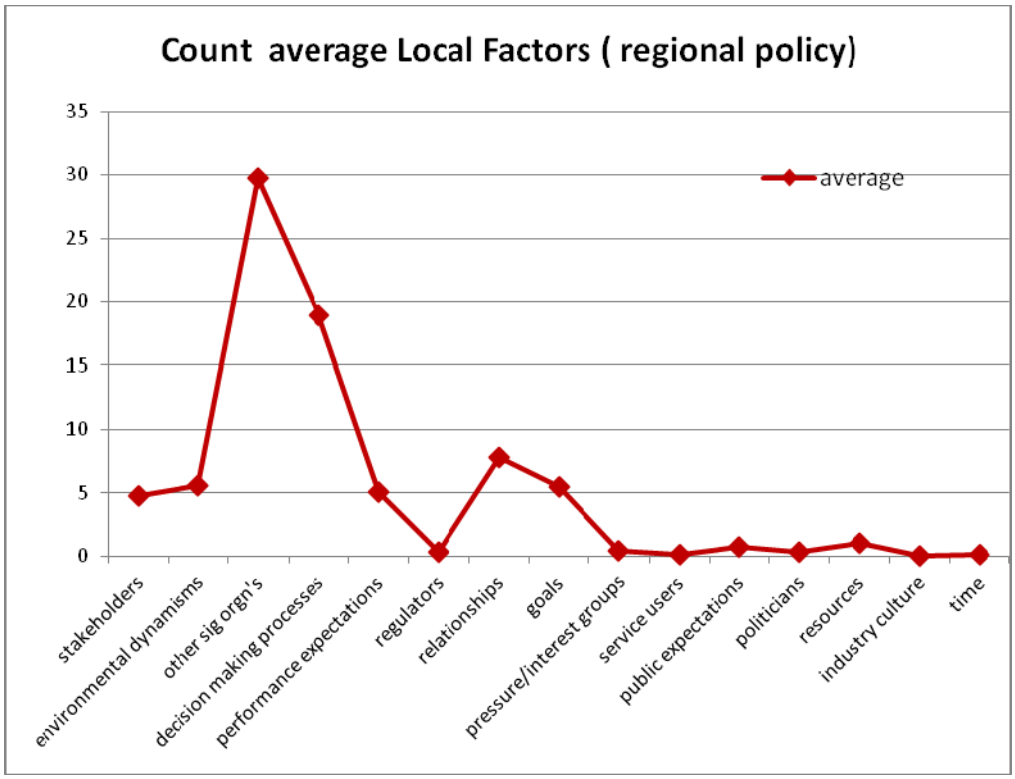
Figure 32 Frequency of organisational internal factors taken into account by PCT CEOs in relation to national policies



19.1.3 Local contextual factors and regional strategies

Figure 33 below shows the **local contextual factors** that CEOs are most likely to engage with when implementing **regional strategies**

Figure 33 Frequency of local contextual factors taken into account by PCT CEOs in relation to regional strategies



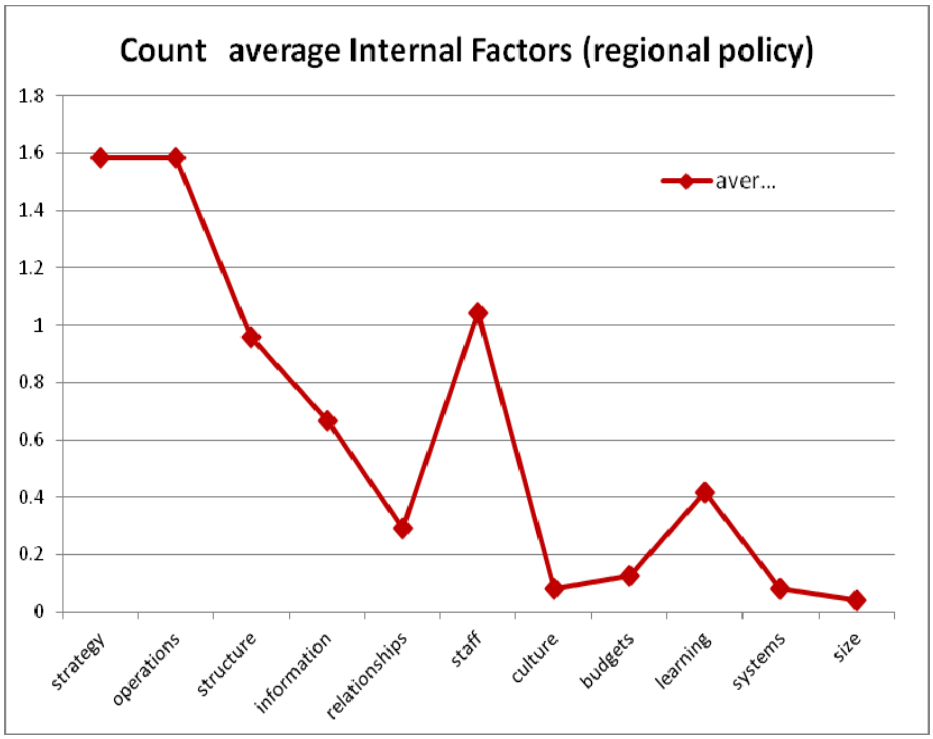
To get a sense of the relative importance of various contextual factors, the contextual factors can be divided into three main categories: factors that lead to events taking place more than once a week, such as other significant organisations and decision making processes; factors that lead to events taking place once or twice a month – these being goals, stakeholders; environmental dynamism and performance expectations; and the remaining factors that are infrequent or never taken into account by CEOs. Over the two month data collection period, the majority of PCT CEOs took part in 30 events (average of three events per week) that involve other significant organisations, in almost all cases that was the SHA. Of these events, two thirds were about decision making processes. The next category consists of factors relating to strategic goals, engagement of stakeholders and environmental scanning in preparation for implementing the RHS. As performance expectations have to be met, the events take place about once a fortnight on these contextual areas.

The findings are again consistent with Project 2 in that there are no first level factors but there were five second level factors, namely, other significant organisations, public engagement, relationships, environmental dynamisms and service users; and three third level factors, namely politicians, decision making processes and stakeholders. Goals and performance expectations that were absent in Project 2 accounted for about around five events each in relation to regional strategies in Project 3. The reason why CEOs did not treat regional strategies in the same way as national policies is not clear but one explanation could be that the former rarely come with targets or sanctions for non delivery.

19.1.4 Organisational internal factors and regional policies

Figure 34 below shows the distribution of **organisational internal factors** CEOs personally engaged with in relation to **regional policies**. As with national policies, the CEOs interact directly with staff infrequently, with the average number of encounters per CEO ranging between 0 and under two events over the two month period. When the CEOs do engage with staff, the focus is on a mixture of operational issues, strategy development, engagement and dissemination of information. That can be for a number of reasons. First, it can be for the same reason as national policies, that is, the CEOs delegate implementation to the TMTs. Second, as is known from Project 2, the RHS at that stage was focusing on specialist hospital services; the proposed changes would have little impact on PCTs other than having to lead the public consultation exercise and getting PCT board endorsement. This may explain why the few activities there were are linked with: strategy, to demonstrate strategic coherence with local strategy; operations, to carry out the consultation; and engaging staff in implementing the strategic change. Structure was part of the decision making governance structure and information was used to support the change proposals. The findings are consistent with Project 2 findings in that information, strategy, structure and operations are the four contextual factors PCT CEOs mentioned in relation to regional strategies, although only the first three are second level factors and operations came up only once.

Figure 34 Frequency of organisational internal factors relevant to regional policies in CEO decision making

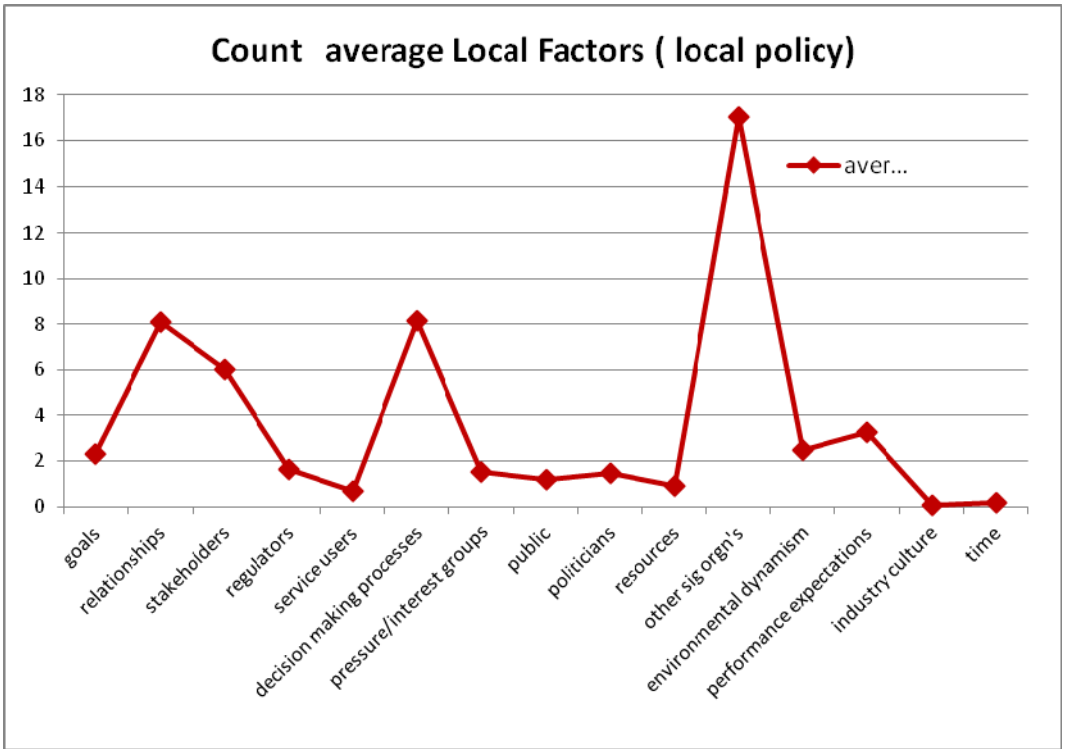


19.1.5 Local contextual factors and local plans

Figure 35 below shows the range of **local contextual factors** that CEOs engaged with most frequently in relation to **local plans**. On the basis of event frequency, there are four categories of contextual factors linked to local plans. Starting with the category with the highest frequency of interactions, the first category of contextual factors, which is associated with, on average, 1-2 events per week, is other significant organisations. There are three contextual factors in the second category, which are associated with, on average, 1-2 events per fortnight, namely relationships, stakeholders and decision making processes. The third category involves factors that are associated with, on average, 1-2 events per month, these being goals, environmental dynamism and performance expectations. The remaining factors are associated with less than one event per month.

The pattern of events shows PCT CEOs to be, on average, engaged in up to two meetings per week with other significant organisations, the main ones being the SHA, local council's Overview and Scrutiny Committees (OSC), and local acute trusts on RHS matters. Around half of the events were about planning for the formal decision making processes. The CEOs also attend on average 1-2 events every fortnight, to build relationships with stakeholders. This may be due to the public consultation coinciding with Project 3 data collection period, during which the CEOs were asked by the SHA to engage with local stakeholders to gather support. The other events that took place 1-2 times a month related to goals in terms of strategic coherence between a top down strategy and local plans and, by their nature, may be linked to performance expectations.

Figure 35 Frequency of local contextual factors taken into account by CEOs in strategic decision making on local plans



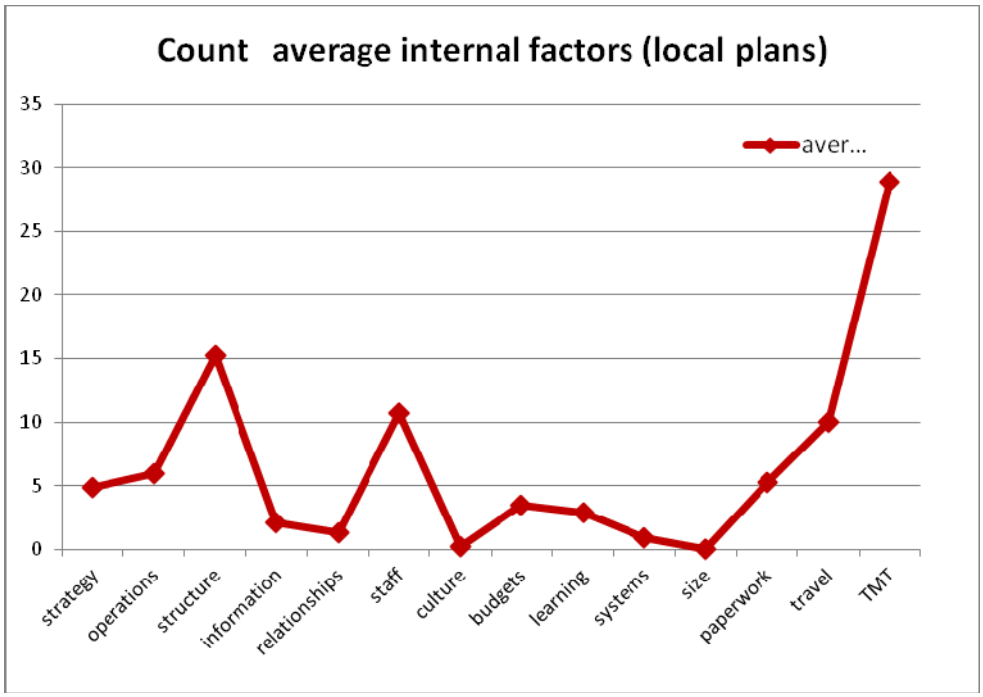
As the RHS proposals would lead to the development of clinical networks in stroke and trauma across the region, issues about estates, facilities, population growth and health needs were all reviewed as part of environmental dynamism. The findings are again similar with those in Project 2 with the exception of time,

service users, politicians and public, which came up as third level factors in Project 2, but did not feature in the CEOs' diaries in practice. It is not obvious why this is so, although a cynical explanation would be that the CEOs were paying lip service to wider stakeholder engagement activities but in practice focused their efforts only on other significant organisations.

19.1.6 Organisational internal factors and local plans

Figure 36 shows the **organisational internal factors** that PCT CEOs were most engaged in, in relation to **local plans**.

Figure 36 Frequency of organisational internal factors taken into account by PCT CEOs in local plans



Compared to previous figures, Figure 36 shows the widest range of results, I have categorised the contextual factors into five categories based on the frequency of CEO diary events:

a) factors associated with greater than an average of two events each week, namely the TMT

b) factors associated with an average of 1-2 events per week – this applies to structures and staff meetings;
c) factors associated with an average of 1-2 events per fortnight – these being strategy, operations and a new factor of management consultants;
d) factors associated with an average of 1-2 events per month – these being information, budgets and learning;
e) the remainder are associated with fewer than one event per month.

19.1.7 Travelling time (temporal)

The diary data also showed some PCT CEOs spending a considerable amount of time travelling to and from meetings, averaging 10 hours in total for those who had accounted for travelling time in their diaries. Surprisingly, only a few CEOs had recorded travelling times. My own experience showed that it is at least two to three times for CEOs of PCTs located further away from the SHA. The same applies to administrative tasks like paperwork.

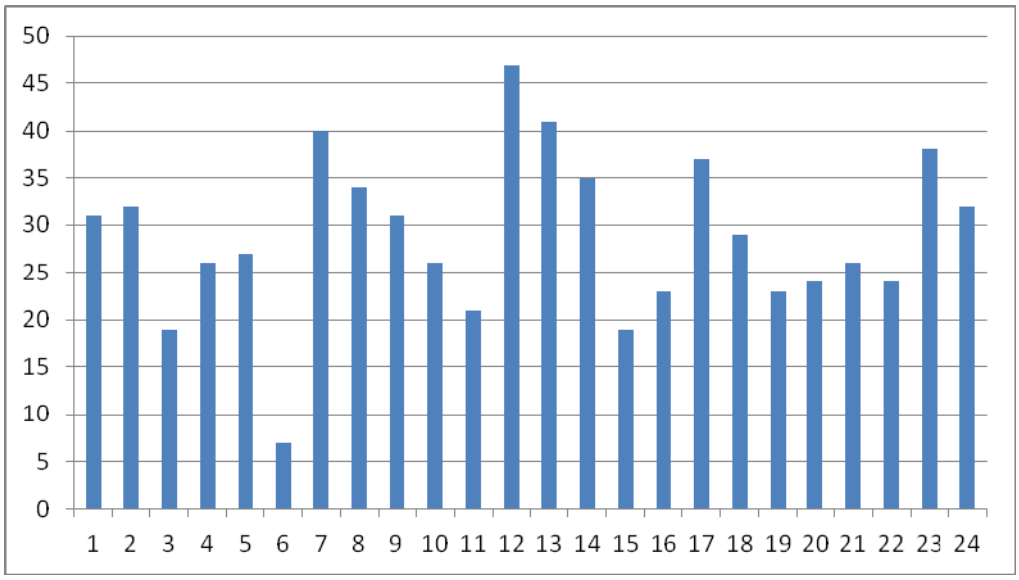
19.1.8 Top Management Team (TMT)

The findings reveal CEOs engaging frequently with their TMT (who are differentiated from staff in definition terms), averaging at least three events per week, which is substantially more than that reported from Project 2. It is not surprising to have structures recording the second highest count frequency, as decision making, governance and accountability structures are part of the structural landscape and account for up to two events every week. Coming third are staff related issues such as attending staff meetings and staff events and not for strategic planning purpose. It is to be expected that the CEOs would take part in events relating to strategy and operations at least once a week in relation to local plans, as the two contextual factors are relevant to strategy development and implementation. A new significant finding is the engagement of consultants (see Figure 38)

While Project 2 identified five relevant contextual factors, namely strategy (the only critical first level factor), structure (second level or major factor) and finance, operations and staff (third level factors), the diary evidence shows PCT

CEOs to actually spend a substantial amount of their time with their TMTs, followed by, in descending order, structure and staff factors, strategy, operations, budgets, learning and information. It is in relation to local plans that the CEOs showed, for the first time, direct involvement in their internal organisation. Figure 37 shows that, as a group, the CEOs averaged just under 30 events with their **TMT** over the two month period, although there is a three-fold variation among CEOs. This may be due to a combination of how diary entries were recorded and CEO management practices.

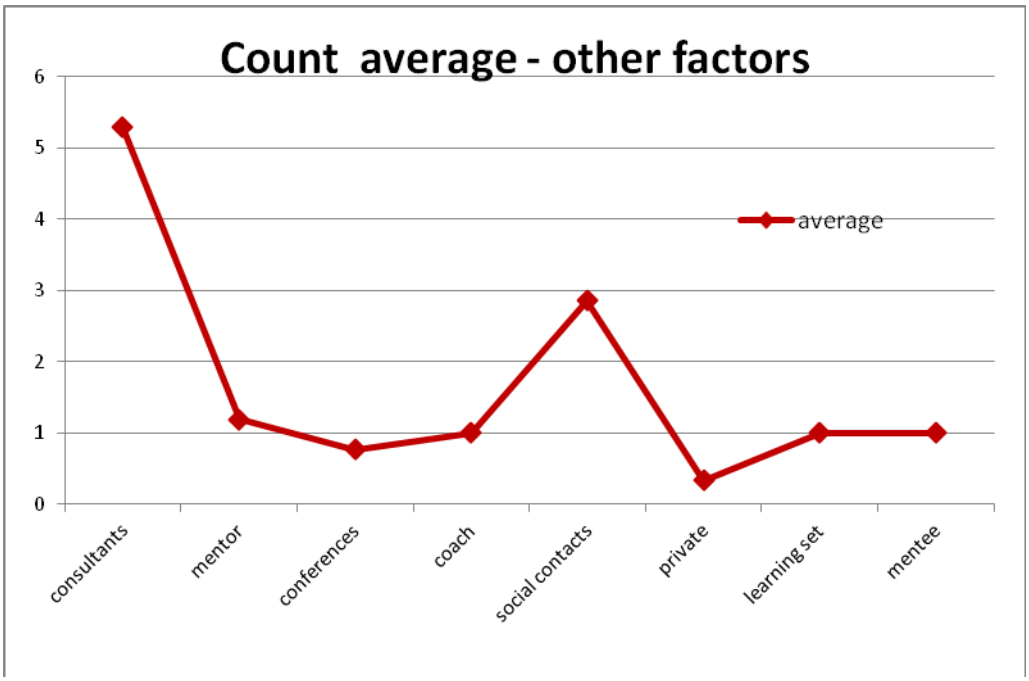
Figure 37 CEOs' interactions (counts) with TMT over two months



19.1.9 New factors

The diary analysis also reveals a number of **new contextual factors** as shown in Figure 38, such as networking, meeting with social contacts and participating in personal development activities. A significant new factor is management consultants who came top with an average of five contacts over the data collection period.

Figure 38 Frequency of other factors that could influence CEO strategic decision making not previously mentioned



SUMS AND AMOUNT OF TIME

The following six paragraphs and charts relate to "**sum**" as in total number of hours spent on respective contextual factors by the CEOs. The results complement the quantitative "counts" data which measure time duration in contact hours as a proxy for intensity of influence.

19.1.10 Local factors and national policies

Figure 39 presents the **local contextual factors** that PCT CEOs spend the greatest amount of their time in relation to **national policies**. It shows that, with national policies, the local contextual factors that CEOs spend the greatest amount of their time are other significant organisations and performance expectations. These factors still only add up to, on average, three hours for other significant organisations and two hours for performance expectations over the two month period. This is consistent with the quantitative findings that PCT CEOs generally do not spend time on national policies if they can delegate to their TMTs.

Figure 39 Total number of contact hours (sum) across contextual factors on national policy

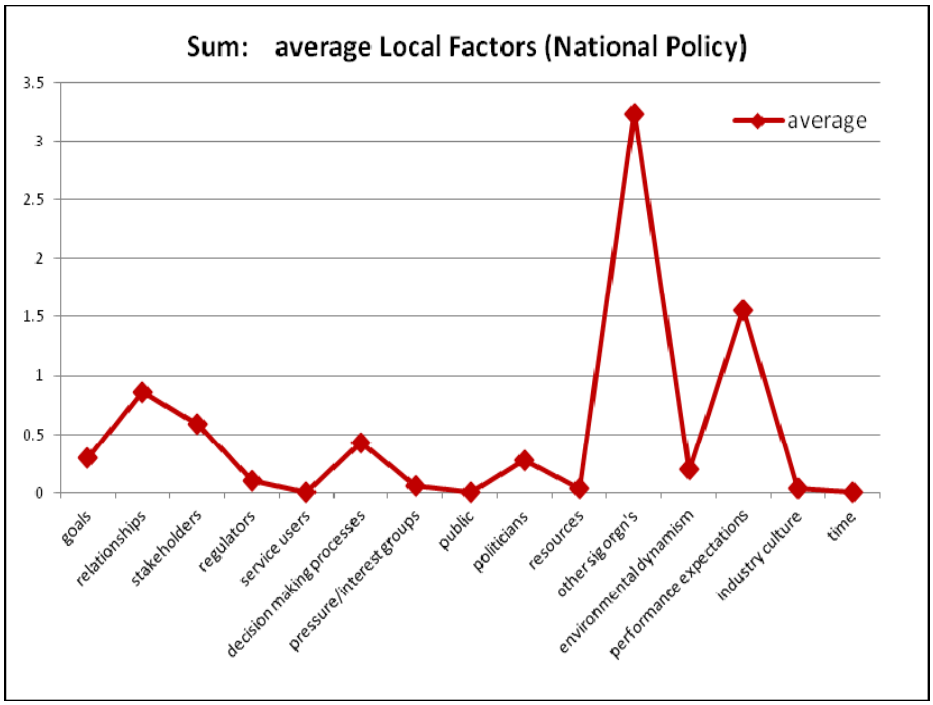
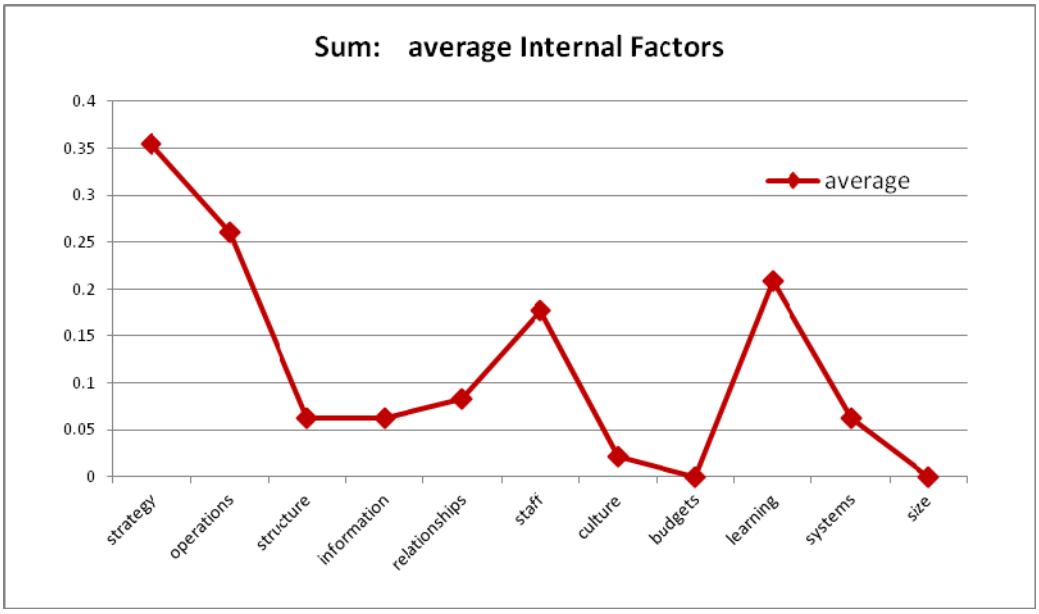


Figure 40 below shows PCT CEOs spend very little time on **organisational internal factors** associated with **national policies**. This is most likely due to CEOs delegating operational matters to their TMT. On the few occasions when they did, the most frequently engaged organisational internal factors were strategy, operations, learning and staff, for reasons discussed earlier.

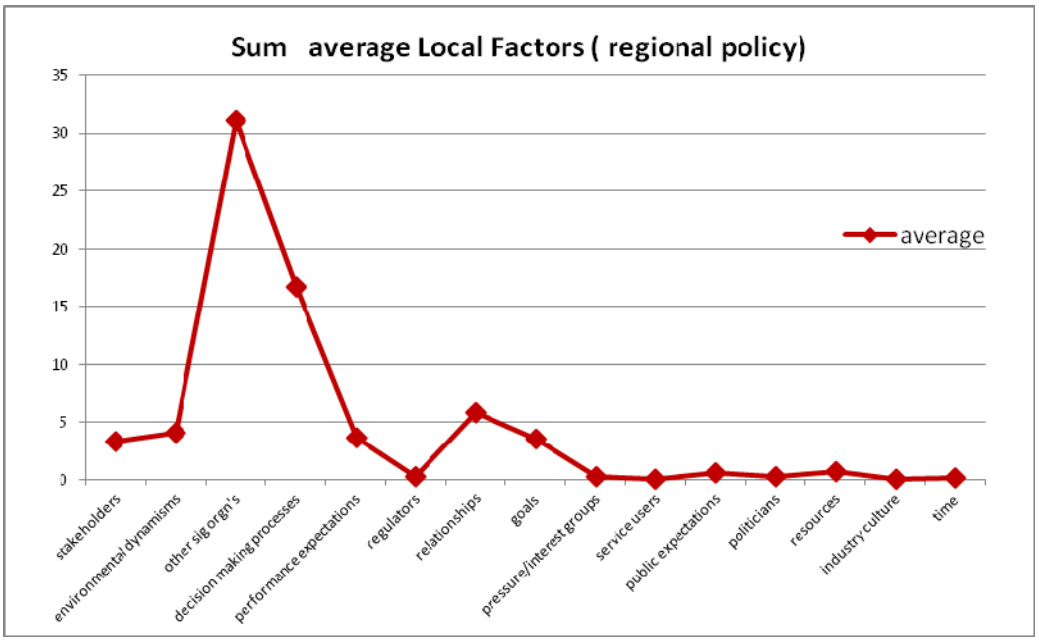
Figure 40 Total number of hours (sum) spent on organisational internal factors in relation to national policies



19.1.11 Local contextual factors and regional strategies

Figure 41 shows the **local contextual factors** that CEOs spend time on in relation to **regional policies**.

Figure 41 Number of hours (sum) of local contextual factors in relation to strategic decisions on regional policies

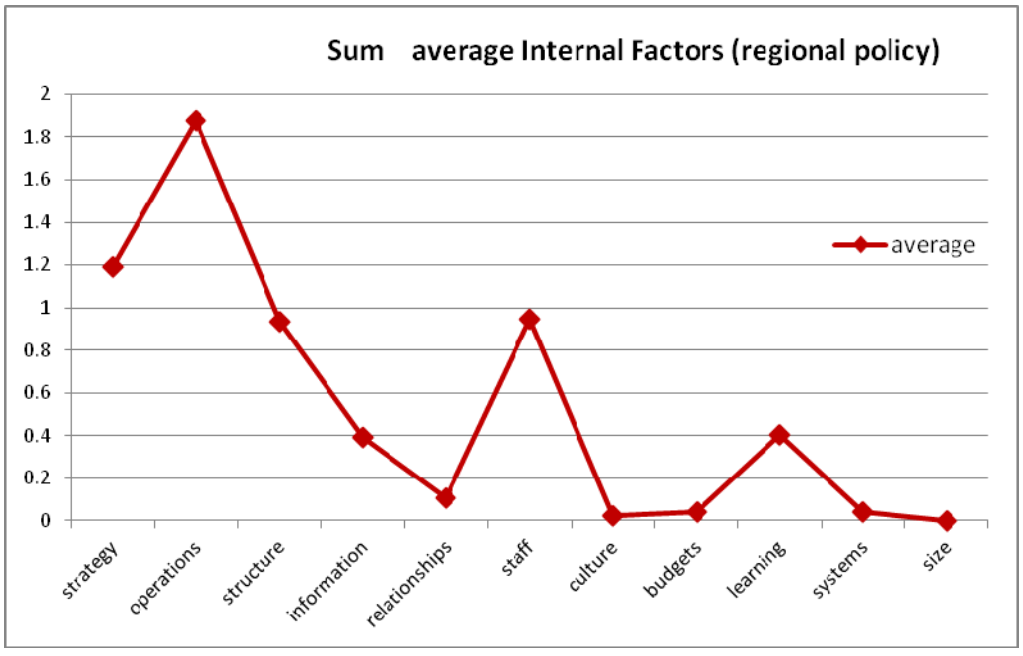


It shows CEOs spending the greatest amount of their time on other significant organisations, with contact time averaging 31 hours over the nine week period, followed by 16.7 hours for decision making processes and 5.9 hours for relationships. The CEOs spend, on average, an hour per month on relationships, stakeholders, environmental dynamism and performance

19.1.12 Organisational internal factors and regional policies

Figure 42 shows the amount of time CEOs spent on **organisational internal factors** in relation to **regional policies**, which averaged between zero to under two hours during the nine week period. The high maximum values shown for operations are skewed by two CEOs with regional lead roles and who were spending relatively more time on internal operational matters linked directly to the regional projects.

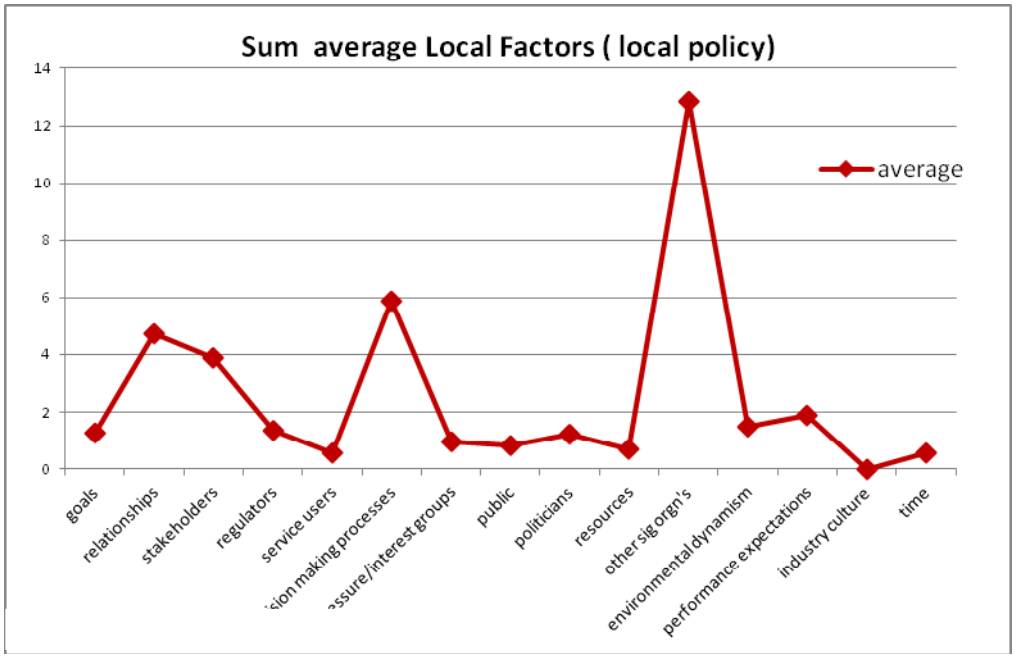
Figure 42 Total (sum) number of hours for organisational internal factors relating to strategic decisions on regional policies



19.1.13 Local contextual factors and local plans

Figure 43 below shows the average total amount of time CEOs spend on each of the **local contextual factors when taking strategic decisions on local strategies** or plans

Figure 43 Total number of hours (sum) PCT CEOs spent on local contextual factors in relation to taking strategic decisions on local plans



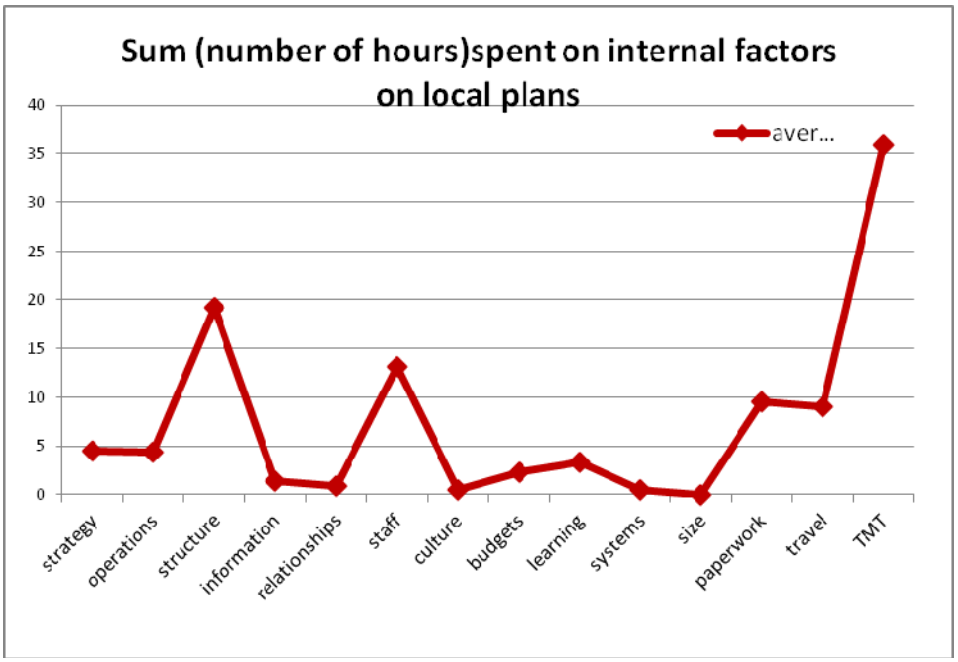
Most local plans are on primary care developments linked to polyclinics. Of the local contextual factors, other significant organisations stand out, with the average CEO spending 13 hours in the two month period with local organisations such as the council, the local hospital and GP organisations as well as the SHA on the local plans alone. The spike was due to a small number of CEOs spending more time than usual with their councils, due to local operational arrangements or difficult local relationships, especially with the overview and scrutiny committee. The CEOs also spend, on average, six hours on decision making processes, five hours on relationship building and four hours on stakeholders. The rest of the time was spent on the other contextual factors, each, besides culture, lasting from half an hour to an hour on average.

This picture of how CEOs spend their time suggests that they believed their involvement to be helpful to those local factors, be it for monitoring purpose or to demonstrate visible leadership to the other contextual groups in the implementation of local strategies or plans.

19.1.14 Organisational internal factors and local plans

Figure 44 presents the amount of time (sum) the CEOs spend on organisational internal factors in relation to local strategies or plans. It shows that CEOs spent the greatest amount of their time on TMT (average of 36 hours) followed by structures (average of 19 hours) and staff (average of 13 hours), then strategy, operations, learning and budgets, which ranged between 2.3 and 4.5 hours on average. A substantial amount of time was spent on administration. The focus on structures and staff here and combined with findings in Figure 43 point towards the CEOs operating in a highly ordered environment with clear roles, processes and rules for engagement and taking decisions.

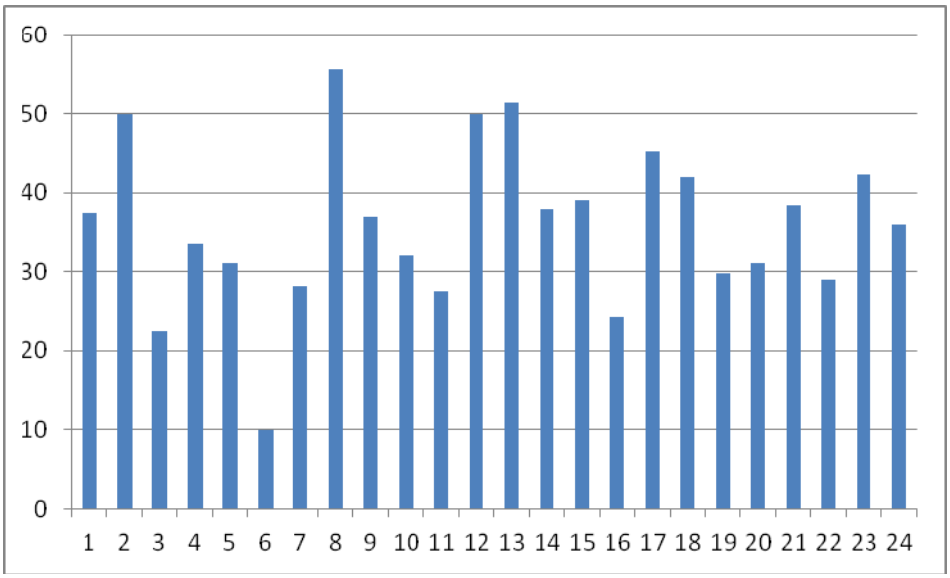
Figure 44 Total number of hours (sum) by organisational internal factors on strategic decisions on local plans



19.1.15 TMTs

Figure 45 shows, by PCT, the amount of time each CEO spent with TMTs. CEOs spent on average 36 hours (range 10-52 hours) with their TMTs over the data collection period, equating to four hours per week. (The CEO (no 6) who spent the least amount of time with their TMT was a very experienced CEO with an experienced deputy.) Yet TMT did not appear as a contextual factor in Project 2. This could be an oversight in Project 2 but the pattern is consistent across the majority of CEOs. Other reasons could be that the CEOs either did not appreciate their TMTs contribution as a significant contributing factor on their own or wanted to project a heroic leader image when they were interviewed. Whatever it is, TMTs clearly play a major and significant role in enabling CEOs to achieve their objectives.

Figure 45 Histogram showing the amount of time (in hours) individual CEOs spent with their TMT during the 9 weeks data collection period



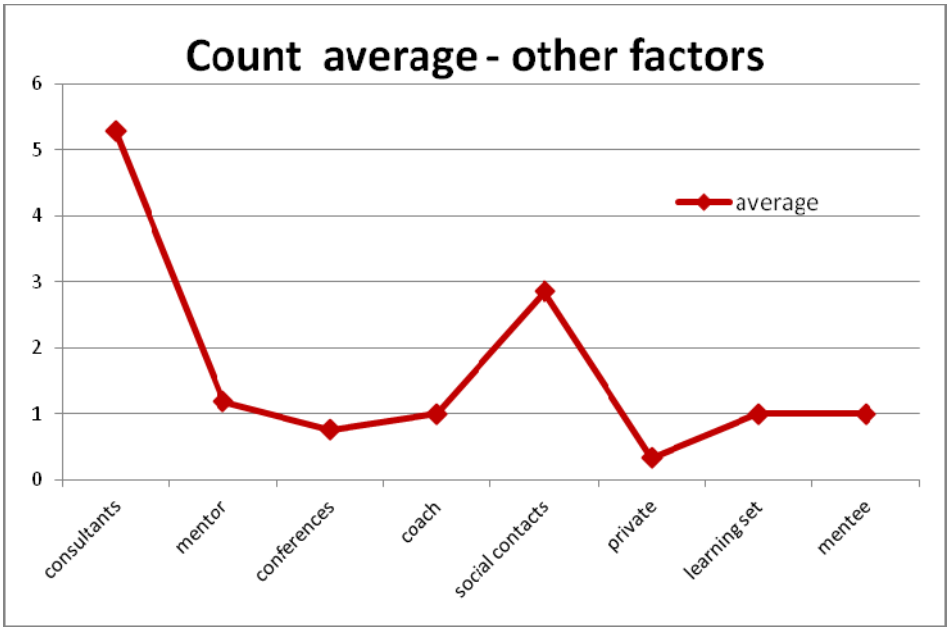
CEOs (by PCT, n=24)

19.1.16 Other factors not limited to strategic decision making

Data analysis reveal a number of other factors, as shown in Figure 46, that were found in PCT CEOs' diary activities The relevance and influence of the

different factors to strategic decision making is unclear from the data, but consultants, mentor, conferences, coach, learning sets, and social contacts would provide external insights that could influence the world view of CEOs. Of the factors, the CEOs spent the greatest amount of time with management consultants, averaging six hours over the two month period.

Figure 46 Average amount of time spent on new factors by CEOs



19.2 Summary of findings

Table 32 summarises the findings from Figure 31 to Figure 46 above, showing the actual values (based on averages) of both count (frequency of events) and sum (total number of hours) of all of the data from the 24 CEOs. Contextual factors displaying high or low counts also show similar proportions in terms of time duration spent by CEOs on those factors, reflecting the factors' relative importance in strategic decision making. The results are colour coded to enable comparisons within as well as between categories. They can be summarised as follows:

a) As a group, PCT CEOs behave in a similar way in how they deal with different types of strategic decisions. They are rarely involved in strategic decisions in relation to **national policies** as these are usually not

negotiable. On the occasions when they became involved in strategic decision making, and there were up to three events totalling 4.8 hours in the two month period, contextual factors that counted were **other significant organisations** and **performance expectations**. This is consistent with the uniform acceptance by CEOs that the best way to deal with national policies is to get on with it. Therefore national policies from the DH generally do not require strategic local decisions. From the CEOs' accounts, they are most likely to delegate to TMTs for implementation.

b) In contrast, the CEO diaries recorded far more activities in relation to **regional strategies and policies**, almost all of which focused on local contextual factors and with little involvement of the PCT itself. When dealing with regional policies, **other significant organisations** stands out both in terms of number of events as well as duration of events, indicating this to be a critical factor for regional decisions. It is also the **most time consuming contextual factor across all scenarios**. The most significant other organisation by far is the **SHA**. As regional strategies require collective agreement of not just PCTs but also stakeholders, it is not surprising that **decision making processes** takes up a substantial amount of CEO time, and is another critical factor. Other notable contextual factors are goals, relationships, stakeholders, environmental dynamism and performance expectations, all factors which are more outward facing and involve managing the dynamism of the environment [insert full stop]

c) Activities relating to **local strategies and plans** occupy a substantial proportion of the PCT CEOs' time. There are however notable differences between how CEOs deal with local versus regional plans, although there are also commonalities. One obvious contrast between the two is the extent to which CEOs are actively involved with their internal organisation. Of the organisational internal factors, structures and staff are the top two contextual factors both in terms of number of events and amount of time spent. They are followed by strategy and

operations which can be explained by the focus on operationalizing strategies and plans. Other regularly considered contextual factors include information, budgets and learning. Although **other significant organisations** emerges again as critical among the local factors, the cited organisations are different, with **councils'** OSC, **local hospitals** and **GP organisations** playing major roles. It is also noted that individuals within those organisations, especially key post holders, local opinion formers and leaders, have their own influence, which might explain why relationships, stakeholders and decision making processes matter as they are about gaining support for decisions on local plans. As with regional strategies, goals, environmental dynamism and performance expectations were highlighted, although not to the same degree of importance, as relevant contextual factors.

d) There are two other significant findings. The first relates to the roles played by the TMTs. From all accounts, all the CEOs hold routine meetings with their TMTs, both as a group as well as on a one to one basis. These executive team meetings are held at least either weekly or fortnightly to deal with both strategic and operational matters. In addition, one to one meetings are used, most commonly monthly but also on an ad hoc basis, to discuss functional issues. The findings show that, as a group, the TMTs have important responsibilities and the largest amount of contact time with the CEOs of any group. Their contributions to informing CEO contextual intelligence development are worth exploring, especially in the light of the upper echelons theory. The second finding is the emerging role of CEO adviser, a concept identified by Arendt et al. (2005) in the literature review.

e) When the results of Project 3 are compared with those of Project 2, there are many similarities and consistencies in what was observed in practice versus what was espoused in theory. There are also notable differences. Where they are the same, Project 3 identifies different emphasis, nuances and magnitude or impact placed on different contextual factors, by how the CEOs deal with different types of strategic decisions. On the

whole, with the exception of TMTs and consultant advisers, almost all of the contextual factors that emerged from Project 2 are found in Project 3. Because Project 3 is based on evidence, the data are more complete, therefore enabling new contextual factors to emerge.

Table 32 Summary of findings from diaries and interviews showing actual average values of counts and sum

	National policy	Regional strategy	Local plans	National policy	Regional strategy	Local plans
Local Factors	Counts	Counts	Counts	Hours (minutes)	Hours (minutes)	Hours (minutes)
goals	0.42	5.50	2.33	0.29 (10)	3.52 (211)	1.30 (78)
relationships	0.96	7.79	8.13	0.86(52)	5.90 (354)	4.74 (284)
stakeholders	0.75	4.83	6.04	0.59 (36)	3.33 (200)	3.91 (234)
regulators	0.13	0.38	1.63	0.10(6)	0.30 (18)	1.36 (82)
Service users	0.04	0.08	0.71	0.00 (0)	0.03 (2)	0.58 (35)
Decision making	0.54	18.96	8.17	0.43 (26)	16.72 (1003)	5.91 (354)
Pressure groups	0.08	0.46	1.54	0.06 (4)	0.30 (18)	0.96 (58)
Public	0.00	0.71	1.17	0.00 (0)	0.64 (38)	0.82 (49)
Politicians	0.21	0.33	1.46	0.27 (16)	0.24 (14)	1.25 (75)
Resources	0.21	1.08	0.92	0.04 (3)	0.75 (45)	0.71 (43)
Other sig orgn's	3.25	29.71	17.04	3.23 (194)	31.11 (1867)	12.86 (772)
Env.dynamism	0.25	5.58	2.46	0.20 (12)	4.05 (243)	1.51 (91)
Performance	2.13	5.04	3.25	1.55 (93)	3.63 (218)	1.89 (113)
Industry culture	0.04	0.00	0.04	0.04 (3)	0.00 (0)	0.02 (1)
time	0.00	0.13	0.17	0.00 (0)	0.14 (8)	0.56 (34)

Internal factors						
Strategy	0.46	1.58	4.88	0.35 (21)	1.19 (72)	4.48 (269)
Operations	0.29	1.58	5.92	0.26 (16)	1.88 (113)	4.40 (264)
Structure	0.08	0.96	15.29	0.06 (4)	0.94 (56)	19.19 (1151)
Information	0.08	0.67	2.08	0.06 (4)	0.40 (24)	1.41 (84)
Relationships	0.21	0.29	1.33	0.08 (5)	0.10 (6)	0.90 (54)
Staff	0.04	1.04	10.67	0.18 (11)	0.95 (57)	13.17 (790)
Culture	0.00	0.08	0.21	0.02(1)	0.02 (1)	0.48 (29)
Budgets	0.38	0.13	3.50	0.00 (0)	0.04 (3)	2.29 (138)
learning	0.38	0.42	2.88	0.21 (13)	0.41 (24)	3.40 (32)
Systems	0.00	0.08	0.92	0.06 (4)	0.04 (3)	0.00 (0)
size	0.00	0.04	0.00	0.00 (0)	0.00 (0)	0.00 (0)
TMT			28.83			35.9 (2154)
Consultants			5.29			5.78 (347)

Key for values

Numbers calculated based of data collection period covering 9 weeks.

Counts = average number of events	Sums = average number of hours (in minutes)
≥18.0 = more than 2 events per week	≥18.0 = averaged 2 or more hours per week

>18.0 but ≥9.0 = 1-2 events per week	< 18.0 and ≥ 9.0 = averaged 1-2 hours a week
< 9.0 but ≥4.5 = 1-2 events a fortnight	< 9.0 and ≥ 4.5 = averaged 1-2 hours a fortnight
<4.5 but ≥2.0 = 1-2 events a month	< 4.5 and ≥ 2.0 = averaged 1-2 hours a month
< 2.0 = less than 1 event a month	<2.0 = less than an hour per month

19.3 Strategic decision making at the away day

During the data collection period, an opportunity arose to explore in depth a critical strategic decision making event involving all of the PCT CEOs in the region. The event consists of an away day organised by the SHA that provided an opportunity to gather insights about how PCT CEOs conceive of their strategic decision making contexts. The concepts and edited quotes relating to the away day were abstracted from the interview transcripts (with key concepts and key words in **bold**) with additional observations from me as a participant observer

19.3.1 CEOs' experiences of the away day

Two relevant activities took place in the week leading up to the away day. The first consists of the couriering of a folder to CEOs the evening before the away day. Marked confidential and not for circulation, "A Case for Change" (folder title) contained a data pack that had been prepared by a management consultancy firm for the SHA. The second relates to information about how the event would be organised. Other than joining instructions, neither information nor agenda was issued despite repeated requests from the CEOs. Combined, the two events created an air of unease with the CEOs trying to second guess the aim of the event and feeling, in some cases, nervous with the mixed messages.

> *When that original case for change came out ..... it made me cross all night and then sick. So the weekend of that 10th, 11th of May was miserable. I had a headache most of the time because I was worried.*
>
> *CEO 13*

> *The information sent out prior to the event ….. were selectively drawn together ….. painted a picture of failure across (the region). Therefore, it clearly wasn't going to be an event around staying as we were ….. the whole thing was* ***primed*** *around some sort of change.*
>
> *CEO 15*

*I picked up **messages** that we were not looking at structural changes ….. (instead) how could we work more collaboratively and more smartly across (the region). So that was the mindset that I took into the fourteenth and the fifteenth.*

CEO 5

*All the **messages** that I got from previous meetings with the SHA was that they were looking for PCTs to improve their performance.*

CEO 1

The unusual **environment** of being closeted in an unfamiliar city hotel with peers, SHA executives and management consultants (around 50 people in all) for 24 hours was a stressful experience for many CEOs.

*The meeting was an alienating experience ….. the **set up**, the **environment** ….. psychologically we were ….. trying to converge into a southern position.*

CEO 21

*And then because we were all together, had been **hot housed** as we had ….. risk of turning into an evangelical meeting…… need pause and take stock in lesser brawl atmosphere.*

CEO 6

*Key influencers that helped that change or made that change, I think were the interaction and the **place**.*

CEO 2

Several CEOs alluded to the event's **design** as being a major factor in achieving its purpose. Many acknowledged being taken down a path by the set up.

*The **methodology** worked …..we got into it. I thought, actually, I have been locked in and made to focus on the issue. We reached an agreement in a day quite quickly.*

CEO 13

*I'm sure the whole process was a **set up** –we didn't really put the options on the table and properly evaluate them.*

CEO 21

*They **didn't ask the right questions** …..*

CEO 5

A number of CEOs used the word "hysteria" to describe the mood at the end of the second day that led to the consensus for PCTs to work in sectors. Cohen (1972) describes hysteria as "a state of mind of unmanageable emotional excesses, like a response to moral panic". It is unclear if the majority of CEOs felt the pressure but some of the quotes clearly show a sense of surprise, albeit in hindsight.

It was almost like some hysteria had got through and the whole thing had been planned …..whole thing was done to actually make people react like that in end.

CEO 17

Everybody ….. and nearly every other part of the southwest was talking about merger, merger ….. it was like, where did this come from….. (EA) I was flabbergasted at the merger – the merger fury that ran around the room at the end of the day, I didn't want that.

CEO 16

It was okay ……. until ..... at the end, it started to emerge that some of our colleagues were feeling that the pressure, the direction, required PCT mergers. At that point I began to wonder whether everybody had taken leave of their senses. At the end of Thursday, when there was a mass rush of the lemmings ….. suicidal, to say...come on...I mean They're insane. ….. people were leaping to a conclusion ….. nobody really understood what the challenges were.

CEO 7

As no **agenda** was issued prior to the meeting, the CEOs interpreted what the agenda might be and prepared accordingly.

*I went into the meeting thinking…..that PCT mergers were off the **agenda**, it wasn't politically acceptable.*

CEO 14

The plenary seemed to bear no relationship to some of the other things ….. the SHA ….. had a fixed position ….. didn't want to hear about difference.

CEO 24

*The reason why I thought that was the real agenda ….. the whole thing was **primed** around some sort of change.*

CEO 15

19.3.2 Rationale given for decision to form sectors

The majority of PCT CEOs were able to explain how they arrived at their decision to merge to form supra PCTs, or sector PCTs. They include CEOs who had changed their minds during the event.

*As we went through the day, it really began to seem to me that anything else other than that would only feel like partial solutions anyway…… to try and do everything just to 31 boards was such a **waste** of time…… It was based on **logic** and there was a sort of emotional thing ….. merger seemed like sensible.*

CEO 20

Over the day, interestingly when we had our breakout ….. two things did change for me. I had believed very strongly and still do believe that you can be a world class commissioner and run services ….. It is probably the critical mass issue.

CEO 8

The work we've done at the sector with (the consultants) already had led me to the view that there were gaps …… I then had a view across the sector and thought, well if that's true across (the city)….. you need to do something. ….. I got a much clearer view that everybody needed to move at a similar pace. At the time, merger felt like the right answer …..that surprised me ….. I thought it was not acceptable.

CEO 24

It seemed to me inconceivable that we could progress (regional health strategy) without formalized collaborative endeavour as PCTs. I strongly held that view

when I went in. Most of what I heard reinforced that view that I had. I didn't particularly change the view by the time I finished the day.

CEO 3

My view was always going to be if we're going to move, we have to move by stealth. You can't do radical or formal mergers upfront. So you have to leave formal merger to the end. Well, that has always been my position.

CEO 13

They drew on past **experiences** in forming their decisions.

Because I had been through "Commissioning a patient led NHS" in another SHA …..a very gut reaction was that I can't do this again. Actually that made me quite concerned about going to that event, but also I had seen that happened here.

CEO 18

I could see, from bitter experience, what the characteristics would be of really good collaborative working. And that (change) is not going to work.

CEO 22

My experience of actually having worked in those sorts of arrangements ….. you've got external pressure.

CEO 15

They were aware of the **personal implications** of any strategic decision, in the sense of what the change would mean for them.

I came away feeling very, very miserable; profoundly depressed really. And I thought ….. I am definitely in the wrong job with the wrong people. What am I doing here?

CEO 21

I knew that, immediately…..to centralize ….. my responsibilities as an accountable officer…..came into question. On that basis I was quite happy ..... to stay local but with no major budgetary responsibility ….. if that was the kind of decision or choice …..but I kind of felt that one had to go with the other.

CEO 10

I've been at the PCT for quite a long time, so it creates an opportunity to do something different on a purely personal level ….. it wasn't going to be a major problem for me on a personal level. So, I was very open to some options.

CEO 15

19.3.3 What actually happened

In the two days, the PCT CEOs were presented with further quantitative evidence, much of which was complex, and all drawing attention to weaknesses in the current organisational set up. There were large amounts of information for the CEOs to take in. As the CEOs were not allowed to discuss with colleagues, this could have adversely affected their sense making and therefore ability to take balanced decisions.

The details of the case, then the change, presented ….. felt very blaming on one level.

CEO 18

A lot of time was spent on the case for change ….. to persuade there was a case of change. ….. no opportunity to discuss or debate a case of not changing, and the risks ….. only looking at a case with change as being a positive thing, not looking at the other side which is actually the way we set around organisational change.

CEO 23

You couldn't argue with the facts and figures ….. from the interpretation of some of them. Some of the data was quite old as well as not relating to the current year.

CEO 5

A number of CEOs felt that they were set up by the SHA towards the eventual decision by the way the event was organised. One CEO (MC) claims to have foreseen the event as a psychological manipulation based on his past experience. The format of workshops, rotating stations, and concentrated

working into the night, created an atmosphere of urgency and pressure. While it was tiring, the CEOs appeared to be excited and energised by the experience.

> *They are normally used to me talking. "Why are you so quiet, M?" ….. I said, "We are about to embark on the process of mass hypnosis that results in mass* ***hysteria****." The process was designed to get everybody to say, "Yes, I will do this!" My colleagues could not see it. ….There was a process that was fumbling the sheep into decision making mode. They all went into the room where that was agreed at the end.*
>
> *CEO 1*

> *Some really good observations about the psychology of the whole event…..how chief executives were all voting for merger and everybody was quite gung ho, it was almost like some* ***hysteria*** *had got through. ….. They have done quite a lot of work ….. directing in the background ….. materials were focused …..to* ***lead*** *you to certain conclusions.*
>
> *CEO 17*

> *It was clearly* ***crafted****….. particularly the afternoon of the fourteenth and early evening, we all went round, looked at the various stations, then went and had dinner, then came back and did more. I felt that there was an* ***underlying agenda*** *and we were* ***being led****.*
>
> *CEO 5*

> *Key influencers that helped that change or made that change ….. were the interactions.*
>
> *CEO 2*

> *It was like a revival meeting…..*
>
> *CEO 21*

A number of CEOs described being **locked-in** as they were isolated from familiar territories against which they could sense check their evolving thinking. As the deadline loomed (the event was due to end at 4pm), the pressure to deliver gathered momentum, and what followed was a rapid escalation to get on

with the change, which, less than 24 hours ago, people were sceptical about, if not hostile.

> *I have been **locked in** and made to focus on the issue. We reached an agreement in a day quite quickly.*
>
> *CEO 13*

> *The process helped ….. all the bad **momentum** gathered during the day. …..if we've done the same process, you know, in series of meetings, we would not got the same energy.*
>
> *CEO 21*

> *I was quite worried about where the **lock in** was taking us. It felt to me we were doing fine till about two o'clock on the final afternoon at which point the whole afternoon, the whole thing just seemed to run away in the blink of an eye.*
>
> *CEO 20*

> *The only way I can describe to you, sort of swept away ….. also the enthusiasm that seemed to be generated for structural change.*
>
> *CEO 5*

While no one was claiming to have been forced to support the decision for PCT mergers (which was subsequently reported as the decision of PCTs), descriptions of the away day experience reveal the covert **coercion** felt by the CEOs.

> *When you've got external **pressure** coming right (at you) about the change ….. that is just about the **bullet** …..I say, okay, you want to change that, I actually agree with you.*
>
> *CEO 15*

> *I wasn't persuaded by the arguments, but I was persuaded that they meant business.*
>
> *CEO 8*

I don't think that we had a single discussion in the whole of that day and half that wasn't ***minded****. With hindsight, I think that last sector discussion, we were* ***blocked in a difficult corner*** *and we had some* ***very strong steer****. It was very difficult, very difficult.*

CEO 10

(The SHA) is ***pushing*** *us to reconfigure. But I don't think (SHA CEO) is a manipulator at all. I would be quite shocked (if he were).*

CEO 16

That last comment is interesting, as are others below, as they display a resistance among PCT CEOs to regard or speak of the **SHA CEO** in anything other than positive terms. He was treated as the sense giver and source of wisdom, at least overtly, although some CEOs qualified their comments. The responses could be due to the fact that the CEOs were being interviewed by a peer and were therefore careful to not make openly adverse comments although the responses were consistent across several CEOs. It is worth noting here that similar observations were made in Project 2.

(SHA CEO)'s view was clear that the structural arrangements in place were partly contributing to the lack of performance across (the region).

CEO 1

We just got to the view about merger ….. (SHA CEO) suggesting that it might be possible. I'm not sure he had seen through or tested it ….. It was possible that he looked upwards, that none of us brought to the party thought it was possible as we looked downward and outward.

CEO 24

I don't know whether (SHA CEO) did this deliberately, but throughout the day, I thought you could distinguish his line from the management consultants' line. They were not the same line. Now, I don't know whether (SHA CEO) had done that as a kind of having the provocation in the room or whether he didn't quite agree with everything they were saying.

CEO 14

I felt more – a bit more reassured when I heard (SHA CEO) speak, because I thought he had a broader view.

CEO 18

19.3.4 Rules and structures governing CEO decisional behaviours

The quotes below (and others elsewhere in the report) give some crucial insights into strategic decision making in the NHS.

There are so many things ….. that don't require any change in structure. They just require …..to stop going to all these bloody meetings….. about structural change in the NHS.

CEO 13

The statement from IS relates to *rules* regulating individual behaviour. With PCT CEOs, the fact that meetings were led by the SHA and attendances were monitored meant they were in effect compulsory. I have seen a register being taken at the monthly PCT CEO meetings where absences were noted and remarked upon by the SHA CEO, thereby reinforcing the norms. The norms also guide behaviours in these meetings whereby open challenges to SHA executives are considered to be career limiting.

I recognised it the minute (SHA CEO) said, you can't recruit a new post at director level….. we are talking structural change. This is where we are at the ball game really.

CEO 11

The quote from TB relates to rules regulating organisational behaviour. Rules in the form of processes enable the SHA to retain control. In TM's case, due to the steps in the recruitment process (from approving job descriptions and salaries to being on the interview panel) requiring SHA approval, they function as a form of control mechanism.

Well we have got no headroom with our management costs, got to afford that in the first place.

CEO 20

RI was referring to rules in the form of policies, in this case setting a limit on management costs expenditure, which constrains what the PCT can do.

> *It is just artificial, the NHS's determination to have their own relationship, which doesn't bear any relationship to anything.*
>
> *CEO 21*

The statement from SO reveals the socially constructed world of the NHS, in which rules and structures, although man-made, are real. These rules and structures, observable or not, were created by figures in authority using power given to them through the NHS accountability framework (*another set of rules*) and exercised in the form of hierarchical relationships.

19.3.5 How PCT CEOs felt throughout the event

The away day was an emotional experience for the CEOs, who reported mostly negative feelings (misled, angry, depressed, disbelief, confused are some of the descriptions used). These emotions could have affected their ability to take rational decisions.

> *I went into it thinking that mergers were off the agenda, because that's what (SHA CEO) had said and that's what I told everyone…… I didn't really take it seriously. Afterwards I felt a bit stupid ….. (as would) any person who went in there believing what they had been told.*
>
> *CEO 21*

> *I left that evening feeling very...utterly and completely furious ..... and in despair with my colleagues.*
>
> *CEO 7*

> *As I sat in that meeting and just listened ….. we should merge and just walked away. I went home that night feeling really quite depressed.*
>
> *CEO 10*

> *I was very surprised at how quickly people jumped to the conclusion that there needed to be structural change. I was very taken aback by that actually.*

CEO 2

There are several references in the CEOs' accounts expressing their concerns with the need to balance meeting the SHA's goal against what they believed to be best for their organisation.

> *I find it was quite confusing and it did not enable me to have a clear thought.*
>
> *CEO 16*

> *Everybody got very enthusiastic ….. I am still not sure whether that was (SHA CEO)'s agenda all along …… I try not to think that (SHA CEO) had taken us through a process.*
>
> *CEO 5*

> *I came out thinking how can I carry enough people? I was thinking, we have seen some improvement ….. and why are we throwing this away so soon? Give us a chance to prove. Well we have got no headroom with our management costs, got to afford that in the first place…... We've all got pressures of some kind. I think we are in a very dangerous place.*
>
> *CEO 20*

The CEOs tried to make sense of the context of what was happening.

> *There is a real risk that we have set about the structure and lost sight of what it is we're really trying to do. It was a very strong sense of wanting to hold on to the critical things.*
>
> *CEO 5*

> *I went in thinking ….. this is the opportunity to sense how hard (the SHA) is going to push on this. If they are going to push hard, what will I give and what won't I give. And merger wasn't, as far as I was concerned, something we were prepared to give.*
>
> *CEO 8*

> *Pragmatically, I thought that if (the SHA) really did mean business, we weren't just going to be able to tweak things.*

CEO 21

> *The big question in my mind ….. was whether the political climate was right. (SHA CEO) had, I felt, skirted around that issue ….. Given the political climate – one, the position of the government, and secondly we just had seen the local government election had seen some significant labour loss to conservative in some councils. So my reading of that political situation was that structural change is just not going to be possible.*

CEO 5

A number of CEOs found themselves in a dilemma of having to respond to two conflicting messages - one from the SHA about PCT merger and the other from their personal uncertainty about the benefits of such a restructure to their organisation.

> *I came out thinking, how can I carry enough people? We have seen some improvement ….. why are we throwing this away so soon? Give us a chance to prove. Well we have got no headroom with our management costs, got to afford that in the first place …… We have all got pressures of some kind. I think we are in a very dangerous place.*

CEO 20

> *I wasn't persuaded by the arguments there, but I was persuaded that they meant business. That is, (the SHA). And therefore doing nothing was not going to be an option. It wasn't something that was going to go away.*

CEO 8

> *Given that this seems to be inevitably where we would be going, I could dig my heels and resist that push for making some change ….. probably wouldn't do my organisation any good.*

CEO 15

19.3.6 Post event reflections

Of the reflections from CEOs, the most frequently expressed are that of anxiety and regret at what they had done in terms of the decision taken, the consequences for them personally and for their organisations. They were also

concerned about how they were going to get the decision through their boards, and the possibility of undoing the decision.

> *I came out of that feeling anxious. I always feel anxious at the end of those because I was thinking, it is very easy isn't it, when you lock yourself right through a day, to get sort of gung ho and then you go back to the ranch and reality bites.*
>
> *CEO 6*

> *On reflection now I disagree with that as a way forward.*
>
> *CEO 17*

> *As I went home, I met a lot of people who were outside and they were all thinking, like, well, what happened to my job now?*
>
> *So, it's quite interesting. I was on my phone to my chairman ….. to tell him that it is all ….. back to the sector. ….. I can't help thinking that we had landed in the place that (SHA CEO) wanted us to land. It looks like he didn't, but I know.*
>
> *CEO 21*

> *Had quite a lot of discussion with the chairman about what was his view, what was my view, boards' view likely to be ….. I guess at that point it changed again …..There was a point probably early in the following week when it became clear there was still quite a lot to play out particularly once the chairs began to get involved.*
>
> *CEO 10*

As a participant observer, I was able to verify the accounts given are accurate descriptions of what happened at the away day

19.3.7 Summary of findings

The away day provided an extraordinary opportunity to study the strategic decision making behaviour of PCT CEOs, as the event shows how NHS management structures operate in a covert decision making context. The key findings are summarised below.

1. The design of the event hindered proper decision making preparation by the CEOs. Information was used selectively to set the scene, and an isolated unfamiliar environment interrupted the CEOs' normal sense making behaviour.
2. The CEOs found themselves in a situation where they were observed constantly and prevented from discussing the evidence. This could have affected their sense making process, although it enabled the SHA CEO to be the sense giver.
3. Over the two days, tacit rules and structures regulating individual behaviours reinforced the social pecking order of all the participants leading to the CEOs' eventual collective agreement to support formation of sectors.

20 FINDINGS

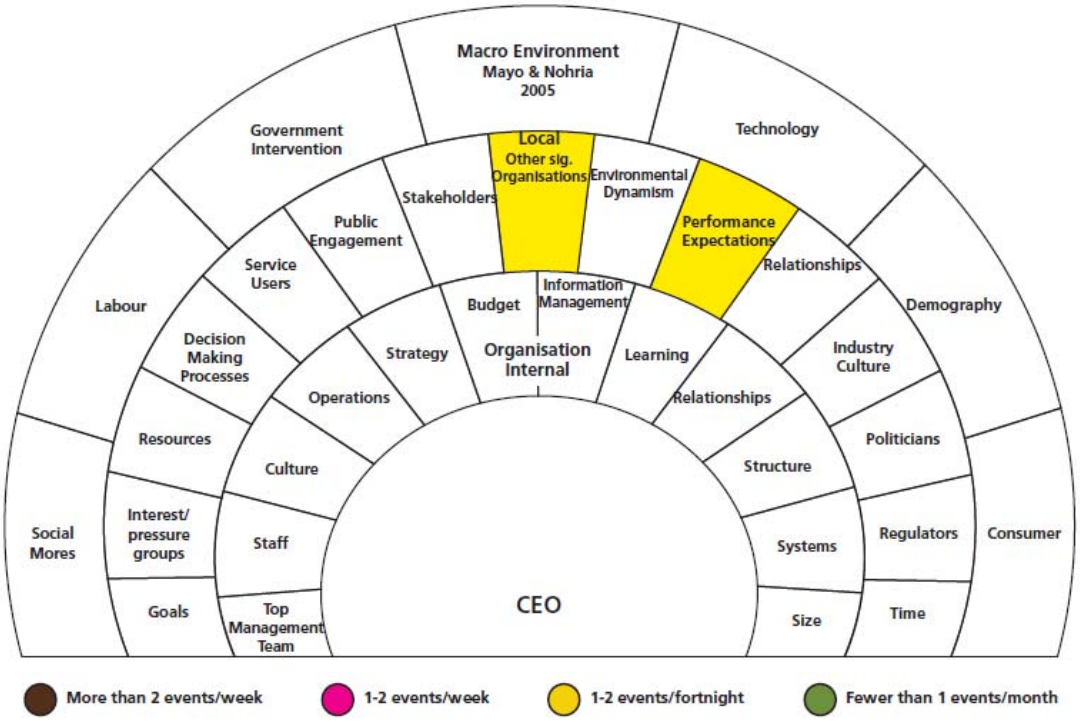
20.1 Relating contextual factors to policy scenarios

The combination of diary and interview data show PCT CEOs taking account of fewer contextual factors in practice than they had espoused in Project 2. Comparing like with like across the three different strategic decision making contexts of national, regional and local strategies, the trends from both Project 2 and Project 3 show the number of contextual factors taken into account by CEOs increasing as local autonomy in decision making increases. PCT CEOs are most likely to engage in local and organisational internal contextual activities if taking strategic decisions on local plans. In contrast, no contextual factor was taken into account routinely by CEOs when responding to national policies although performance expectations and other significant organisations matter when there are performance issues. Strategic decisions are rarely needed for national policies as national specifications mean PCT CEOs are bounded in their decision making. Regional policies fall somewhat in between the two. The summary results across the three decision scenarios are shown in Figure 47 to Figure 49, with contextual factors shown in colours reflecting their relative importance to contextual intelligence of PCT CEOs.

20.1.1 Contextual factors and national policies

Figure 47 shows the contextual factors relevant to PCT CEO strategic decision making on national policies. It shows CEOs spending very little time on national policy matters but they would do if there were performance issues. Then, the focus would be on meeting the performance expectations and engaging other significant organisations, this being the SHA, which is responsible for PCT performance management, and the other organisations whose cooperation is required for achieving the target. This finding contrasts with the findings from Project 2 which, although also showing performance expectations as a critical factor, followed by other significant organisations, the majority of CEOs indicated valuing stakeholders, information management, time and organisational strategy.

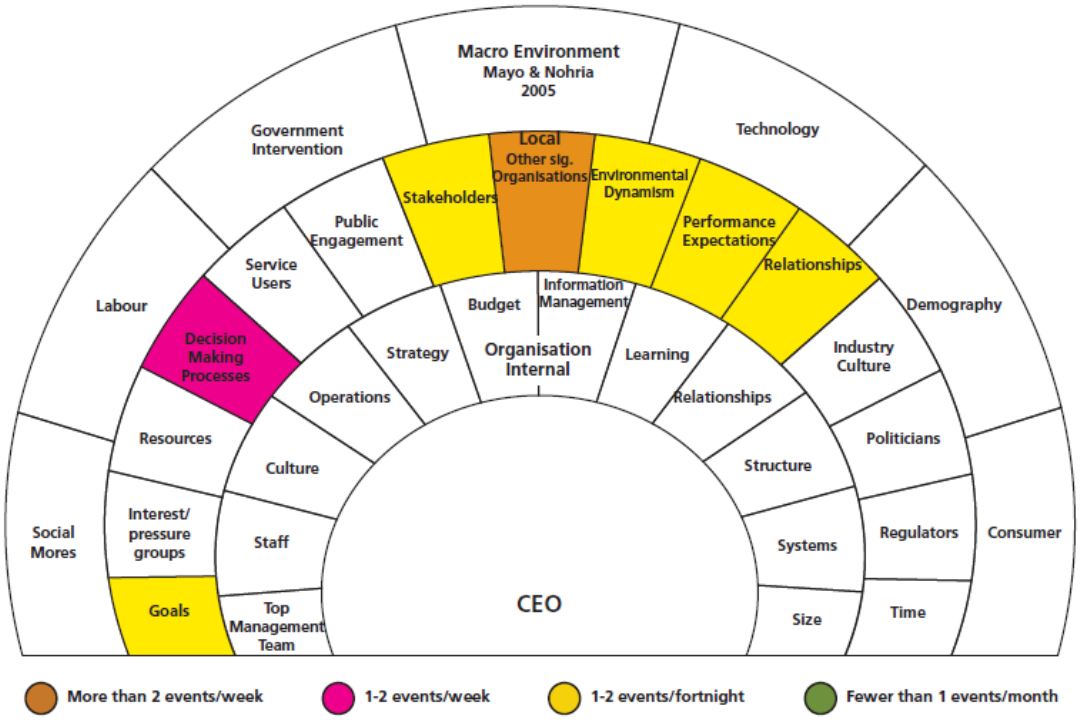
Figure 47 Contextual intelligence of PCT CEOs on strategic decision making on national policies



20.1.2 Contextual factors and regional strategies

Figure 48 shows the contextual factors relevant in PCT CEO strategic decision making on regional strategies. It is not surprising that “other significant organisations” is a critical factor, with 90% of the time and contact frequency being spent with the SHA. The next most important contextual factor is decision making processes, which can be explained by the need to demonstrate governance in strategic decision making as well as to engage stakeholders. The third group of contextual factors are in relation to local goals, gaining local stakeholders support and fit with existing environmental factors.

Figure 48 Contextual intelligence of PCT CEOs on strategic decision making on regional strategies

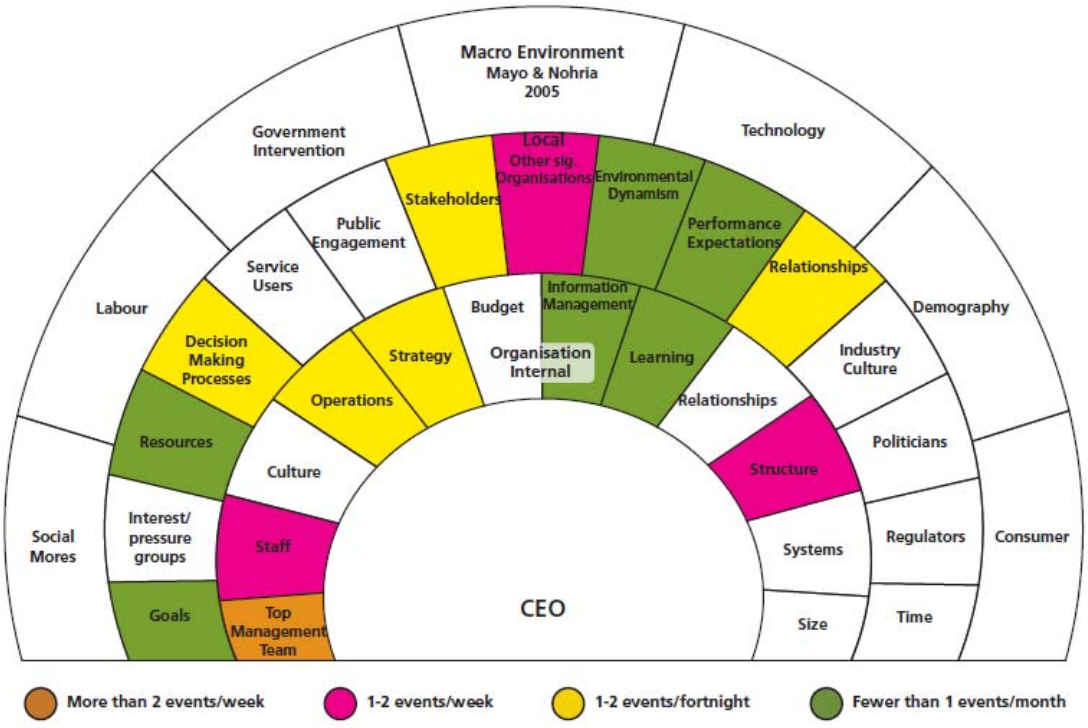


When the findings here are compared to that in Project 2, the most significant difference is the marginal presence of the SHA among the espoused views; only two CEOs had mentioned the SHA in Project 2, yet it was a critical factor in Project 3. The opposite was seen in public engagement and service users, which the majority of CEOs espoused taking account of in Project 2 but did not actually spend any time on the two activities in practice. Decision making process came out as a more important factor in practice than in theory. Finally, a majority of CEOs espoused valuing information and strategy, but in practice did not take the two factors into account, nor any other organisational internal factors. The discrepancies in the contextual intelligence models between the two projects would suggest that where regional strategies are concerned, the SHA plays a central role in influencing how PCT CEOs approach strategic decision making, more indirectly than directly.

20.1.3 Contextual factors and local plans

Figure 49 shows the contextual factors PCT CEOs take account of when taking strategic decisions on local plans. The diagram shows that many more contextual factors were taken into account in local plans compared to national and regional policies.

Figure 49 Contextual intelligence of PCT CEOs on strategic decision making on local plans



It is not surprising that TMTs came top as a critical factor as they would usually be asked to implement these plans. The other important contextual factors are structures for governance and implementation, and staff engagement. In the context of local plans, other significant organisations usually means the local statutory organisations, namely the council, the local hospital trust and GP organisations which would usually play significant roles in local NHS plans. As would be expected with strategic plans, in practice, the CEOs also spent time on strategy and operations (to operationalise the strategy) while engaging local stakeholders in the decision making processes.

Interestingly for local plans, the findings in Project 3 differ somewhat from Project 2 but not to the same extent as for national and regional plans. In Project 2, over 90% of the CEOs had identified other significant organisations, environmental dynamism and organisational strategy as critical contextual factors but in practice, the impacts of these factors on strategic decision making appear to be variable. A majority of PCT CEOs said in Project 2 they would take account of local goals, decision making processes, stakeholders and structures. No one mentioned TMT members. Yet, TMT came out as a critical contextual factor for all CEOs, with every CEO spending substantial amount of their time with their TMT. The rest of the factors show variable degree of differences, which may be simply reflect the differential situations in local health economies. Across all three strategic decision scenarios, the organisational internal factors of size, systems and relationships did not come up in theory or practice, showing they don't count in PCT CEO strategic decision making.

20.1.4 Summary of findings

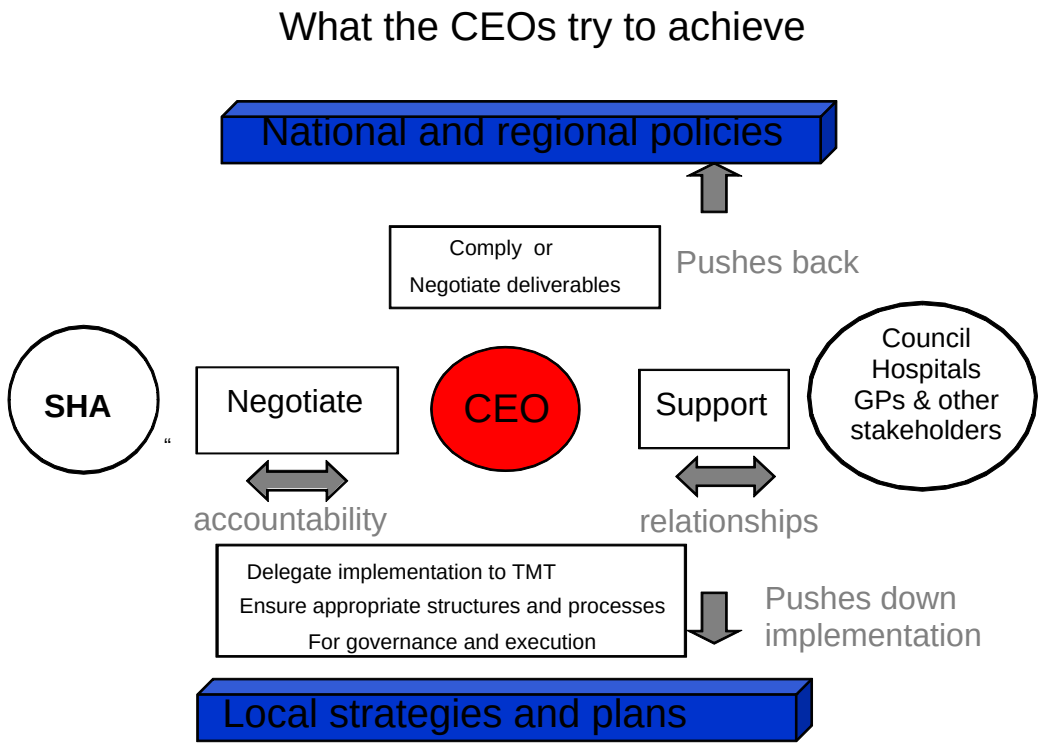
In summary, the frequency and duration of entries are indicative measures of a contextual factor's impact on PCT CEO strategic decision making. The most influential and critical contextual factors are TMT, other significant organisations, structures and decision making processes. The CEOs engage with their TMTs to delegate and review implementation as well as to get help with their own sensemaking. They engage with staff as part of visible leadership rather than involving them in strategic decision making but will want to involve internal organisational structures such as the trust board for governance purposes. The CEOs also engage with other significant local organisations whose cooperation is necessary for strategy implementation. Implementation of regional plans usually require engaging with stakeholders and other significant organisations, notably the SHA, as the nature of such plans often extend beyond PCT boundaries.

In each of the three strategic decision making contexts of national, regional and local plans, the contextual factors that PCT CEOs take into account in strategic decision making differ, except for other significant organisations which as a

group remains constant throughout, showing the importance of relationships. With national policies, compliance is expected, and as the performance expectations are normally clearly specified, the CEOs rarely have to take strategic decisions other than to delegate implementation. However, should there be problems with performance, the CEOs would focus on the performance expectations and the significant organisation, such as the DH or SHA, to renegotiate the deliverables and seek support. The same applies to regional strategies, although there is usually more room to manoeuvre, so the CEOs may try to negotiate with the SHA on the deliverables and to win support. In return, the SHA expects PCTs to support its strategies.

As regional strategies may not be relevant to local health economy plans, PCT CEOs would use formal decision making processes to engage key local stakeholders. In both scenarios, the tendency is to push back the top down strategies and policies. As PCTs still have to implement these requirements, the CEOs would delegate implementation to the TMTs. They will want to ensure that appropriate structures and processes are in place to deliver and to demonstrate governance and accountability. These factors also apply to local plans and strategies which are usually developed in conjunction with key local stakeholders, in particular other significant organisations, and have to take account of organisational internal factors for implementation. When PCT CEOs take strategic decisions, they will be mindful of the need to achieve through others, hence the importance of relationships both within and out of the organisation. What the PCT CEOs attempt to achieve at each interface is summarised in Figure 50.

Figure 50 PCT CEO strategic intent at each interface with key contextual factors



20.2 How contextual intelligence influences PCT CEO strategic decision making

Project 3 set out to answer four questions which are addressed below

20.2.1 Relationship between contextual factors and decision contexts

Question 1 asked if PCT CEOs take different things into account when making different kinds of decisions. The answer is a resounding yes from the findings above. What is interesting about the results is that in all three policy contexts, the only contextual factor that is constant is “other significant organisations”. Table 8 in Project 2 lists the organisations and their sub- structures such as committees and partnerships that PCT CEOs said played a significant role in

local strategic decisions. The organisation that showed the biggest difference between Project 2 and Project 3 is the SHA - cited by one in six CEOs in Project 2 but accounted for the most time spent with an external organisation in all diaries. This suggests the SHA's influence in PCT strategic decision making is not straightforward and is present even when it does not play a direct role.

As for the other significant organisations, although not directly in the NHS structure, the council is influential on a number fronts – as commissioner and provider of social care; its OSC has legal powers to hold local health services to account, are just some the influential roles. The list also reveals that these significant organisations are not one whole but consist of several key players – senior leaders and key office holders who play significant roles within their organisational structures, and have to be related to in different ways. Another complex group is GPs who are involved in the local health economy under a number of guises. The list shows the wide and complex scope of relationships on which a PCT CEO has to build in order to engage local stakeholders and knowledge about who matters for what contribute to contextual intelligence.

20.2.2 Common approaches to decision making

Question 2 asked if the PCT CEOs show a common pattern in approach to strategic decision making. National policies and regional strategies usually come with guidance on performance expectations or required actions which effectively set the boundaries for strategic decision making and a common approach. Decision making process was a consistent major contextual factor for CEO decision making on regional and local strategies in both Project 2 and Project 3. This is not surprising as, in addition to national policies setting out how strategic decisions are to be taken, the SHA also sets regional guidance and processes for reaching and approving such decisions. Add to that the PCT's own governance structure, the constraints start to shape the pathway for PCT strategic decision making and may explain why decision making process is such a major consideration for PCT CEOs. For politically sensitive decisions, PCTs have to be able to demonstrate they have followed due process as failure to do so can result in their referral to the court for judicial review. Strategic

decisions on national policies rarely allow discretions in local decision making which may also explain the standard approaches.

20.2.3 Differences between PCT CEO theories of action and practice

Question 3 asked if there were differences between what PCT CEOs say they do (theory) and what they actually do (practice). A summary of differences between espoused contextual factors versus factors in action is shown in Table 33. Comparing the espoused theories with theories in use in strategic decision making by PCT CEOs, the following observations are made:

On national policies, no single contextual factor stands out as critical, indicating that contexts as a whole do not influence CEO decision making in these instances. (A critical factor is defined as one that has been identified by at least 90% of the CEOs. Major contextual factors are those that have been identified by a majority (>50%) of CEOs.) The only major contextual factor that is consistent across both theory and practice is performance expectations. It also tops the list in terms of frequency, which is to be expected. Differences in the rest of contextual factors may be due to the CEOs relegating responsibility for implementation, leaving them to engage other significant organisations when necessary.

On regional strategies, other significant organisations, notably the SHA, and decision making processes, are critical contextual factors. This is to be expected, as the SHA sets the directive and holds CEOs accountable for delivery, and delivery requires decision making processes. The surprise is that these two factors are missing from CEOs' accounts in Project 2, which may either be an oversight or reflect their tacit acceptance by CEOs. The major contextual factors that are consistent in both theory and practice in strategic decision making are environmental dynamism, relationships and stakeholders. Performance expectations and goals also influence CEOs strategic decision making, for reasons similar to national policies.

When taking decisions on local plans, the critical factors espoused by CEOs – environmental dynamism and strategy – were different to those used in

practice, namely TMT and structure. The latter may reflect a focus on the organisation's capacity for implementation, in contrast to the former which are more relevant during planning stages, although strategy is a major factor in practice. The major contextual factors that are consistent between the two are other significant organisations and decision making processes. Differences in the rest of the factors again reflect a focus on strategy implementation.

Table 33 Contextual factors taken into account by PCT CEOs in different decision making contexts: espoused factors versus theories-in-action (critical factors in bold)

Decision context	espoused theories	theories-in-use
National policies	performance expectations structure strategy stakeholders time	performance expectations other significant organisations
Regional strategies	information strategy other significant organisations relationships public engagement	**other significant organisations** **decision making process** performance expectations goals environmental dynamism relationships stakeholders
Local Plans	**environmental dynamism** **strategy** other significant organisations decision making process stakeholders goals structure	**TMT** **structure** other significant organisations decision making process relationships strategy operations stakeholders

20.2.4 Other factors in PCT CEO decision making process

Question 4 asked if other factors play a part in PCT CEO decision making process. There are two other notable observations. The first relates to the roles of TMTs, which although not elucidated in the study, show them to have important responsibilities and the most contact time with CEOs. Their contribution to CEO contextual intelligence development is worth future exploration in the light of the upper echelons theory (Hambrick and Mason, 1984). The second concerns the role of CEO adviser (Arendt et al., 2005) as an intermediate model of strategic decision making. Saxton (1995) described the contributions of consultants in these instances as expert, provocateur, and legitimizer. All three roles were observed in the study. The impact of third parties on strategic decision making has emerged as a potentially significant factor in the CEO's advisory systems. It was mentioned by a minority of CEOs, but would be a factor worthy of further research

20.3 Further insights on PCT CEO contextual intelligence development

The away day provided an extraordinary opportunity to study the contextual factors in use by PCT CEOs when taking a critical strategic decision in response to a regional strategy. From the CEOs' accounts, three contextual factors stood out as being most influential. The first factor being the environment for decision making, notably how, on this occasion, the event's design and structure enabled the SHA to steer the decision making process. The second is information – ranging from what was presented (the information was selectively negative and out of date) and how it was presented, including the underlying messages that was not explicit. As the CEOs were unable to verify the data in their usual ways including checking with their TMT and board, their sensemaking could be compromised. The third consists of structures and rules guiding behaviour; some of which were explicit (for example the CEOs voting for PCT mergers) while others were less so (such as not openly challenging the SHA CEO, and herd behaviour). In practice, a strategic

decision of this significance will have to undergo formal decision making structures and processes, even if an agreement has been reached informally.

The most influential contextual factors, as defined by frequency and duration of activity, are structures, other significant organisations and TMT. What the diary and event have in common is identifying the SHA as the other significant organisation. Because of the way the away day was structured, TMTs were not accessible to the CEOs, which would explain their absence from CEOs' accounts. For the same reason, individual CEOs were unable to consult their chairman and board about the decision to merge PCTs. So while the PCT governance and decision making structures may be absent, the accountabiity structure between the SHA and PCTs was clearly present at the away day.

There are two particular observations from this event worth noting about how PCT CEOs take strategic decisions. The first observation is about the underlying structures and rules governing strategic decision making in the NHS. There appear to be at least two decision making processes: formal procedures which operate in public, and informal processes that operate in private. The second observation relates to rules guiding individual decisional behaviour. From their reports the CEOs felt under pressure to behave in a certain way and the desire to comply led to acquiescence to the SHA's tacit demand. While they overtly supported the decision that was taken, the CEOs were clearly unhappy with the situation they found themselves in and reacted to this, although most were unable to voice their frustration during the event and professed surprise at the eventual outcome. By virtue of not voicing their concerns, the CEOs colluded in a strategic decision that would eventually lead to the demise of their organisations as well as their own roles. It is clear from the CEOs' accounts that they recognised this conflict, although some, at least, arrived at a resolution of the decision they had come to. As the decision is possibly one of the most strategic that could be taken by PCT CEOs, it is important to understand the reasons for their behaviour. It also reveals a deeper insight into the mechanisms that may underlay the influence of other significant organisations

(in this case the SHA) as a significant factor in CEO strategic decision making in practice.

20.4 Theorising PCT CEO strategic decision making and contextual intelligence

20.4.1 CEO decision making in a socially constructed NHS

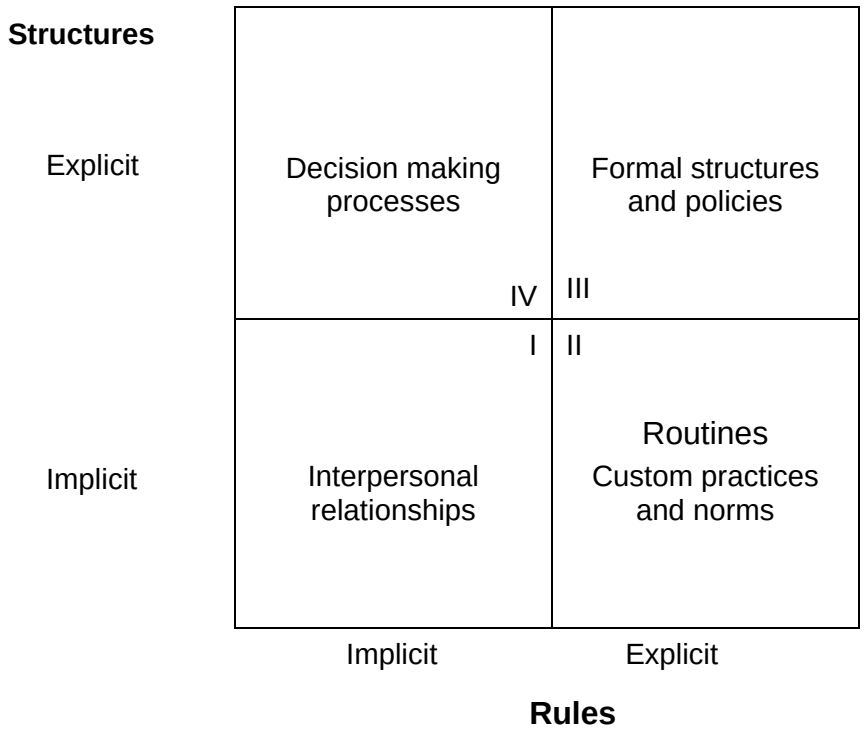
What the diary and away day data reveal about PCT CEO strategic decision making is that contextual factors that have the most impact, namely organisational structures, decision making process, relationships and behavioural norms, are social constructions of the system in contrast to macro level factors in the corporate sector.

A significant finding in Project 3 is the rationale behind the relative influence of different contextual factors in PCT CEO strategic decision making. The results show how contextual factors operate is influenced by rules and structures governing strategic decision making. *The Oxford Thesaurus* (2007) describes *structures* as not only physical formation or construction, but also the organisation, system, arrangement, design, framework, and patterns of how things work. How structures work is determined by rules. While formal relationships between PCTs, the SHA and the DH are structured, those of interpersonal nature between senior leaders tend to be informal and unstructured. It is evident from diary and interview data that organisations and individuals who have a stake in PCT strategic decisions are also engaged at varying levels of structures and modes. The PCT CEOs may have agreed at the away day to merge PCTs but the decision still had to go through a formal decision making process by their boards as part of the governance structure. Even social norms have elements of structure, as seen in PCT CEOs regulating their behaviours at the away day and supporting strategic proposals that they disagree with but felt unable to speak out against due to the hierarchical relationship with the SHA.

20.4.2 Structures and rules underlying Contextual Intelligence

What is apparent from the data is that the structure of contextual factors can vary in their visibility. It is partly this differential level of visibility that affects how a structure works. In addition, how structures operate in practice and in theory are also governed by rules which also vary in transparency. Explicit or formal rules include policies and legal requirements that are usually put in writing but even then still may not operate accordingly. Formal structures normally have explicit rules but interpretation and flexibility of the rules may be known only to experienced insiders. The tacit knowledge of informal rules such as custom practice and norms are not usually written down but can be observable. The PCT CEOs knew from experience that new rules can be created, and existing rules changed or abolished, unilaterally and without prior warning by the SHA or Department of Health. The process for decision making provides further opportunities for tacit rules to be exercised. In order to understand the underlying mechanisms for the different conceptions of structures and rules, data analysis looked for patterns that had created these structures. From the findings, a two dimensional model of structures and rules influencing CEO strategic decision making on a regional strategy in this specific away day event is shown in Figure 51

Figure 51 A two dimensional model of underlying contextual factors of structure and rules



But first, the rationale for each cell in the model is explained.

Cell 1 Interpersonal relationships

All of the CEOs spend substantial amounts of time on relationship building activities, especially with key individuals from other significant organisations, their TMT and internal staff. The CEOs foster interpersonal relationships where there is common purpose, as was evidenced in both Projects 2 and 3. Berscheid (1983) describes interpersonal relationships as usually involving some level of interdependence. As the NHS is one system, most things that impact on one part of the NHS is likely to have some level of impact on the others, especially in a geographical region. For example, the SHA needs PCT CEOs' cooperation to implement change across the region whilst the PCT CEOs need the SHA's support to implement local change. In PCTs, CEOs count on their TMT for functional expertise, to implement agreed

plans and to engage staff in service delivery. The structures underpinning such relationships are usually not explicit by connections, ranging from engagement to strategic alliances, with rules being based on mutuality.

Cell II Custom practice, routines and norms

Here, the rules may be explicit but the structures are implicit. An example is the social order operating between the PCT CEOs and SHA CEO. The Establishment Order for PCTs sets out the legal roles and responsibilities for the PCT Board and the CEO being accountable to the chairman of the board but the Accountability Agreement for PCT CEOs (Appendix I) cuts across this, with CEOs being held to account by the DH through the SHA CEO, in a grandparent role. While the two structures conflict in terms of accountability lines, the PCT CEOs know that staying in their posts requires the SHA CEO's support. Tacit knowledge of expected behaviours, or norms, led to the "turkeys voting for Christmas" results which prepared the grounds for subsequent decision making in public. The CEOs' behaviours reinforce the power structure which ensures that every player, PCT CEOs and SHA CEO included, knows their place in the organisational hierarchy.

Cell III Formal structures

In contrast to personal relationships and networks conducted at individual levels, statutory public organisations like PCTs are legally constituted, with formal structures and explicit operating rules and regulations that are written down and published. The legal Orders of Establishment for PCTs define the governance structures and rules required to create lines of responsibility and accountability. As part of their constitutions, PCTs are required to implement top down strategies, policies and plans. The CEOs acknowledge they have limited discretions in decision making where there is a requirement to comply with national policies. Their focus is then on achieving the required performance expectations, which they appear to delegate in line with the

organisational structure. As such policies often require the cooperation of other statutory organisations such as councils and NHS Trusts as well as GPs, the CEOs' diaries contain activities involving all these other significant organisations. PCTs also have statutory duties such as public consultations on strategic change that have to be met.

Cell IV Decision making process

As statutory public bodies, PCTs have to follow formal decision making process when taking decisions of strategic importance as would be in the case of PCT mergers. This is to ensure compliance with governance regulations as well as ensuring that critical decisions are given the due consideration and stakeholders consulted where necessary. In practice however, as is evident from the case of the away day, decision making processes can be either visible or invisible, or both, depending on how a process operates. The CEOs' diaries show evidence of formal decision making processes and the holding of public consultation and stakeholder engagement on the regional health strategy. Further, even after the CEOs have agreed to PCT merger at the away day, the decision must still be formally taken by the PCT Board to fulfil governance requirements. The term "process" is both a noun and a verb. When used as a noun, processes are like recipes and can be treated like formal constructions. In contrast, the "processing" or operationalisation of processes contain elements of time and operator variability, meaning different rules could apply. Decision making processes may not be observable. The findings reveal time delay in the process is sometimes adopted as a less visible control mechanism.

20.5 Conceptualising PCT CEO contextual intelligence

20.5.1 Decision contexts and hierarchy of contextual factors

By combining Project 2 and Project 3 findings, a summary of the key contextual factors forming the contextual intelligence of PCT CEOs in different strategic decision context is shown in Table 34 Matching strategic decision context with

hierarchy of contextual factors-Table 34. A comparison of the findings from the two projects is presented in Table 33.

Table 34 Matching strategic decision context with hierarchy of contextual factors-

Policy context	Contextual factors – first level (critical)	Contextual factors –second level (important)
National		Performance expectations SHA
Regional	SHA Decision making processes	Performance expectations Relationships Stakeholders Environmental dynamism Local goals
Local	TMT Other significant organisations Structure	Decision making processes Relationships Stakeholders Strategy Operations (implementation)

Table 34 summarises the key contextual factors that PCT CEOs take into account in strategic decision making for different policy contexts. The contextual factors have been categorised here into two levels: first level or critical factors are those which more than 90% of CEOs have identified as being critical to strategic decision making; and second level factors which were deemed important by the majority of PCT CEOs. Both were evidenced by citations in Project 2 and diary activities related to the relevant factors.

For national policies, there were no critical factors but performance expectations and the DH and SHA have been identified as important factors. This can be explained by the PCT CEOs accepting compliance with national policies as standard practice, but becoming involved personally in managing performance if necessary. On occasions of underperformance, the CEOs would usually be

held to account by the SHA in its regional head office role as system performance manager.

For regional strategies, the SHA is understandably a critical factor; however, its strong presence in PCT CEOs' strategic decision making context warrants assigning the SHA to be a contextual factor by itself, rather than grouping it with other significant organisations. Decision making processes are clearly central to strategic decision making, as they enable PCTs to demonstrate good governance and to engage local stakeholders to win support. As regional strategies come from the SHA, there would usually be elements of performance expectations. When regional strategies are supportive of existing local plans, many CEOs would use this opportunity to accelerate their local plans. The corollary is that when regional plans contradict existing local goals and strategies, the PCT CEOs would try to negotiate with the SHA on a compromise if possible. In all cases, the engagement of key stakeholders especially other significant organisations, and taking account of environmental dynamism in the local health economy are significant factors in implementing regional strategies.

For strategic decision making on local plans, a number of organisational internal factors play critical roles, specifically TMT and structure. Work to do with operations or implementation usually falls to TMT so their capacity and capability are priority considerations for CEOs, all of whom spent substantial amount of contact time with their TMTs. TMTs sometimes act as a sounding board to the CEO but their main contribution to strategic decision making is less about the strategic decision itself and more about supporting the decision making process and then taking the work forward. For local plans, other significant organisations are no longer the SHA (although the SHA still has an oversight role) but those in the local health economy, especially the council, the local hospital and GPs. At the local level, relationships are important, especially at the inter-personal level and with key office holders and politicians. For local plans to be implemented, they often require the cooperation and support of these organisations and individuals. Formal decision making processes are used to engage stakeholders for their support.

To summarise, as a group, PCT CEOs demonstrate a common approach to strategic decision making. Other than specific local issues, they are likely to take account of similar contextual factors when responding to similar strategic decision making scenarios. Ironically, the CEOs focus on inward and upward rather than outward is contradictory to the national policy direction to put patients first and to prioritise the patient experience. For the conflict to be resolved, it will require a different approach to policy formulation that changes how the structures and rules work in practice.

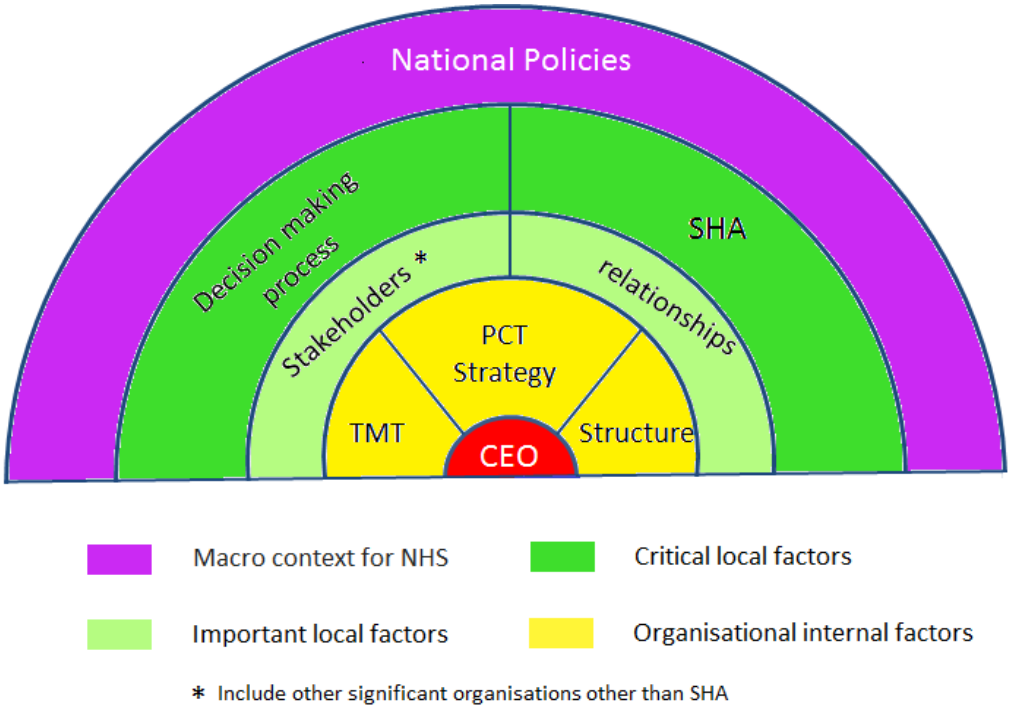
20.5.2 PCT CEO Contextual intelligence – a new conceptual model

The research draws the following conclusions. One, the contextual factors taken into account by PCT CEOs relate to the author of the policies, strategies or plans. Two, PCTs are required to implement national policies, which the CEOs prioritise over any other decision trigger. Three, the most important contextual factors for regional strategies are the SHA due to reporting lines, and decision making processes to demonstrate governance. When taking strategic decisions on local plans, the CEOs' focus is on having the right structures for decision making and engaging stakeholders, especially significant local organisations such as the council, local hospitals and GPs. In all cases, the CEOs delegate implementation to their TMT. Finally, as a group, PCT CEOs demonstrate a uniform pattern of strategic decision making behaviours that reflect contextual intelligence as summarised in the new conceptual model in Figure 52.

The new PCT CEO contextual intelligence model for strategic decision making, which I call the new rainbow model, is drawn from the findings of both Projects 2 and 3. It shows the functional world of PCTs, and therefore PCT CEOs, to be based entirely on what is set out in national policies. National policies can range from legislations to guidance, but all seek compliance or actions in one way or another. National policies are usually issued by the DH but can also be from arms-length bodies such as regulators. The DH not only allocates annual budgets to PCTs, it also sets prices and pay, as well as the operating rules for the whole NHS. It therefore replaces the external world faced by the corporate

sector with an internal market, which removes the need for PCTs to pay attention to macro level factors.

Figure 52 A new model of contextual intelligence for PCT CEO strategic decision making (new rainbow model)



I have already discussed the criticality of the SHA and decision making process in 20.5.1 above.

Project 2 (Table 18) includes a list of key stakeholders in the local health economy. The most important organisations, other than the SHA, are the council, the local hospital and GPs. All these organisations contain important individuals, who, due to their positions, expertise or portfolio, the PCT CEO need to engage in the strategic decision making process. There is a duty of partnership on PCTs and other statutory organisations including councils. Effective partnerships require the CEO to invest time in building constructive relationships with these local stakeholders.

Last but not least are the three contextual factors within the PCT itself. I have explained the TMT contributions above. PCT strategy is included as it and local goals overlap and both were identified as important contextual factors by a

majority of PCT CEOs as well as being relevant to strategic decisions. Structure was also identified by a majority of CEOs as a major factor but its significance as a critical factor is compounded when considered in its two dimensional forms as an contextual factor underpinning PCT CEO contextual intelligence.

21 CONCLUSIONS

The research set out to answer eight questions relating to contextual factors that NHS PCT CEOs take into account in different strategic decision contexts. The research has enabled the following conclusions to be drawn.

PCT CEOs define their strategic decision making contexts by where the policies, strategies or plans come from. They take different contextual factors into account when making different kinds of strategic decisions. There is also a hierarchy in contextual factors which can be categorised into critical and important, depending on their influence on strategic decisions. The number of contextual factors CEOs are likely to take into account is far fewer than the comprehensive literature based model although there are similar patterns of contextual factors and influence across CEOs. These help shape a common model of PCT CEO contextual intelligence in strategic decision making. The CEOs are likely to follow a similar decision making process as their rationalities are bounded by NHS rules and structures regulating their behaviours. The implications are that PCT CEOs need to be sensitive to the nuances and subtleties of the relevant contextual factors to understand their decision making contexts, enabling mitigating actions to be taken to achieve effective decision outcomes. However, the maintenance of the necessary awareness requires a major focus of activity and attention on inwards (downwards) and upwards at the expense of outwards.

Appendix H

Approach to coding diary events - examples

1. All routine meetings with board and chairman e.g. 121 with chairman, attendances at board meeting and subcommittees are coded under "organisational internal factors/structures", with 100% of the time allocated to that factor

2. All routine121s with Executive Directors and direct reports are coded under Top Management Team (TMT), with 100% of the time allocated to that factor

3. Performance review meeting with a local acute trust, lasting 1.5 hours – coded under "local plans/ local factors" and subcategories of 1.0 hour for other significant organisations and 0.5 hour for performance expectations.

4. Quarterly 1 hour meeting with chair and CEO of neighbouring acute trust who is a major provider of acute services to a number of PCTs in the sector– coded under "regional strategy/ local factors", and 0.5 for "other significant organisations" and 0.5 for "relationships"

5. Attendances at Local Authority Overview and Scrutiny Committee for 1.5 hours – coded under local factors, local plans, and allocate 0.5 to other significant organisations, 0.5 to politicians, 0.5 to performance expectations

6. SRO or CEO Lead for regional project – 121 with project manager, coded under local factors, regional strategy and allocate time to other significant organisations, goals, and decision making process

7. Joint chair (with acute trust CEO) of programme board for strategy – 2 hours coded under local factors, regional strategy, with time allocation 0.5 other significant organisations, 0.5 decision making process, 0.5 goals, 0.5 relationships

8. South West region CEOs Forum – all provider and commissioner CEOs – 2 hours coded under local factors, regional strategy, and 0.5 other significant organisations, 0.5 decision making process, 0.5 stakeholders, 0.5 relationships

9. Meeting an Assistant Director on primary care strategy for 30 mins- coded under organisational internal factors, local plans/ 0.25 for strategy and 0.25 for staff

10. Meeting with MP – coded under local factors, local policy/politicians

11. SHA chair visited to find out about commissioner and provider relationships locally involving two specific sites – 4 hours visit coded under local factors, local plans/ 2 for other significant organisations, 1 for environmental dynamism, 1 for relationships

12. Cardiac network meeting, chair for 2.5 hours – coded under local factors, regional strategy, as 1 for other significant organisations, 1 for decision making process, 0.5 for goals

13. Decontamination project board 2hours – chair – coded under local factors, regional strategy/ 1 as other significant organisations, 0.5 for decision making processes, 0.5 for goals

14. Chair the Prison Partnership Board 2.5 hours – coded under local factors, national policy/ 1 for other significant organisations, 0.5 for decision making processes, 0.5 for goals, and 0.5 for resources, all under national policy

15. Chair Regional Provider Board 2 hours – coded under local factors, regional strategy as 1 for other significant organisations, 0.5 for decision making processes, 0.5 for goals

16. Supporting interim PH director in a meeting of PH leads internally –1 hour meeting coded under organisational internal factors, local plans/ 0.5 staff and 0.5 operations

17. LIFT strategic partnership board 1.5 hours coded under local factors, regional strategy/ 0.5 other significant organisations, 0.5 for decision making processes, 0.5 for resources

18. SW region PCT CEOs 3 hours – coded under local factors, regional strategy /1 other significant organisations, 1 decision making processes and 1

relationships

19. SW region PCT CEOs and Directors to discuss World Class Commissioning development 4 hours – coded under local factors, national policy/ 2 hours on other significant organisations, 1 each on stakeholder and performance expectations

20. Professional Executive Committee/SMT – 3 hours coded under organisational internal factors as 1 for stakeholders, 1 for strategy and 0.5 each for SMT and structure

21. Non routine telephone call with chairman to discuss personnel issues – coded under organisational internal/ 0.25 as structure and 0.25 under staff

22. Strategic Board for children and young people – 2 hours coded under local factors, national policy/1 for other significant organisations, and 0.5 each for decision making process and stakeholders

23. Joint Committee of PCTs (JCPCT) – 2 hours coded under local factors, regional strategy / 1 for other significant organisations, and 0.5 each for decision making process and stakeholders

24. Emergency planning – meeting for 30 minutes with trust Emergency Planning leads regarding SHA policy for staff- coded under organisational internal factors, regional strategy/ 0.5 to staff

25. Learning Organisation development programme supported by NHSL – 3 hours coded under organisational internal factors, regional strategy /2.5 for learning and 0.5 for consultants

26. Regional PCT CEOs business meetings (routine) -1.5 hours coded under local factors, regional strategy / 1 other significant organisations and 0.5 decision making processes

27. PCT CEOs monthly meeting with SHA CEO – 2 hours coded under local factors, regional strategy /1 for other significant organisations, and 0.5 decision making processes and 0.5 relationships

28. SHA organised Chairs and CEOs lunch 1.5 hours – coded under local factors, regional strategy /1 for other significant organisations, and 0.5 for relationships

29. Telephone call with a Community leader – 0.5 hours coded under local factors, local plans/0.25 each for relationships and pressure groups

30. Tel call with CEO of neighbouring acute trust that didn't get Monitor approval – 0.5 hours coded as other significant organisations

31. Joint Staff committee 2 hours – coded under organisational internal/1 each to staff and relationships

32. Networking interactions or events coded under local factors, regional strategy or national policy/relationships

33. A meeting with local trust CEO to discuss strategy jointly with PEC chair and chair for an hour – coded as 0.25 each for other significant organisations, goals, relationships, and stakeholders

34. Anything to do with personnel issues is coded under staff

35. Annual leave – items in diary are not coded

36. Strengthening commissioning meetings 2 hours coded as local factors, regional strategy /1 to other significant organisations, 0.5 to goals and 0.5 to environmental dynamism

37. Working from home is treated the same as at work.

Appendix I

PCT Accountability Framework

October 2006

ACCOUNTABLE OFFICER MEMORANDUM FOR CHIEF EXECUTIVES OF PRIMARY CARE TRUSTS

1. You are hereby appointed as the NHS officer responsible and accountable for funds entrusted to your Primary Care Trust (PCT). This memorandum describes your responsibilities as an Accountable Officer, and relates them to my overall accountability for funds voted by Parliament for the National Health Service. In fulfilling your role as Accountable Officer you will also wish to bear in mind your responsibilities to the PCT Board of which you are a member. The corporate role of the Board is clearly set out in the Codes of Conduct and Accountability issued by the Secretary of State in April 1994 and subsequent revisions within the Corporate Governance Framework.

Functions of Primary Care Trusts

2. The functions of PCTs are:-

    (a) to improve the health of the community;

    (b) to secure the provision of high quality, safer services;

    (c) to integrate health and social care locally.

3. A PCT will combine primary care development and the commissioning of hospital and community health services with the provision of community health services.

4. The essence of your role as Accountable Officer is to see that the PCT carries out these functions in a way, which ensures the proper stewardship of public money and assets. The paragraphs below set out this responsibility in more detail.

Relationship between the Accounting Officer and Accountable Officers

5. My responsibilities as Accounting Officer are set out in a memorandum sent to me on appointment. In essence, I am responsible for the propriety and regularity of public finances in the NHS; for the keeping of proper accounts; for prudent and economical administration; for the avoidance of waste and extravagance; and for the efficient and effective use of all the resources in my charge.

6. Your role as Accountable Officer for your PCT is very similar to mine as Accounting Officer for the NHS in England. I require you to observe the same general requirements as are laid on me, and to ensure that the primary care trust's officers also abide by them.

7. This memorandum deals with the relationship with the Secretary of State and to Parliament, to whom PCTs are nationally accountable for the performance of their functions and for meeting statutory financial duties.

8. PCTs are accountable to the Strategic Health Authority and hence to the Secretary of State for Health, who delegates to me responsibility for supervision of performance.

9. I am accountable both to the Secretary of State and, in my Accounting Officer role, directly to Parliament. A similar dual accountability applies to the Chief Executives of PCTs, who are responsible both to their Boards and, as Accountable Officer, via the Accounting Officer, to Parliament. You are therefore accountable through me to Parliament for the stewardship of resources within your PCT.

Statutory Accounts

10. I sign the Summarised Accounts of health bodies in England and by virtue of this responsibility I can be summoned to appear before the Committee of Public Accounts (PAC) to deal with questions arising from those accounts or from reports made to Parliament by the Comptroller and Auditor General.

11. The summarised accounts are derived from the statutory accounts of individual PCTs. You are, together with the Director of Finance, responsible for ensuring that the accounts of the PCT which are presented to the PCT Board for approval are prepared under principles and in a format directed by the Secretary of State with the approval of the Treasury. These accounts must disclose a true and fair view of the PCTs income and expenditure, and of its state of affairs. You will sign these accounts, along with the Director of Finance, on behalf of the Board.

12. Reflecting your role as Accountable Officer, you will sign statements in the accounts (as indicated in the Manual for Accounts) outlining your responsibilities as Accountable Officer and with respect to Internal Control.

13. The PAC will continue to regard me as the main respondent to any enquiries, especially where the issues are wider than an individual health body. The Committee may however call other witnesses, and I may require you to accompany me at a hearing. I shall in any event look to you for support and information in my dealings with the PAC.

Effective management systems

14. You should ensure that the PCT has in place effective management systems that safeguard public funds and should assist the Chairman of the Board to implement the requirements of corporate governance as exemplified in the Codes of Conduct and Accountability.

15. Managers at all levels should:
    a) have a clear view of their objectives and the means to assess achievements in relation to those objectives;
    b) be assigned well-defined responsibilities for making the best use of resources;
    c) have the information, training and access to the expert advice they need to exercise their responsibilities effectively.

16. Managers should be appraised and held to account for the responsibilities assigned to them under (a) and (b) above.

17. You are responsible for achieving value for money from the resources available to the PCT and for avoiding waste and extravagance in the organisation's activities. You are responsible for following through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the Audit Commission and the National Audit Office (NAO). You are also responsible for using to best effect the funds available for commissioning healthcare, developing services and promoting health to meet the needs of the local population.

18. You should provide such information as is requested by the NAO. You should co-operate with external auditors in any enquiries into the use your PCT has made of public funds. I may also ask you to provide information on any points raised by external auditors that generate public or Parliamentary interest. Your arrangements for internal audit should comply with those described in the NHS Internal Audit Manual. You must ensure prompt action is taken in response to concerns raised by both external and internal audit.

19. Effective and sound financial management and information are of fundamental importance. Whilst this is the operational responsibility of the Director of Finance you, as the Chief Executive and Accountable Officer, have a primary duty to see that these functions are properly discharged. You should also ensure that the assets of the PCT are properly safeguarded.

Regularity and propriety of expenditure

20. You have a particular responsibility for ensuring that expenditure (discretionary) by the PCT complies with Parliamentary requirements. The

    basic principle which must be observed is that funds should be applied only to the extent and for the purpose authorised by Parliament. You must:-

    - not exceed your cash and resource limits;
    - draw the attention of Parliament to losses or special payments by appropriate notation of the statutory accounts;
    - obtain sanction from the Department of Health for any expenditure which exceeds the limit delegated to the PCT; this includes any novel, contentious or repercussive expenditure, which is by definition outside your delegation;
    - ensure that all items of expenditure, including payments to staff, fall within the legal powers of the PCT, exercised responsibly and with due regard to probity and value for money;
    - comply with guidance issued by the Department of Health on classes of payment which you should authorise personally, such as termination payments to general and senior managers;
    - have systems to ensure that payments to all contractors are properly due;
    - ensure that all expenditure is correctly attributed, in particular that expenditure which is subject to a cash and resource limits is accounted for against the relevant budget;
    - ensure that the PCT has appropriate systems in place to counter fraud by patients or contractors, in accordance with SofS Directions, the NHS Counter Fraud and Corruption Manual and with such other instructions on countering fraud and corruption against the NHS as may be notified by the Counter Fraud and Security Management Service, an independent Division of the NHS Business Services Authority.

21. The Codes of Conduct and Accountability incorporated in the Corporate Governance Framework manual issued to NHS Boards by the Secretary of State are fundamental in exercising your responsibilities for regularity and probity. As a Board member you have explicitly subscribed to the Codes; you should promote their observance by all staff.

Advice to the PCT Board and Executive Committee

22. As the Accountable Officer you have a responsibility to see that appropriate advice is tendered to the Board and Executive Committee on all matters of financial probity and regularity, and more broadly on all considerations of prudent and economical administration, efficiency and effectiveness. The Director of Finance has a special responsibility to support you in this role; you should ensure that he or she is fully aware of this obligation, is professionally qualified and has the requisite skills and experience.

23. If the Board or the Chairman of the Board or Executive Committee is contemplating a course of action which you consider would infringe the requirements of propriety and regularity, you should set out in writing to the Chairman of the Board and the Board your objection to the proposal and the reasons for it. If the Board decides nonetheless to proceed, you should seek a written instruction to take the action in question. You should ensure that the audit committee, which has specific terms of reference and delegated powers to inquire into matters of propriety and regularity, and which may require your attendance before it at any time, receives copies of the documents that describe your objections.

24. You should also inform the Strategic Health Authority and Department of Health, if possible before the Board takes its decision or in any event before the decision is implemented so that the Department of Health can if necessary intervene with the Board and inform the Treasury.

25. If the Board or Executive Committee is contemplating a course of action which raises an issue not of formal propriety or regularity but affects your responsibility for obtaining value for money from the PCT's resources, it is your duty to draw the relevant factors to the attention of the Board and Executive Committee. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. If exceptionally you have given clear advice that the course proposed could not reasonably be held to represent good value for money and the Board seems likely to overrule you, you should inform the Health Authority and the Department of Health so that it can intervene if necessary. In such cases, and in those described in paragraph 24 above, the Accountable Officer should as a member of the Board vote against the course of action rather than merely abstain from voting.

DAVID NICHOLSON

ACCOUNTING OFFICER

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