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The impact of incentives for competition and co-operation on the  
behaviour of health care organisations: a case study of the planning and  
provision of diabetes services in the English NHS

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## Declaration

I, Marie Sanderson, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed

A handwritten signature in cursive script that reads "MSanderson". The signature is written in black ink on a light blue rectangular background.

## Abstract

This thesis explores the co-ordination of public services through an examination of the way organisations in the English NHS negotiate incentives for competition and co-operation to deliver co-ordinated care to diabetic patients. Whilst the bodies responsible for the planning and provision of local services in the English NHS need to co-operate to ensure the co-ordination of services across organisational boundaries, they are also subject to a wide range of system reform mechanisms which encourage competition between the providers of services. The tension between these incentives raises questions about how organisations and professionals understand their objectives in this environment, and how this understanding translates into the relationships between organisations as they work together to plan and provide co-ordinated services.

Both the wider institutional context affecting competition and co-operation in the NHS, and commissioner and provider behaviour in the local context are examined. This examination is conducted in the light of the hierarchy, market and network modes of co-ordination. The research examines the applicability of the theories of 'co-opetition' and Ostrom's Institutional Analysis and Development framework as analytic frameworks to help understand the behaviour of NHS organisations and professionals as they work together to provide co-ordinated services. Theories of behaviour from game theory, economics, economic sociology and organisational studies are also explored to identify the rules of behaviour which organisations and professionals follow.

The review of the decisions of national regulatory bodies suggested that the promotion of competition was secondary to other concerns, although this position appeared to be changing following the implementation of the Health and Social Care Act 2012. Whilst co-opetition and Ostrom's IAD framework are concerned with how incentives for competition and co-operation can co-exist and can be managed for the benefit of all, at a local level the impact of incentives for both competition and co-operation on the behaviour of organisations and professionals was blunted by the predominance of hierarchical modes of co-ordination. Local context was found to be important in shaping the deployment of incentives for competition and co-operation, and establishing the rules of behaviour. Where organisations and professionals were exposed to incentives for both competition and co-operation, the delivery of services did not appear to be unduly affected, but lack of trust inhibited the sharing of sensitive information between parties, and reduced the quality of interactions in relation to other activities.

It is suggested that the development of network relationships within the NHS hierarchy should be encouraged in order to realise the benefits which can be gained from close co-operative working relationships between organisations.

## **Dedication**

For James, Eve and Nathaniel.

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## List of Abbreviations

The following abbreviations have been used in the text.

AWP	Any Willing Provider
AQP	Any Qualified Provider
CA 1998	Competition Act 1998
CC	Competition Commission
CCG	Clinical Commissioning Group
CCP	Cooperation and Competition Panel for NHS funded services
CQC	Care Quality Commission
EA 2002	Enterprise Act 2002
EC	European Commission
EU	European Union
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GPwSI	GP with Special Interest
HSCA 2012	Health and Social Care Act (2012)
IAD	Institutional Analysis and Development
ICP	Integrated Care Pilot
LSHTM	London School of Hygiene & Tropical Medicine
NHS	National Health Service
NHSA 2006	National Health Service Act (2006)
NIHR	National Institute for Health Research
NPG	New Public Governance
OFT	The Office of Fair Trading
PbR	Payment by Results
PCT	Primary Care Trust
PMS	Personal Medical Services
PRCC	Principles and Rules for Cooperation and Competition
QOF	Quality and Outcomes Framework
SLC	Significant lessening of competition
TFEU	Treaty on the Functioning of the European Union
UK	United Kingdom

## **Chapter 1**

### **Introduction**

#### **1.1 Introduction**

This thesis is concerned with the issue of co-ordination, and specifically the issue of the co-ordination of public services in the light of incentives for both competition and co-operation. The issue of co-ordination is addressed through an analysis of the way organisations in the English National Health Service (NHS) negotiate incentives for competition and co-operation to plan and provide co-ordinated care to patients.

This introductory chapter describes the introduction of incentives for competition into the provision of NHS services, and the issues raised by the combination of incentives for competition and co-operation. It situates this particular policy issue within the wider context of the theory of co-ordination, and the use of incentives for competition in the provision of public services. The chapter describes the research questions which are addressed by the thesis. The relevant theoretical and empirical literature is briefly discussed, and the deficiencies in the literature that this thesis addresses are summarised. The chapter closes with a brief description of the contents of each chapter.

#### **1.2 Policy background**

Since the NHS was established in 1948 both the allocation of state funded resources and the delivery of state produced health services have been co-ordinated by centrally led administrative decision-making. However, in line with other public services in the UK, such as social services, education and housing, since the early 1990s there has been ongoing interest in introducing elements of the market into the state run service. These type of systems have become known as 'quasi markets', which are systems in which the provision of a service is undertaken by competitive providers as if in a market, but where the financing of the system and the purchasing of services is still managed by the state (Bartlett and Le Grand, 1993). The separation of roles between the state run purchasing of services, and the provision of services through competition is described as the purchaser/provider split. The Conservative Government of the early 1990s first introduced some quasi market mechanisms into the NHS based on two central beliefs. Firstly, that the administration of the NHS was fundamentally inefficient because it contained no incentives for quality and efficiency improvements and secondly, that competition, and specifically competition on the

supply side (concerning the provision of services), was the way to achieve improvements (Enthoven, 1985). The belief that competition within the NHS will lead to improvements in efficiency, quality and responsiveness to consumers has been adopted by both Conservative and Labour governments since that time (Bartlett et al., 1998, Jones and Mays, 2009), and during the last decade the notion that production in a competitive environment is of benefit in the provision of public services has become 'conventional wisdom' (Klein, 2010). In 2010 the Coalition government stated its commitment to competition in the provision of NHS services in England, on the basis that it will bring benefits of innovation, service improvement and increased productivity to the NHS (Department of Health, 2010b). The Health and Social Care Act 2012, which came into force in 2013, has placed the commitment to competition in the NHS in England within a clear legal context.

However there are also clear requirements for NHS organisations to co-operate with each other. Inter-organisational co-operation is acknowledged as an 'essential behaviour' in the provision of 'seamless and sustainable care' to patients (Department of Health, 2010e). It is often the case that a patient needs to see a number of different professionals to deal with a problem in a number of different settings. Patient care can be complex and expensive, and expertise and technical facilities limited, leading to dependencies between organisations. NHS specific legislation gives organisations within the NHS a statutory duty to co-operate (NHS Act 2006, s72) and upholds the need for the promotion of integrated working where this improves quality, reduces inequality of access and reduces inequality of outcome (HSCA 2012, s1).

The tension between incentives for competition and co-operation within the NHS has been noted by policy commentators (e.g. Ham, 2008), and the existence of market like conditions in today's NHS raises questions about how organisations understand their objectives in the current policy environment and how this translates into their relationships with each other. Concern has been expressed both that competition led initiatives are policy barriers to integrated services (Ham and Smith, 2010, Ham, 2007), and that, conversely, integration can be 'anti-competitive' (Lewis et al., 2010).

This thesis addresses this issue by exploring how the conflicting demands of competition and co-operation affect the behaviour of organisations in the English NHS as they work together to plan and provide services.



### **1.3 The co-ordination of public services**

Whilst this thesis focuses on a particular policy issue in the English NHS, at its centre is the issue of co-ordination. Co-ordination here is taken to mean ‘the bringing into a relationship otherwise disparate activities or events’ (Thompson, 1991, p3). Co-ordination is required when a task is too large for a single organisation to undertake. Even simple endeavours may require co-ordination between two or more parties. For example, if I need a table, it is unlikely I will have the materials and the expertise to produce this myself in isolation, and the production of the table will involve the co-ordination of the supplier of the raw goods, the producer of the table, and perhaps even a third party who will sell the table to the customer.

Co-ordination in relation to public services, such as health services, is complex. The overall purpose of the NHS in England is to act as a comprehensive health service designed to secure improvement in the physical and mental health of the people of England, and in the prevention, diagnosis and treatment of physical and mental illness (HSCA 2012 s1 (1)). However the ways in which this overarching aim is to be achieved are necessarily diverse and multiple, and the outputs are hard to measure. Co-ordination is further complicated by the volume and range of organisations and professionals involved in the planning and provision of public services. Many organisations and professionals are involved in the provision of services within the NHS, such as NHS Trusts and NHS Foundation Trusts (across acute, community and mental health services), independent sector providers of services, General Practitioners (GPs) and pharmacists. Moreover a further group of organisations have responsibility for the commissioning (purchasing) of services. Whilst co-ordination may be challenging in this setting, it is also important. Patient pathways through services may necessitate treatment from a variety of professionals in a variety of settings in the treatment of a single condition. Control needs to be exerted over the planning of services across a population, to ensure that comprehensive services are available. Factors of this nature make the co-ordination of health services, and indeed other public services, both challenging and important to achieve.

It is important to make a distinction between co-ordination and co-operation. Although the terms are used interchangeably in some contexts, for the purpose of this thesis there is a distinction between co-ordination which suggests the deliberate imposition of order on to potentially conflicting objectives (Thompson et al., 1991, p3), and co-operation which is conceptualised as a ‘joint action for mutual benefit’ (Clements and Stephens, 1995, p527).

Therefore there is a clear distinction that can be made between co-operation in which parties are acting each in their own interests, and co-ordination, where parties may act, or be coerced into acting, in a way that does not coincide with their direct interests (Stephens and Anderson, 1997).

#### **1.4 The role of incentives**

Achieving co-ordination in any setting is problematic as parties (both organisations and the individuals within them) may have divergent interests and motivations. The issues encountered in relation to the co-ordination of tasks can be explored and addressed through the theory of incentives. Economic theory suggests that the two main issues relating to the delegation of tasks which necessitate the use of incentives are conflicting objectives and decentralised information (Laffont and Martimort, 2002). Individuals are thought to act in pursuit of their own self-interest, and those to whom tasks are delegated (agents) may have different objectives to the person delegating the task (principal), related to the pursuit of their own self-interest. Furthermore, the principal may not have access to all the information available to the agent, for example they may not be able to observe all the actions of the agents. These fundamental factors complicate the act of delegation and the achievement of co-ordination.

Incentives are mechanisms which motivate behaviour, and which can be used by the principal in the form of rewards or punishments to compensate for the problems caused by conflicting objectives and decentralised information and to achieve the desired behaviour. Whilst the discussion of incentives is often couched in economic terms, there are many different motivations for behaviour, and subsequently, many different types of incentives which address these varying motivations. Incentives may be financial or non-financial, explicit or implicit, they may be aimed at individual, team or organisational level (Ratto et al., 2001). It is thought that the distinctive features of the public sector may mean that incentives in the public sector work differently to other institutional contexts, and factors such as issues of idealism and professionalism, and altruistic motivation carry greater weight (Dixit, 2002, Le Grand, 1995).

The interaction between these incentives can be complex. For example, in the NHS it is common for those providing services to be incentivised by monetary awards relating to the achievement of agreed targets, and it is also acknowledged that many of those individuals

working within the NHS may have other more altruistic motivations relating to the quality of services (Ratto et al., 2001) .

### **1.5 Hierarchies, markets and networks**

Co-ordination can be achieved in a variety of ways. A key conceptual model used in the analysis of organisational behaviour in this thesis is the classification of modes of co-ordination into the models of markets, networks and hierarchies (Thompson et al., 1991). These models are defined by the use of different incentives to co-ordinate behaviour. The three models represent ideal types, and it has been argued that, rather than seeing them as mutually exclusive, they might more usefully be conceptualised as interdependent forms which may exist simultaneously to a degree within a single organisation or institutional context (Bradach and Eccles, 1989). Indeed, this thesis argues that in the case study area, the commissioner used a predominantly hierarchical mode of co-ordination, with elements of market and network mechanisms.

The NHS is traditionally organised as a hierarchy. In a hierarchy co-ordination is achieved through the conscious control of tasks through a vertical structure to achieve a predefined objective. Members of a hierarchy are motivated to co-operate through their employment relationship, concerns of career mobility and personal advancement (Powell, 1991). Within a hierarchy action is the result of deliberate control, and individual activity is constrained in the pursuit of a social goal. Economic incentives for competition are absent in a hierarchy, although members of a hierarchy may compete in order to improve their position in the hierarchy. Co-ordination is achieved through the exertion of rules.

The model of the hierarchy is seen by some as in a dichotomous relationship with that of the market (Williamson, 1975). The model of the market is based on the notion, from economic theory, that co-ordination within a market is spontaneous, as the pursuit of self-interest brings the most benefit to society. In this model, co-ordination is incentivised by competition which, in a free market (in which competition is unimpeded by interference from government) will lead to the production of the right goods in the right quantity for society. Co-operation is spontaneous within the market. When organisations' self-interest co-incides this may lead to the identification of reasons to co-operate. They may, for example, work together to reduce competition in the market, or they may work together in a supply chain relationship.

Definitions of networks vary, but they can be characterised as informal modes of co-ordination (Thompson, 2003) between organisations (6 et al., 2006, Thompson, 2003), or between organisations and individuals (6 et al., 2006). A key mechanism of co-ordination in networks is trust. Participants in a network are incentivised by the continuation of long term relationships, based in norms of reciprocity and reputational concerns (Powell, 1991).

It may be argued that the NHS can be understood most accurately as containing a mixture of modes of co-ordination from hierarchies, markets and networks (Exworthy et al., 1999). The NHS is fundamentally a hierarchy in which the allocation of resources and the delivery of services is co-ordinated by centrally led decision-making. Policy since the 1990s has seen the introduction of market incentives to NHS services, encouraging competition between the providers of NHS services. Networks meanwhile can be identified in multiple settings in the NHS, both in 'mandated' and 'non-mandated' form (Sheaff et al., 2011), such as locally co-ordinated groupings of the professionals and organisations involved in the planning and provision of services for a specific condition, or 'clan' relationships between individuals within a single profession.

The use of market incentives is generally considered complicated in relation to the provision of public services. Public services have a 'multiplicity of dimensions' (Dixit, 2002, p697) which means that competition in the market is not, in and of itself, sufficient or appropriate to address the task of co-ordination of public services. Firstly, whereas in a private sector organisation the owner's interest is paramount, in relation to public services there may be multiple stakeholders, such as taxpayers and the general public, the government and unions who have an interest in the planning and provision of services. Secondly, public sector organisations have outcomes which are not verifiable or contractible, and it may be difficult to tell when an ultimate goal has been achieved. Thirdly, those planning and providing services may get utility (satisfaction) from aspects of the task because of an idealistic or ethical purpose rather than money income. Fourthly, due to these difficulties public services may be provided by a monopoly, and there may be a lack of competitors.

## **1.6 The institutional context**

These difficulties with the use of incentives for competition in relation to public services mean it is important that incentives for competition are used carefully, and assumptions cannot be made that incentives will function in the same way in relation to the provision of

public services. Policy in respect of NHS competition has aimed to address some of the problems of the market and incentives in relation to public services by carefully targeting the use of competitive incentives, and encouraging co-operation. Whilst since the early 1990s various models have been introduced to achieve market incentives in the English NHS, the fundamental mechanism used has remained the division of the roles of purchasing and providing health services, where the state retains control of overall resource allocation but competition is introduced to co-ordinate the allocation of resources to the providers of services.

Establishing the institutional context in which organisations and professionals plan and provide services is therefore a key task. 'Institutional context' can be defined as 'the set of fundamental political, social and legal ground rules that establishes the basis for production, exchange and distribution' (Davis and North, 1971, p6). There is a complex regulatory and policy framework of national and European laws, NHS specific regulation and best practice guidance and professional codes of conduct in place at national level which set expectations of behaviour regarding the operation of competition and co-operation in the English NHS, consisting of both NHS specific legislation and rules, and national and European laws which relate to procurement and competition. This thesis focuses on a time of change in the NHS specific legislation and rules. It covers firstly the period before April 2013 where competition and co-operation in the English NHS was governed by NHS specific rules outlined in the 'Principles and Rules for Co-operation and Competition' (PRCC) (Department of Health, 2010e) which were overseen by the 'Co-operation and Competition Panel for NHS Funded Services' (CCP). Secondly it covers the period following HSCA 2012, in which the regulation of competition in the NHS was significantly altered by the creation of an economic regulator, Monitor, and the clear extension of competition law to apply to the planning and provision of NHS services.

The enactment of this policy and regulatory framework occurs in two ways, both of which merit investigation. Firstly, the national regulatory bodies are responsible for making decisions about the operation of competition in particular cases. These decisions provide important indications to the organisations and professionals in the NHS of the way competition and co-operation should be functioning, for example, and the way in which the need to protect and promote competition is being balanced against other concerns. Secondly, local commissioners in the NHS are encouraged to take responsibility for balancing the combination of competition and co-operation in their locality, and dealing with disputes

locally in the first instance. They can choose whether services should be subject to competitive tendering by inviting provider organisations to tender for services to win a contract. They can also choose whether to open up services to 'any willing provider' in which any providers who meet the minimum standards can compete for patients (a competition 'within the market') (Department of Health, 2010f). The different courses of action lead to different types of incentives for competition, most notably controlling whether competitive relationships are one off or continuous throughout the provision of services, and this may in turn affect the way organisations co-operate with each other.

### **1.7 Understanding organisational behaviour**

In order to understand organisational behaviour in the light of incentives for competition and co-operation it is important to establish the 'rules' regarding their use in the NHS. This thesis takes the approach that rules are socially situated, and understanding and interpretation of rules may differ between parties (Ostrom, 2005). To gain an understanding of organisational behaviour as they approach inter-organisational relationships it is therefore necessary to take account of formal, written rules, but also to be sensitive to unwritten rules of behaviour such as norms, and to look at the understanding of rules held by different players and in different settings. The interpretation or enactment of rules can also be influenced by factors in the local context, for example the other organisations in existence, and their financial health.

Game theoretic approaches suggest that a number of factors in addition to rules may also influence behaviour, such as players, outcomes and payoffs. Behaviour also may be affected by factors such as communication, repeated interaction which may lead to trust, or which may lead to a strengthening of competitive relationships. Two alternative approaches based on game theory are important to this thesis. Firstly, the notion of 'co-opetition' which suggests that organisations can compete and co-operate simultaneously to mutual benefit (Brandenburger and Nalebuff, 1996). Secondly, Ostrom's Institutional Analysis and Development Framework which was developed around the notion that individuals can self organise to solve common collective problems (Ostrom, 2005). Both these approaches not only suggest ways that incentives for competition and co-operation can be handled by organisations and individuals, but they also provide frameworks for the identification and analysis of the factors which are influencing behaviour.

In addition to the impact of the rules and elements of the local setting on behaviour, organisations and professionals may be susceptible to particular motivations when deciding how to interact with others. For example organisations may make decisions about how to interact based on the cost of conducting organisational relationships (transaction cost economics). Alternatively organisations or professionals may make decisions based on social relationships such as gaining and preserving approval and status, or on the basis of trust. Decision-making processes in organisations themselves may affect the decisions which are made.

## **1.8 Diabetes care**

An important element of the thesis is the examination of the impact incentives for competition and co-operation are having on the planning and provision of services. The thesis will focus on the planning and provision of diabetes services. Diabetes is a condition which requires the co-ordination of services from a variety of providers, thereby necessitating co-operation, and there is also a number of ways of configuring services across organisations, thereby providing a platform for the establishment of competition between providers. In common with the provision of services for many long term conditions, the co-ordination of a variety of services is key to the delivery of care for people with diabetes. People with diabetes are at risk from a number of complications: they have a greatly increased risk of suffering from conditions such as damage to the eyes (diabetic retinopathy), damage to the nerves (diabetic neuropathy), angina, cardiac failure, heart attack, stroke and renal failure (diabetic nephropathy) (Department of Health, 2001a, Levy, 2007). The co-ordination of services from a variety of professionals regularly to monitor people with diabetes and help them manage their condition is therefore a key aspect of the management of diabetes (Ham, 2007) in order to give people care when they need it, to stop the development of avoidable complications, and, at a system level, to increase efficiency. The presence of multiple conditions, such as those associated with diabetes, increases the risk of poor co-ordination of services (Schoen et al., 2008). As a consequence, the input required needs to be co-ordinated carefully, and can often require a complex response from organisations and professionals (Nolte and McKee, 2008).

Whilst diabetes services are likely to be spread across a variety of professionals and organisations, there is also a variety of possible service models in existence for the co-ordination of diabetes services (Arowobusoye and Furlong, 2008), creating scope for

organisations to make decisions about how they should interact with others to provide services. Aspects of the diabetes service may be provided in either community or secondary care settings (Department of Health, 2005, Department of Health, 2001b), and there is also scope for the extension of diabetes services which are provided in primary care (Calvert et al., 2009). Local commissioners have responsibility for deciding which model of service provision ought to be in place for diabetes, in consultation with the diabetes networks (commissioner-led networks made up of representatives of the bodies involved in the planning and provision of diabetes services in a local commissioning area (Diabetes UK, 2012)), patients and clinicians (Department of Health, 2006). These factors have implications in the light of incentives for competitive and co-operative behaviour in relation to diabetes. Firstly, diabetes is an area where commissioners might want to open up competition between service providers in order to encourage the establishment of different service models, including the shift of services from secondary to primary care settings. Secondly, given this, it is likely that the co-ordination of diabetes services will be affected by provider competition. Thirdly, given the need for co-ordination to provide the spectrum of services required by people with diabetes, productive inter-organisational relationships should also be encouraged.

### **1.9 Research aim and objectives**

The aim of this research is to examine the way health care organisations and health care professionals in the English NHS understand the current policy and regulatory environment, including incentives for competition and co-operation and how this affects their relationships as they plan and provide services. Through this examination the research also aims to explore the implications of the findings for co-ordination in relation to the provision of public services generally.

The objectives of the research are as follows:

In relation to the **national policy and regulatory framework** to understand how the need for competition is being balanced against other needs by regulatory bodies, and how the rules are being interpreted at a regulatory level by:

- Establishing the way incentives for competition and co-operation are dealt with in the policy and regulatory framework in place at the time of the research



- Establishing and analysing the decisions taken by regulatory bodies regarding the operation of competition and co-operation at the time of the fieldwork

In relation to **inter organisational behaviour** to explore how the policy and regulatory framework is understood and implemented at a local level by:

- Exploring how commissioning organisations understand and implement the policy and regulatory environment
- Using the analytic frameworks provided by the game theory approaches to explore inter-organisational behaviour in the light of theories of behaviour from economics, economic sociology and organisational studies

To explore the impact of incentives for competition and co-operation on **the planning and provision of diabetes services** by:

- Mapping the provision of diabetes services across organisations
- Examining the behaviour of organisations and professionals when planning and providing services in the light of incentives for competition and co-operation, and using the analytic frameworks and theories of behaviour described above
- Exploring how the co-ordination of diabetes services has been affected by incentives for competition and co-operation from an organisational, professional and patient perspective

### **1.10 Research question and methods**

The fieldwork conducted in this thesis sought to address the following research questions:

- 1) How do organisations planning and providing NHS services understand the policy and regulatory environment, including incentives for competition and co-operation, and how does this understanding affect their objectives?
- 2) What are the objectives of professionals, particularly managers and clinicians, involved in the planning and provision of NHS services in the current environment, and how do these objectives affect their behaviour?
- 3) In the current environment, how do those organisations and professionals approach their relationships with each other in relation to the planning and delivery of care for diabetic patients?
- 4) What is the patient experience of the co-ordination of services in this environment?

The theoretical and institutional issues underlying this thesis, including the complexity of the environment health care organisations operate in, suggest that research methods are required which are sensitive to exploring phenomena within a real life context, and allowing a rounded, in-depth and socially situated analysis. For this reason a case study design was selected. Case study methodologies are also a recognised research method in research into organisational behaviour (Keen, 2008). The research consisted of single case study of the planning and provision of diabetes services in a local commissioning area. The case study consisted of the local commissioning organisation and the providers of diabetes services across primary, community and secondary care in the area. The methods used were semi structured interviews with NHS staff, documentary analysis, observation of NHS staff meetings and interviews with patients.

The analysis of the data was conducted in the light of the theoretical framework described in section 1.7. In applying these theories to an examination of NHS organisational and professional behaviour the thesis will draw out learning about the theories themselves. This approach is particularly relevant in relation to the theories of co-opetition (Brandenburger and Nalebuff, 1996) and Ostrom's Institutional Analysis and Development (IAD) framework (Ostrom, 2005), which have not been applied to empirical studies of behaviour in the NHS before.

### **1.11 The contribution of the thesis**

The impact of incentives for competition on the planning and provision of services in the English NHS has been the subject of a wide range of studies. However, only a small cohort of these studies have direct relevance to the issues being explored by this thesis. These studies relate to interorganisational relationships in the light of the introduction of the quasi-market in the 1990's (e.g. Bennett and Ferlie, 1996, Flynn et al., 1996, Allen, 2002), and to the competitive environment in the period from 2002, when market incentives were again the subject of policy (e.g. Bartlett et al., 2011, Allen et al., 2012a, Porter et al., 2013, Sheaff et al., 2015).

Although, as explored in Chapter 2, these studies provide insights of value to this research, they do not directly address the question of interest to this research, namely exploring the impact of incentives for competition and co-operation on the behaviour of organisations and professionals in relation to the planning and provision of a single service. A number of studies examined the behaviour of commissioners in relation to the contracting of a particular

service (Bennett and Ferlie, 1996, Flynn et al., 1996, Allen, 2002, Porter et al., 2013), but these studies have tended to focus broadly on the relationship between commissioners and providers, rather than look at the relationships between providers. The relationships between provider organisations has been an issue which has received less attention. Studies that do examine provider/provider relationships directly, have not included a focus on a specific service (Dixon et al., 2010, Bartlett et al., 2011, Frosini et al., 2012, Allen et al., 2014a). Powell et al (2011) conducted a study examining the effect of complex policy initiatives on interactions and dynamics between organisations, and included within the study a focus on three tracer conditions, including diabetes. However this study did not directly examine the impact of incentives for co-operation and competition on organisational behaviour, and was not primarily interested in the co-ordination of services. There have been studies from outside the NHS (Muijen and Ford, 1996, Johnson, 1997) which focus on the co-ordination of services in the 'managed' market of the 1990's, however these do not concern the specifics of the NHS context.

Furthermore, there have been very few studies of co-opetition in relation to healthcare (Barretta, 2008, Peng and Bourne, 2009, Mascia et al., 2012), and none in relation to the NHS, and no studies relating to the application of Ostrom's IAD Framework in an NHS setting.

Therefore a study which addresses competition and co-operation in the light of provider relationships and the impact this has on the planning and provision of a particular condition represents a unique contribution to the field. An additional aspect in which this study provides a unique contribution is in the use of the approaches of co-opetition (Brandenburger and Nalebuff, 1996) and Ostrom's IAD framework (Ostrom, 2005) to aid the analysis of the empirical data.

### **1.12 Contents of the thesis**

The theoretical context of the thesis and its relation to other empirical studies is explored in Chapter 2. The chapter discusses three areas of theory, each serving a different purpose in relation to the thesis. Firstly an explanation of models of co-ordination which provide an important contextual backdrop to the research. Secondly, a discussion of the relevance of game theory as a tool of analysis, including the frameworks of co-opetition (Brandenburger and Nalebuff, 1996) and Ostrom's IAD framework (2005) and how these will be used in the analysis of data. Thirdly, the chapter describes the theories from economics, economic sociology and organisational strategy which have relevance to the basis on which

organisations and the individuals within them make decisions about how to approach relationships with others. The chapter then proceeds to review the empirical studies which have relevance to the research aims and objectives. The chapter closes with a discussion of the key findings from the theoretical and empirical literatures in the light of the research aims and objectives.

Chapter 3 is concerned with the institutional context. It begins by describing the policy background relating to the introduction of competitive incentives to the English NHS from 1990 onwards. The remainder of the chapter is concerned with an identification and analysis of the policy and regulatory framework concerning competition and co-operation in the English NHS which was in place at the time of the fieldwork (June 2011 – October 2013), consisting of: the relevant EU and UK laws; NHS specific laws; NHS specific rules and guidance relating to competition and co-operation; the bodies responsible for the enforcement of rules for competition and co-operation; the operation of contracts and price setting; and the relevance of the regulation of quality. In addition, the chapter describes and interprets the decisions regarding the operation of competition in the NHS made by national regulatory bodies during the fieldwork period.

The research methods used in the fieldwork are described in Chapter 4. The chapter discusses how the research design addresses the objectives of the study, and how the limitations of the research design were mitigated where possible. The chapter describes in detail the methods used in the fieldwork to gather and analyse data, and also critically appraises the methods used and how they, and my own identity, may have influenced the process of data collection and the research findings.

Chapter 5 focuses on describing the provision of services for adults with Type II diabetes in the case study area. Using data from interviews with professionals involved in the planning and provision of services, meeting observation and organisational documents, it describes the organisations and health care professionals involved in the planning and provision of care for adults with Type II diabetes in the case study area, and the way in which services were arranged during the field work period. The chapter also draws on data from interviews with a small number of patients with Type II diabetes, to describe the co-ordination of services from the patient perspective.

The findings in relation to the commissioner's interpretation and enactment of the policy and regulatory environment in the case study area are considered in Chapter 6. It is argued

that the commissioner had significant freedom to use incentives for competition and co-operation as it wished, but that in practice the use of incentives for competition was limited by local factors. The chapter describes the commissioner's predominantly hierarchical approach to the co-ordination of provider activity.

Chapter 7 explores the relationships in the case study area between the organisations and professionals involved in the provision of diabetes services. It examines both organisations' overall strategy and the relationship between organisations and individuals when planning and providing diabetes services. In addition to identifying the importance of local context in influencing provider behaviour, the chapter differentiates between the way incentives influenced behaviour in relation to different organisational activities, including the delivery of services, and in relation to different groups of individuals.

The thesis concludes with Chapter 8. This chapter summarises and discusses the findings of the research in the light of the research aims and objectives, and in relation to NHS policy, the theoretical framework and other empirical studies. It also discusses the strengths and limitations of the research. The chapter closes with a discussion of the contribution the thesis has made, suggests how the findings are useful for policy makers and areas which may benefit from further research.

## Chapter 2

### Theoretical context

#### 2.1 Introduction

As outlined in the previous chapter, the focus of this thesis is an examination of how organisations and professionals approach their relationships with each other in the light of incentives for competition and co-operation. The purpose of this chapter is to identify and explore the theoretical frameworks which are pertinent to an examination of the competitive and co-operative behaviour of NHS organisations in the policy environment at the time of the fieldwork, and to situate this research in relation to existing empirical studies which address similar issues.

There are three areas of theory which are covered in this chapter, each of which serves a different purpose in relation to the thesis. Firstly, the chapter discusses models of co-ordination of inter-organisational activity which provide an important contextual backdrop to the research. Secondly, the chapter discusses the relevance of game theory to the thesis. Game theory will be used as a tool of analysis; it provides a framework to compare the theories of organisational behaviour which comprise the third section of this chapter. Thirdly, theories which describe the basis on which organisations make their decisions about how to approach inter-organisational relationships are explored, from within economics, economic sociology and organisational strategy.

The first section of this chapter discusses theories relating to the co-ordination of organisational behaviour. Of central concern to this thesis is how the co-ordination of organisations' activities is affected by the incentives deployed in local health systems. The discussion of behaviour in the NHS is based around the notion that the institutional context in which organisations are operating contains incentives for behaviour. A common lens used to discuss the co-ordination of organisational activity, and indeed to discuss the co-ordination of social life generally, is the distinction between hierarchies, markets and networks. The first section therefore discusses the relevance of the hierarchies, markets and networks model to the thesis. An issue particularly pertinent to this thesis and connected to theories of co-ordination, how co-operation occurs in competitive situations, is also explored.

The second area of theory discussed in this chapter is game theory. Game theory provides a way of analysing, predicting and talking about the interactions of organisations and

professionals. Approaches based in game theory are used in this thesis as a 'meta theoretical language' (Ostrom, 2005) in which two specific game theory approaches (Brandenburg and Nalebuff's 'co-opetition' (1996) and Ostrom's IAD (2005) are used as frameworks to help understand and compare theories of behaviour.

The final theoretical area for discussion in this chapter concerns theories of behaviour: the 'rules' of behaviour which organisations and professionals follow. There are many possible frames which can be used to analyse inter-organisational behaviour and it is common to use more than one theory when trying to understand behaviour (e.g. Giddens et al., 2006, Williamson, 2000). In my analysis I focus on theories grouped around three main schools; theories of economics, which look at the behaviour and interaction of 'economic agents'; 'personalistic' approaches which can be broadly characterised as economic sociology; and theories pertaining to the workings of organisations, which are grouped together here under the label of organisational theory.

After the theoretical literature has been discussed the chapter summarises the empirical studies which are relevant to this research. The vast majority of the studies considered are concerned with the NHS and focus on organisational behaviour within a competitive NHS environment or the co-ordination of services between organisations.

## **2.2 Literature review methods**

Before commencing the review of the theoretical and empirical literature, it is important to clarify the methods used to identify the relevant literature. The literature review was an ongoing iterative process throughout the doctoral research, which ensured that, firstly, as theory developed during data collection, relevant literature was identified, and secondly that new literature which emerged during the doctoral research period was captured. The process undertaken to identify the literature can be most closely aligned to the model of 'realist' review (Pawson et al., 2005). This is an approach which aims to develop understanding of action in complex social situations. Instead of attempting to identify literature in order to make a definitive judgement about, for example, the success of an intervention, a realist review focuses on trying to understand the complex interactions between initiatives and their context. The general approach underlying a realist literature review is the use of an iterative process to identify literature with the aim of refining theory.

The process began with a background search to identify and explore the theories and key concepts relevant to the broad research question. This was conducted in a variety of ways.

The starting point was the idea of co-opetition which had been suggested to me as an interesting way of approaching organisational responses to a combination of incentives for competition and co-operation. An initial overview of co-opetition was gained from literature identified through internet searches. The co-opetition literature was strongly grounded in wider theoretical fields which then informed further reading, in particular those of industrial organisation, organisational studies, economics and economic sociology. An understanding of the fundamental concepts of game theory was gained through participation in a summer school at the London School of Economics, which in turn led to the identification of further relevant sources. Literature was identified through internet searches, 'snowballing' from references and identification of sources through discussion with colleagues. This general reading to explore and refine my understanding of the key concepts helped to define the specific research questions, and to generate some early hypotheses about how NHS organisations might approach their relationships with each other and why.

A more formal search strategy was employed to identify empirical evidence which addressed the behaviour of organisations when exposed to incentives for competition and co-operation. The aim of this search was to identify how theory worked in practice in contexts similar to that being explored through the thesis. Three databases (Web of Science/PUBMED/Business Science Premier) were searched resulting in over 1000 hits, these were reviewed based on titles and abstracts, and 97 relevant documents were identified. The search terms used consisted of combinations of the terms 'competition', 'co-operation', 'co-ordination', 'NHS' (and 'National Health Service'), 'health care', 'quasi-market', 'integration', 'collaboration', 'co-opetition' and 'Ostrom'. Other inclusion criteria were documents available in the English language; documents available in printed or downloadable format; documents based on secondary research which synthesized relevant studies, or primary research involving quantitative or qualitative data. No other filters, for instance regarding study design, were used as the aim was to identify a wide variety of sources. The purpose of the database review was not to exhaust the literature but to identify relevant evidence, and to use this as a base to identify further literature using a 'snowballing' technique consisting of hand searches using the references of retrieved literature. Literature was selected which firstly looked at the behaviour of organisations in the light of the NHS quasi-market, secondly which dealt with the integration of health services in the light of incentives for competition and co-operation and thirdly, which specifically examined health services in the light of co-opetition or Ostrom's IAD framework. Where relevant empirical studies were identified these were recorded in a standard table which noted the study



methods and the aspects of the findings which were of relevance to the research questions and key theories.

Relevant literature, both theoretical and empirical, continued to be identified throughout the field work, data analysis and writing up periods. In particular, the data analysis led to the identification of 'hierarchy' as an important concept relating to organisational behaviour in the case study area. Subsequently, the empirical studies identified were revisited to establish any relevant findings, and theoretical literature relating to hierarchy, in particular the literature discussing the divisions and interactions between market, networks and hierarchies was explored.

A search was also conducted to identify relevant policy documents. This is described in Chapter 4.

### **2.3 Selection of preferred theories**

The notion of game theory is central to this thesis, and was selected as the framework through which to examine organisational behaviour in the NHS for a number of reasons. Game theory is a common way of thinking about strategic interactions in real life, and is often applied to the analysis of behaviour in business settings, for example the analysis of price setting in oligopolies. The growing emphasis on, and use of, incentives for competition in NHS policy at the time the research questions were framed, and at the time of the fieldwork, raises questions about the applicability of this framework to the analysis of organisational behaviour within the NHS, an approach which is largely untested. Two approaches associated with game theory were identified as particularly of interest: co-opetition (Brandenburger and Nalebuff, 1996) and Ostrom's (2005) work on the management of common pool resource problems and development of the IAD framework. These are both approaches which seek to apply the essentials of game theory to real life situations by recognising and accommodating the complexities of the rules, players and contexts of real life interactions. Whilst game theory generally, and co-opetition and the work of Ostrom specifically, have not been used to any great extent to study interactions within the NHS to this point the work of Taylor Gooby (2008) is an exception, who has written about the development of competition in the NHS from a game theoretic perspective, drawing in part on the work of Ostrom.

There is, of course, a number of alternative approaches which draw on a broad game theory approach to understand the complexities of strategic interactions in real life. An example of one such approach is Fligstein's 'theory of fields' (2001) which adopts a sociological approach

to understanding behaviour within games ('fields') in order to study how actors can gain the co-operation of other actors. However, the frameworks of co-opetition and Ostrom were chosen for the following reasons. Firstly, with reference to Ostrom, the emphasis of the framework on common pool resource problems, which is not present in other approaches, was thought to chime with the particularities of the finite budget in place in the NHS, and the need to use this in the most 'efficient' way. Whilst the framework has been applied in many other settings such as water management and forest governance, its applicability to health services is apparently relatively unexplored.

Co-opetition, like the Ostrom model, is concerned with the creation of mutually beneficial outcomes for parties involved in interactions. Unlike Ostrom however, co-opetition is concerned purely with the opportunities for actors within the market place to work together to increase opportunities for profit making. This was a theory which had not been widely associated with the provision of health services, although it had much wider exposure as a way of approaching organisational interactions in the market. The value of the co-opetition model therefore was in its clearly 'market'-centric approach to behaviour, which provided a contrast to the more 'network'-based approach of Ostrom. It was anticipated that this would enable the analysis to compare the applicability of the two models, and thereby draw some conclusions about actors perceptions about the type of environment in place in the NHS at the time of the fieldwork.

#### **2.4 Hierarchies, Markets and Networks**

The question being addressed by this thesis concerns the co-ordination of social interaction, specifically how the mix of incentives for competition and co-operation in place in the NHS at the time of the fieldwork affected the way organisations and professionals approached their relationships with each other when planning and providing services. Co-ordination is necessary when a task is too large for a single organisation to undertake. For example, in relation to the provision of health services within a local area it is not possible that a single organisation could undertake all the tasks necessary to address all the health needs of the community. Co-ordination is required because organisations, and indeed the individuals working within them, may have different aims. The goal of co-ordination is the achievement of an aim wider than individual organisations aims:

*'Various agents and agencies can be 'ordered', 'balanced', 'brought into equilibrium', and the like, by the act of co-ordination. Without co-ordination these agents and*

*agencies might all have different and potentially conflicting objectives resulting in chaos and inefficiency.’ (Thompson et al., 1991, p3)*

The issue which is of particular concern in relation to this thesis is how the co-ordination of disparate organisations to achieve a single task is achieved, in an environment in which organisations are subject to incentives that encourage them to compete and co-operate. The models of hierarchies, markets and networks suggest a threefold classification of the way such co-ordination might be achieved. It is also argued that, in practice, the models can be intermixed within a single institutional context, and this issue is discussed at the end of this section.

### ***Hierarchies***

The NHS is fundamentally a hierarchy in which the allocation of resources and delivery of services is co-ordinated by centrally led decision-making. Hierarchies achieve co-ordination through the conscious control of tasks to achieve a predefined objective within a vertical tiered arrangements of subunits. Weber, an influential proponent of hierarchy, argues that bureaucracies (hierarchies within organisations) are the best system for achieving maximum efficiency because they are based on the ‘exercise of control on the basis of knowledge’ (Weber, 1968). The important characteristics of bureaucracy, as identified by Weber, were that officers were appointed on merit, each with an official and clearly defined competence, their performance was monitored by superiors, and their work conducted according to prescribed rules (ibid.). In a hierarchy behaviour is co-ordinated to achieve policy objectives. Members of a hierarchy have low flexibility in their behaviour, they are motivated to act through their employment relationship, concerns of career mobility, and personal advancement (Powell, 1991). Hierarchies purposively construct their own incentives and sanctions, which are used to achieve the co-ordination of activities.

The NHS, before the introduction of the quasi-market (and with the exception of GPs), could be viewed as a single hierarchy. Unlike bureaucracies in the market, which are internally hierarchical and externally subject to co-ordination by market forces, the NHS was co-ordinated solely by hierarchy. Of course in actuality, despite Weber’s vision of rational control of a single purpose in the hierarchy, behaviour within a hierarchy is more complex. A number of criticisms have been levelled at hierarchy. It is thought unable to cope with fluctuations in demand and unforeseen alterations (Powell, 1991). There are criticisms that the incentives of a hierarchy are too weak in the absence of prices (Williamson, 1975). It has

also been suggested that hierarchy is unable to cope with performance evaluation where tasks are unique or ambiguous (Ouchi, 1980). Furthermore, it is suggested that hierarchy is less efficient than spontaneous co-ordination through the market and limits freedoms (von Hayek, 1991). Simon (1957) points out that achieving the alignment of action in hierarchies is complicated as individuals within organisations often have differing perceptions of goals. In his analysis of the NHS hierarchy, Klein notes that in practice decision-making is complicated within the NHS, and the relationship between central government decision-making and the day to day decisions being made may be 'tenuous' (Klein, 1984). Issues affecting organisational decision-making are explored in section 2.6 below.

### ***Markets***

In contrast to the conscious and carefully controlled co-ordination of activity within a hierarchy, co-ordination in the market occurs spontaneously and is driven by the exchange of goods and services between parties for an agreed price (Levacic, 1991). Within the field of economics, competition is commonly seen as a beneficial mechanism which produces the most efficient use of resources, based on the idea that it is the pursuit of self-interest which brings the most benefit to society (Smith, 1999). Competition in a free market (in which competition is unimpeded by interference from government) will therefore lead to the production of the right goods in the right quantity for society. Competition is seen to lead to efficiency: as the producers of goods are incentivised to become internally efficient and make their resources work harder in order to compete in the market, the whole industry as a result becomes more efficient, and producers are again driven to innovate to find ways to use existing resources even more efficiently (Vickers, 1995). This process has benefits for all in terms of the co-ordination of activity. On the consumer side it delivers the products which customers want, for the lowest price possible, and on the producer side the best producers reap the best rewards, and are incentivised to innovate and improve. Co-operation is also incentivised in the market and occurs spontaneously when organisations' self-interest coincides.

### ***Networks***

A significant area of study concerning inter-organisational relationships focuses on networks. Definitions of networks vary, but they are loosely characterised as informal modes of co-ordination (Thompson, 2003) between organisations (Thompson, 2003, 6 et al., 2006), or between organisations and individuals (6 et al., 2006). Networks can be conceptualised as a

third mode of governance, with co-operation mechanisms which differ from the mechanisms of the market (price, transactions, exit) and those of the hierarchy (rules, commands, authority). A key mechanism of co-ordination in networks is trust and co-operation (Thompson et al., 1991). Whereas from an economic perspective market transactions are thought to function best when they are based around anonymous firms who are interchangeable, interactions within networks involve 'counterparts known and specific, rather than being numerous anonymous sellers and buyers' (Dubois, 1998). It is suggested that long term relationships between organisations in networks can lead to co-operative relationships, even between competitors. Richardson suggests that one of the differences of network relationships from others is that network members make plans together in advance to co-ordinate their activities (Richardson, 1972).

Networks can be identified in a wide variety of settings within the context of the NHS, and can serve a variety of purposes. Close working relationships between provider organisations involved in the production of a single service can be classified as network relationships (Ferlie and Pettigrew, 1996). A common distinction is made between mandated and non-mandated networks (e.g. Sheaff et al., 2011). Networks can exist between individuals within a single profession (professional networks), which can be both formally mandated by the NHS hierarchy or can be based on personal relationships, or can exist across organisational boundaries between individuals involved in the co-ordination of a particular service. Networks can also exist at an organisational level, such as formal risk sharing agreements, or agreements to work together to provide a particular service.

### ***Relationship between hierarchies, markets and networks***

Hierarchies, markets and networks are ideal types of co-ordination, and in reality co-ordination can contain elements from more than one model. A common belief in relation to these three modes of co-ordination is that organisations will self-organise to find the most efficient way of conducting business (Williamson, 1996). Clearly this is not always possible within the NHS policy environment in England, where organisations are subject to a mixed environment in which elements of the market have been introduced to the hierarchical structure. In real life these control mechanisms may be combined: the concept of a market/hierarchy dichotomy is thought to be unrealistic (Elsner et al., 2010, Borzel and Risse, 2010), and it is argued that the notion of a continuum of hierarchy through to market, with network in between is not borne out empirically (Exworthy et al., 1999). For example, in addition to the deployment of elements of competition in a hierarchy, markets may also

contain elements of hierarchical co-ordination. Most obviously organisations in markets may be internally hierarchical, however additionally markets themselves may operate in the 'shadow' of hierarchy (Borzel and Risse, 2010), for example regulatory agencies monitor activity in relation to industries such as telecommunications and gambling. Furthermore Stinchcombe (1985) argues that hierarchical co-ordination can be achieved through the use of contracts in the market, which secure manipulable incentive systems, methods of adjusting costs, structures for dispute resolution etc. (ibid.).

Whilst the public sector has been traditionally categorised as a hierarchy, there is an emerging notion put forward by those, such as Osborne (2006), who have developed the notion of New Public Governance (NPG), which suggests that, in the contemporary public sector, the overarching hierarchy contains within it a 'plural state' in which 'multiple inter-dependent actors' develop public services, using network like mechanisms of trust, and negotiation within long standing relationships (ibid.). It is argued that NPG is a response to the complex problems faced by today's public services which exceed the capability of any single entity to resolve, such as failures in public services delivery, the financial crisis, a high level of individualisation, a multiplicity of values (Koppenjan and Koliba, 2013) and the fragmentation of 'siloed' public service provision (Pollitt, 2003). NPG contends therefore that within the state network systems operate in the 'shadow' of the hierarchy. Furthermore, in relation to the NPG model it has been argued that the hierarchy fulfils an important role in the mandating and leadership of the network approach (vander Elst and de Rynck, 2013). Certainly, more parochially, it has been noted in relation to the NHS that hierarchy, market and network mechanisms co-exist, and that the particular mix in existence at a particular place and time is a combination of the policy framework and the local context (Exworthy et al., 1999).

Chapter 3 discusses in more detail the institutional environment in which organisations were operating, including the degree of freedom which existed at a local level at the time of the fieldwork for commissioning organisations to how to deploy incentives, and the local context of the case study is explored in relation to the empirical data in Chapters 5, 6 and 7.

### ***The role of co-operation in competitive situations***

Regardless of the precise mix of incentives impacting on organisational behaviour at the time of the research, it is clear that organisations are subject to an environment in which there

are incentives both to compete and co-operate with each other. This chapter now proceeds to consider the role of co-operation in competitive situations.

When a market is operating under perfect conditions, organisations have no reason to co-operate with each other. A perfect competitive market is one in which organisations are essentially 'atomistic', so small that their actions have no impact on others. In this model there are few interrelationships between organisations, either direct competitors or producers and suppliers, and few reasons for organisations to nurture co-operative relationships with each other. However a perfect market only exists in certain conditions: there should be a large number of producers of the same product, which has a large number of potential purchasers, there should be few barriers to entry to or exit from the market, perfect information about price and quality of products should be available to both buyers and sellers, and there should be no disadvantage for new producers (Wonderling et al., 2005).

Perfect competition is a largely theoretical concept, and it is clear that in reality inter-organisational relationships play an important role in markets. The most common form of market is the oligopoly. In an oligopoly there are a few firms present in the market, which has entry and exit barriers, and the products sold are all slightly differentiated. Oligopolies are characterised by organisations' awareness of their interdependence (Burke et al., 1988). In an oligopoly the behaviour of one organisation will have an impact on the fortunes or position of another, for example a change in output by one organisation such as a change in the quality of their product, will affect the profits of another organisation. Furthermore when in turn the second organisation changes their output in reaction to the drop in business, for instance by dropping their prices, others in the market will in turn be affected and will take action accordingly, and so forth.

These interdependencies give organisations a reason to try to predict the behaviour of others, and brings the possibility of choosing action strategically based on these predictions. When organisations' self interest co-incides this may lead to the identification of reasons to co-operate. For example, Child and Faulkner suggest that strategic alliances between organisations are based on 'the attempt to formulate common goals on the basis of not wholly complementary objectives' (1998, p45). The ways in which organisations may co-operate can be categorised into two groups, horizontal co-operation and vertical co-operation.

### ***Horizontal co-operation***

Horizontal co-operation, or 'competitive interdependence' (Pfeffer and Nowak, 1996), takes place between competing organisations. A common explanation for co-operation between direct competitors is that organisations are motivated by the desire to reduce competition within the market (ibid.). Market competitors may collaborate to agree a common price structure, or work together to limit the interest of others by attempting to prevent the entry of new organisations into the market (Burke et al., 1988). The shared interdependencies of direct competitors may also lead to strategies which consider the long term viability of the market, and avoid actions which risk devaluing the product (Porter, 1985). Strategies must be chosen carefully with regard to the interests of competitors, since if organisations compete directly by pursuing the same strategy in the same market then the outcome may be unprofitable for both.

However, there are other, less defensive, reasons why organisations who directly compete with each other for resources might work together. Evans' study of strategic alliances in the airline industry (2001) suggests organisations might enter alliances with each other for reasons such as risk sharing, economies of scale, and ensuring access to assets, resources and competences. These are examples of situations where co-operation is motivated by a shared reward that the organisation would not be able to achieve alone.

Two main problems are identified in relation to co-operation between direct competitors in markets. The first problem is the inherent instability of co-operative relationships. Coalitions are viewed as problematic due to lack of stability and co-operation carries with it inherent risks of free riding or one partner changing strategy. Secondly, co-operative behaviour may be unwelcome in competitive markets when competition is reduced to an extent that the market no longer functions to bring benefits to the consumer, and/or when the activity of smaller firms is curtailed (Geroski, 2006). Collusive practices are prohibited in the legal structures of many countries. In the UK the Competition Act of 1998 and Articles 81 and 82 of the Treaty on the Functioning of the EU prohibit anticompetitive agreements between businesses, cartels (agreements between businesses not to compete with each other) and abuse of dominant positions in markets (for example charging different prices to different customers) (Office of Fair Trading, 2010).



### ***Vertical co-operation***

Vertical co-operation occurs between organisations which are not in direct competition with each other.

A common concept in vertical co-operation is that of supply chain management. Supply chain management seeks to establish efficiencies through improving the co-ordination of the activities of the organisations involved in the production of a single product (Allen et al., 2009). It can be applicable to a two party relationship, a chain of suppliers or indeed a network of interconnected businesses (Harland, 1996). Whilst market relationships generally entail the premise that producer organisations would continually barter with a variety of suppliers for the best rate, the drive to improve co-ordination means that the relationship between organisations in the chain develops beyond the impersonal or adversarial relationships envisaged in the one off transactions of the perfect market. A number of concepts centre on the development of a long term co-operative relationship between producers and a small number of suppliers, which aim to make efficiency gains through closer working and joint learning in the production and supply process, such 'flexible specialisation' (Sabel, 1994). These are discussed in section 2.6.

### ***Co-operation in the NHS - integration***

Co-operation between competing organisations in markets can take a variety of forms. At one end of the continuum, co-operation is achieved via a merger of two organisations into a single legal entity, or the creation of a joint venture in which two or more organisations form a separate new legal entity, and at the other end of the continuum organisations may choose to co-operate through much looser arrangements such as 'tactical alliances' in which there is no legal basis to the arrangement. In the NHS co-operation is often referred to as integration.

Inter-organisational and inter-professional co-operation is acknowledged as an 'essential behaviour' in the provision of 'seamless and sustainable care' to patients (Department of Health, 2010e, p12). It is often the case that a patient needs to see a number of different professionals to deal with his/her problem in a number of different settings. Patient care can be complex and expensive, and expertise and technical facilities limited. The need for co-operation in health services is often referred to as integration. The term encapsulates a variety of types of co-operation which are differentiated by type, breadth, degree and process (Nolte and McKee, 2008). A broad definition is that integration concerns the co-

ordination of separate but interconnected components which should function together to perform a shared task (Kodner and Spreeuwenberg, 2002). Integration can take place at a service, organisational or clinical level (Fulop et al., 2005). It has also been conceptualised as occurring at macro level (across a whole population), meso level (for a particular patient group) and at micro level (for an individual patient) (Curry and Ham, 2010). It can occur horizontally between people providing similar services, or vertically between different sectors (e.g. primary and secondary care). A range of mechanisms can be used in the attempt to achieve integration, from market led mechanisms involving contract agreements, network arrangements characterised by either formal contract or informal agreements, and top down co-ordination through bureaucracy in a single organisational structure. Examples of integration may therefore include individuals from the same organisation or different organisations working together in teams, networks with or without a single budget focused on a particular service, or organisation-led initiatives from shared financial arrangements to merged organisations (RAND Europe et al., 2010, Lewis et al., 2010). Examples of initiatives to achieve the integration of diabetes services are given in Chapter 5 (Diabetes chapter).

Discussions of integration in health care are complex due to the indistinct use of the term itself, together with a proliferation of alternative or associated terms. Whilst outside the health care sector efforts of separate entities to work together are referred to by terms such as 'co-ordination', 'co-operation' and 'collaboration' (Axelsson and Axelsson, 2006), there are further health sector specific terms such as 'seamless care', 'co-ordinated care', 'managed care' and 'continuity of care' which tend to be used without clarity regarding the underlying concepts or differences between the terms (Nolte and McKee, 2008, MacAdam, 2008). An important distinction exists between the co-ordination of services from the perspective of those providing and planning services, and 'continuity of care' which refers to the patients' experience of the co-ordination of services.

The importance of integration within a health care setting is clear in those areas where care for a particular condition spans organisational and professional boundaries, and is therefore particularly important when considering services for people with chronic illness such as diabetes. However the effectiveness of different forms of integration, and therefore the impact of organisational competition on integration, remains uncertain, and indeed the data gathered for this thesis suggest that factors other than organisational competition have a significant impact on the integration of services. It is thought that the benefits of integrated care can occur as a result of integration at clinical and service level rather than requiring

organisations to integrate (MacAdam, 2008, Curry and Ham, 2010). Indeed, services can be badly co-ordinated within a single organisation (Burns and Pauly, 2002). It is also noted that there are many barriers to successful integration at clinical and service level due to the professional, institutional and legal difficulties which can inhibit collaboration, even between GPs and other doctors practising at different stages of the health care system (Bevan and Janus, 2011). Bringing services together may itself lead to problems of fragmentation, for instance due to changes in job roles or increased workload (MacAdam, 2008), and full integration to create a new service or organisation can itself carry the possibility of creating fragmentation in relation to existing services (Leutz, 1999). Studies have shown that organisational integration does not necessarily lead to more integrated care (King et al., 2001) and indeed there is limited evidence about the outcomes of different types of integration (Ramsay et al., 2009). Many of the studies of integration have focused on the organisational outcomes (Ouwens et al., 2005), and if they have focused on patient benefits have focused on the outcomes of care for the patient, rather than the patient experience of the co-ordination of services (Ramsay et al., 2009). Some exceptions to this are Glasby and Duffy (2007), Carlson et al (2007) and Guthrie et al (2010).

This section has explored the various models of co-ordination which are open to organisations in the NHS and the ways in which co-operation might be secured in the light of incentives for competition. The chapter now considers the relevance of game theory to the thesis.

## **2.5 Game theory**

Game theory is an important approach which informs the analysis of data in this thesis. In particular two approaches, co-opetition (Brandenburger and Nalebuff, 1996) and Ostrom's IAD framework (Ostrom, 2005), are drawn on, not only as they suggest ways competition and co-operation can be dealt with by organisations and individuals in ways which bring benefits for all involved, but also as they provide frameworks for the analysis of the factors influencing behaviour.

Game theory takes a mathematical approach to understanding behaviour in situations in which outcomes depend upon the interaction of players, and success depends on accurately anticipating the choices of others. Game theory uses models which are 'stylised representations of reality' (Cabral, 2000, p49) to highlight universal rules and behaviour. These games have important relevancies for behaviour in the real world. Game theory

envisages each interaction between actors (individuals or organisations) as consisting of players, rules, outcomes (possible actions) and payoffs (the utility of each player). Game theory is useful to the analysis of organisational behaviour in this thesis, as it facilitates an analysis of how organisations strategise. In the thesis, game theoretic approaches will be used as a framework to analyse the environment in which organisations are operating and the rules which apply when they decide how to act.

As a theory based in the concept of rational choice, game theory, at its most traditional, sees players as preference maximisers who have complete information on all options concerning the costs and benefits of possible actions, and act to maximise their preferences. Alternatively, individuals may be seen as having the goal of 'satisficing' rather than maximising within an acceptability threshold when things are 'good enough' (Simon, 1955). Game theory encapsulates the assumption that all players are rational and have a common knowledge of rationality, and that they all understand the rules of the game (Hargreaves Heap and Varoufakis, 1995). It also assumes that payoffs (utility) can be calculated and known by all players. Behaviour therefore depends on payoff and rules. One of the broad philosophical issues arising in game theory is the degree to which players can hold different preferences, for instance different attitudes to risk. One theory is that there are different 'types' of players with different preferences and players need to identify who they are dealing with (ibid.).

It is theoretically possible that in some situations, the strategy a player should pursue is obvious. In these situations a player has a 'strongly dominant' strategy which is better than all other choices, no matter what strategy other players pursue (Ratcliff, 1997). It is rare that this is the case and it is more likely that games with most resonance for organisational behaviour are games in which the interplay of payoffs and responses are more complex, and in which strategy must take into account a prediction of the behaviour of other players. A common game applicable to inter-organisational relationships is 'The Prisoners' Dilemma' (see box), in which there is a conflict between incentives for competition and co-operation. The Prisoners' Dilemma is a non communication game, so although the players know the pay offs they cannot communicate. Although they know the rational strategy is not to confess (i.e. to co-operate with each other) they cannot be sure the other player will act that way, and so act to minimise their potential losses.

### *The Prisoners' Dilemma*

This is a two player game, in which the players are being separately questioned by the police. Each has the option to confess to the crime or to keep silent. If only one player confesses, the other goes to prison for a long time and the 'grass' receives a financial reward. If both confess both go to prison, but for a shorter term. However, if both players keep silent, both go free.

'The Prisoners' Dilemma' illustrates the difficulty in pursuing co-operative behaviour in competitive situations in which players cannot communicate with each other and indicates that competition (pursuit of a strategy to reduce personal losses) will dominate. The problem with this, of course, is that the Prisoners' Dilemma is a situation in which 'pursuit of self interest by each leads to a poor outcome for all' (Axelrod, 1984, p7). The Prisoners' Dilemma is used to describe oligopoly situations where organisations would gain more if they co-operated, but instead compete (Cabral, 2000), for instance it is used to explain the breakdown in price fixing arrangements and joint ventures. The paradox of co-operation is also related to a more general concept of 'social dilemmas'. Social dilemmas result from a situation in which a group has shared usage of a common output, and in which each individual in the group can decide whether to contribute or not. A well known social dilemma is The Tragedy of the Commons (Hardin, 1968) (see box below). There is resonance between common resource problems of the type described in 'The Tragedy of the Commons' and the planning and provision of services in the English NHS. This is explored in relation to Ostrom's IAD framework below.

### *The Tragedy of the Commons*

Herders share a common piece of land, on which they are each permitted to graze their cows. It is in the herders' individual interests to graze as many cows as he can onto the land. However, grazing more cows on the land carries a risk of overgrazing. The herders know that overgrazing has risks for all, but each individual herder will gain more from grazing one individual cow as, if they limit their cows, this would further exacerbate the loss of income resulting from overgrazing.

In reality, 'players' can often communicate with each other, and may be able to use this to enhance the likelihood of co-operation. Context is thought to be important in influencing

behaviour and rather than being 'fixed', ability and/or willingness to co-operate may be affected by a number of factors. Experiments by game theorists have led to a number of proposed factors which may increase the likelihood of co-operative behaviour and encourage it to persist.

Firstly, it is thought that co-operative behaviour is influenced by the number of times the interaction between parties is to be repeated (Axelrod, 1984). In repeated games the interaction is different because there is the opportunity to reward or punish your opponent for past behaviour and players can also build reputations (Hargreaves Heap and Varoufakis, 1995). In relation to repeated Prisoners' Dilemma games, it has been noted that players learn to trust each other, and co-operate (Burke et al., 1988). Players in games can have an 'evolving co-operative history' which may change the relationship to make them more likely to co-operate (Parkhe, 1993), and it is also thought that, if interactions and the pay offs from co-operation are frequent, co-operation will be promoted (Axelrod, 1984). Parkhe hypothesises that in relation to organisational alliances the 'shadow of the future' has more impact the more the firms are intertwined (Parkhe, 1993). However repeated games do not necessarily result in co-operation, and it is possible that competitive relationships may also be strengthened by repetition (Hargreaves Heap and Varoufakis, 1995).

Secondly, whilst game theory assumes that all actors are rational and will act to maximise their utility, it can be argued that actors are subject to micro and macro motivations. It is possible there are different types of players who have different preferences, and that some players may be more pre-disposed to certain behaviours. One suggestion is that players can be divided between straightforward maximisers and constrained maximisers (Gauthier, 1986). Whilst the straightforward maximiser acts to maximise based on self interest at all times, the constrained maximiser will co-operate if they expect others to do so. Therefore it is possible that 'contingent co-operation' may occur in which a player will co-operate based on their assessment of the other player. Furthermore it has been suggested that when players communicate face-to-face they often agree strategies and honour their agreements (Ostrom, 2010). In addition to these micro motivations, macro motivations may also impact on players' behaviour. Macro motivations for co-operation consist of value systems or incentives, for instance, contracts and sanctions may change the Prisoners' Dilemma game (Williams, 1988). Game theory experiments have found that external regulation discourages voluntary co-operation (Frey and Oberholzer-Gee, 1997, Reeson and Tisdell, 2008). The size of pay offs to players is also likely to have an impact on behaviour (Parkhe, 1993).

There are clear limitations to the use of game theory to analyse the behaviour of NHS organisations. A key limitation relates to the concept of rationality and the emergence of uncertainty. In the real world it is often not feasible to make the assumption that all players have access to the same information. When considering an environment as complex as that in which NHS organisations function, it is possible that parties will not have the same information, or complete knowledge about the strategies of each other or indeed be clear about the potential rewards or costs of the actions open to them. For example it is feasible that organisations in the NHS, and indeed the various professionals working within them, may have different motives, beliefs, communication options and payoffs. The utility may also differ, for example in the context of the planning and provision of NHS services, utility may relate to the income the provision of services may generate, or it may relate to service quality. When this type of information is unknown it is very difficult for players to predict how other players will act. It is also unlikely that the outcome of real life interactions such as those in the NHS will be easily translated into a win/lose dichotomy. These difficulties explain the propensity to use game theory in an organisational context in a normative way to tell organisations how they should analyse situations in order to achieve competitive success rather than to examine behaviour.

In spite of the inconsistencies apparent when applying game theory in its entirety to NHS organisational behaviour, some broad generalities relating to behaviour in competitive situations may be illuminating. Firstly, the literature suggests that players tend to engage in either competitive or co-operative behaviour within a game. This suggests that combining co-operation and competitive behaviour within the same 'game' between the same players may be problematic. In relation to a consideration of NHS organisations' decisions in the contemporaneous climate it suggests that mixing behaviours would be difficult unless activities were divided into clearly separate games. Secondly it is likely that context plays a role in affecting behaviour. The main contextual factors affecting behaviour are previous organisational interactions, the expectation of ongoing future interaction, notions of the 'type' of the other player, governance structures and the size of the payoff.

### ***Alternative approaches based in game theory***

There are two frameworks (co-opetition and Ostrom's IAD framework) which apply game theory to behaviour in a more flexible and context specific way. Both theories are concerned with moving away from win/lose scenarios to finding solutions which can benefit a number of players. These frameworks are used to aid in the analysis of organisations and professional

behaviour in the case study. Neither framework represents a complete fit with the rules and behaviour which were observed in the case study, however, as will be seen, the general approaches of both frameworks are very illuminating when considered in relation to the behaviour observed in the case study and the local institutional context.

### Co-opetition

In contrast with the learning from game theory, the theory of 'co-opetition' (an interpretation of game theory from the perspective of organisational strategy) suggests that organisations can compete and co-operate simultaneously to mutual benefit (Brandenburger and Nalebuff, 1996). The approach has been most clearly defined by Brandenburger and Nalebuff, although subsequently co-opetition has been developed and investigated empirically by a number of others (e.g. Bengtsson and Kock, 2000, Padula and Battista Dagnino, 2007). A central concept of co-opetition is that competition does not necessarily have detrimental side effects, and that co-operation is not always positive for all those involved (Barretta, 2008). Brandenburger and Nalebuff suggest that rather than aiming to do better than their competitor at all times (as is assumed in conventional game theory approaches) organisations would benefit from tailoring their strategies to co-operate with each other in order to increase the size of the market ('value creation') and then to compete with each other to secure their share of the improved market ('capturing value'). Whilst it is not appropriate to talk about increasing the size of the market in terms of the provision of NHS healthcare as the budget for health care is fixed at the point at which organisations are planning and providing services, it has been suggested that the equivalent benefits would be gained through making the existing budget work more effectively (Goddard and Mannion, 1998), through increasing innovative practice, or reducing the cost of organisational inter-relationships.

The co-opetition approach envisages organisations operating in a much more complex environment than that of games which result in clear win/lose binaries. A fundamental belief is that the pursuit of win/lose strategies is often counterproductive in a business environment, as tactics which result in a short-term gain at the expense of a competitor may result in a retaliatory strike, turning interactions into lose/lose outcomes. An example of this process is an initial undercutting of price by one firm, which escalates into a price war, damaging the profits of all parties. Co-opetition suggests that to be successful, organisations should be more flexible about their decisions to compete, and more open to co-operating with competitors when it is mutually beneficial. Whilst game theory indicates that it is



difficult to combine competitive and co-operative actions between the same players within a single game, co-opetition suggests that it is possible to combine the two approaches to mutual advantage, and focuses on the interplay between the two strategies (Bengtsson and Kock, 2000).

Co-opetition suggests organisations explore ways of avoiding direct competition. Brandenburger and Nalebuff recommend that organisations identify strategies which will add value to their own product without detracting from those of others. In an ideal world organisations would be able to identify 'trade-ons' which are ways to both improve quality and cut cost. Whilst imitation of strategies or products by competitors is commonly seen as detrimental, the co-opetition approach suggests that imitation can be a neutral act, or can even help the industry as a whole. For instance it is argued that airline loyalty schemes are of benefit to all parties, and the adoption of loyalty schemes across the airlines was not to the detriment of the company which first introduced them (Brandenburger and Nalebuff, 1996).

Brandenburger and Nalebuff suggest business situations should be conceptualised by organisations as a Value Net, consisting of four groups of players: customers, suppliers, competitors and complementors. The element within the Value Net which is of particular interest is the complementors. A complement to a product or service is described as 'any other product or service that makes the first one more attractive' (Brandenburger and Nalebuff, 1996, p12), either to customers or suppliers. Complements are an important tool in making the pie bigger ('value creation'), and should be identified by organisations and partnerships built accordingly. Complementors have an oppositional relationship with competitors, as competitors are products and services that make your own less attractive. An example of complementarity in the health sector is the relationship between drug companies and GPs. GPs do not buy drugs directly, but their prescribing decisions can create affiliations with specific branded drugs. Reciprocal complementarity encapsulates the win/win possibilities of relationships. It is of course possible for players to have multiple roles in the Value Net, and can therefore occupy both the competitor and complementor role in relation to different aspects of their functions.

#### Differences between game theory and co-opetition

There are important differences between conventional game theory and co-opetition. These concern the rationality of players, the 'fixed' nature of the game and the impact of players

on the game itself. In the co-opetition approach organisations are envisaged as having differing perceptions of the same situation, and differing levels of astuteness. Although games in conventional game theory tend to be envisaged as hermetically sealed, co-opetition sees business as essentially one large game, in which actions have many potential repercussions. Indeed, organisations are encouraged to analyse how their entry to a particular game will change it, by quantifying their 'added value'. Instead of being purely motivated by profit within a clearly defined game, organisations are motivated by many concerns including long term relationships, interpersonal relationships, emotional responses, and will make decisions taking a wide range of factors from dispersed situations into account. Relationships are a part of added value, particularly relationships with customers and suppliers. Therefore, rather than being pre-existing, games are defined through the perceptions of players

Importantly, organisations can alter games to their advantage. Unlike game theory where the rules are fixed, rules within the co-opetition framework are seen as having more flexibility. Rules can be provided by law, custom or contract. Brandenburger and Nalebuff are interested in the influence players can have over contract rules, seeing the other two aspects as fixed. Contract rules offer the opportunity for players to define the game in their favour, and to steer away from win/lose situations. For instance a supplier organisation may wish to instigate a 'meet the competition' clause with a buyer, whereby they are given the option to match any lower contract price which is offered by a competitor.

An area not examined in detail by Brandenburger and Nalebuff, but addressed by others who conduct empirical studies of co-opetition, is how inter-organisational relationships are managed when co-operation and competition occur between the same organisations. A number of studies examine co-opetition (e.g Bengtsson and Kock's (2000) study of brewery, lining and dairy industries in Sweden and Finland, Mariani's (2007) study of opera houses, Bonel and Rocco's (2007) study of a drinks firm), and there are two studies of co-opetition in health care settings (Barretta, 2008, Peng and Bourne, 2009). These studies examine the way competitive and co-operative interchanges between organisations may be separated, for instance by proximity to customer, organisational department and the uniqueness of resources (Bengtsson and Kock, 2000), and by the role regulatory bodies can play in introducing co-operation into competitive situations (Mariani, 2007). Those studies conducted in health care have explored similar issues. Barretta's study of co-opetition between health care trusts in Italy (Barretta, 2008) found that competitive and co-operative

behaviours were managed in organisations through splitting roles between managers and clinicians. Peng and Bourne's study of healthcare in Taiwan found that competitive and co-operative relationships were split depending on the complementarity of resources and when the field of competition was clearly separated from that of co-operation (Peng and Bourne, 2009).

#### Institutional Analysis and Development (IAD) Framework

A similarly context dependent approach is advocated by Ostrom. Using a game theoretical approach, Ostrom has also developed a framework to analyse the rules in place and being used by actors in social situations in relation to deciding whether to compete or co-operate with other actors (Ostrom, 2005). Whilst co-opetition focuses on an organisational setting, Ostrom is concerned with common pool resource problems in any setting, specifically how to encourage co-operation between participants in situations where there is a limited common resource. It is traditionally seen that there are two possible solutions to common resource problems. Firstly to treat the common pool resource as a private good, or secondly to introduce government regulation. However Ostrom suggests that individuals can self-organise to solve collective problems, without direct control by the government, and can establish and enforce rules limiting the appropriation of common pool resources. The framework identifies the principles, rules and characteristics which are shared by systems that successfully self manage. Indeed through her extensive research and examination of case studies Ostrom believes that self managed systems can perform better than government managed systems (Crawford and Ostrom, 1995, Ostrom, 2010).

The most common application of this framework is to situations where there is a limited physical resource to be shared, for example the framework has been used in studies of irrigation systems (Benjamin et al., 1994) and forest governance (Gibson et al., 2000). However there are some similarities between common resource problems and the allocation of the resources to support the planning and provision of services in local health economies in the English NHS. Local NHS commissioners have fixed annual budgets to be used for the provision of health services to the local population. These budgets, unlike the natural resources generally referred to in common resource problems, are limited and finite, and of course are not a renewable resource at risk from overgrazing. However there is an argument about using the resource (the local NHS budget) in the 'right' or most efficient way. If used wisely across the health community, and if organisations co-ordinate their activities, then resources will go further, will be used more efficiently, and savings in one area can be spent

in another. If organisations all took their individual maximum, especially in the light of incentives such as Payment by Results (PbR) (the national tariff payment for activity) and Any Qualified Provider (AQP) (an initiative whereby any registered provider may offer a service at tariff), they would not be willing to help with the development of pathways which took activity away from themselves, although these pathways might be most efficient for the health community as a whole. Eventually as a result of this, there may occur general degradation, akin to overgrazing, in services in the area due to the development of a commissioner deficit or because resources are not being distributed in an efficient way.

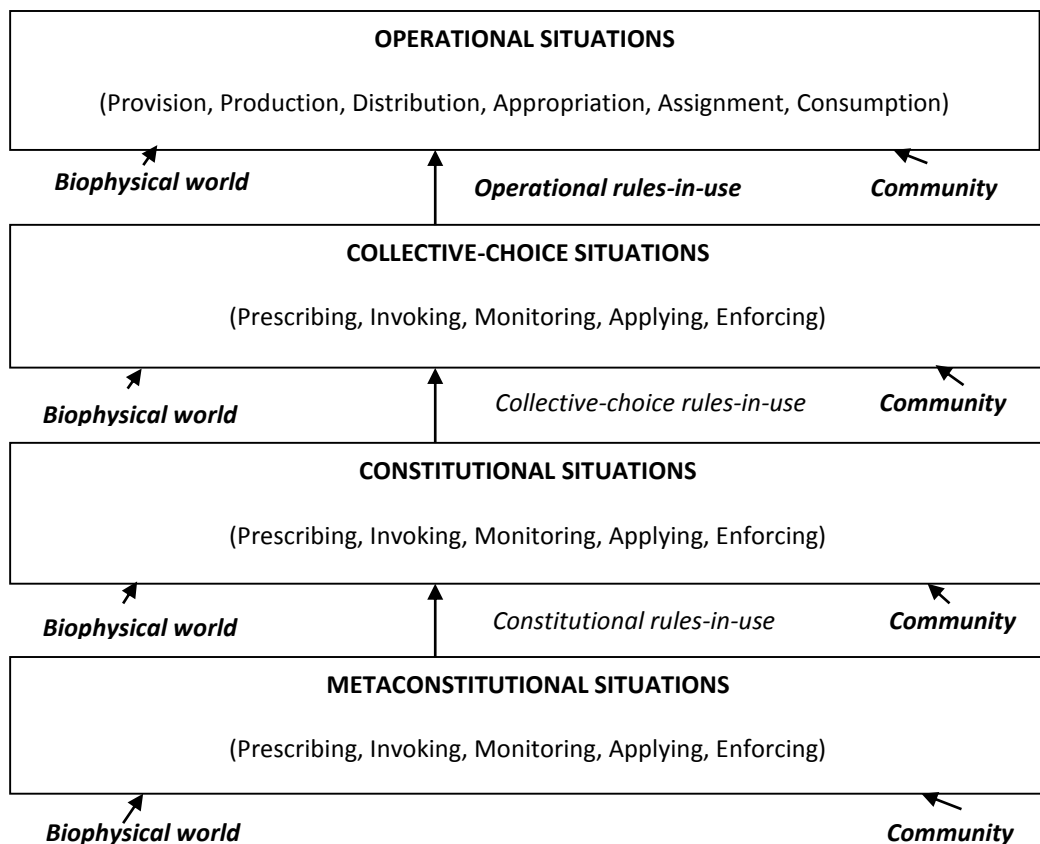
The approach used by Ostrom is broadly based on game theory and, like co-opetition, seeks to identify the components of the game (here termed the 'action arena') by distinguishing between players (either individual or composite actors) who hold positions and, who, within each game, have possible actions, differing levels of knowledge and differing perceptions of costs and benefits. In Ostrom's framework behaviour can be affected by a wide variety of factors. Like co-opetition, the IAD framework takes account of exogenous variables, such as material conditions and attributes of communities. A key element of the variables identified in the IAD framework is the rules governing behaviour. Like co-opetition, Ostrom's framework sees rules and games as being created and controlled by participants.

Whilst the IAD framework shares many similarities with co-opetition, there are two areas of difference which I wish to highlight. Firstly, the nature of rules in the IAD framework is different. In co-opetition, behaviour within games is subject to laws, customs and contracts, and contracts are seen as an important site of negotiation between players, allowing the 'rules of the game' to be altered. The rules of interest within co-opetition are identified as contracts. However, within the IAD framework, there is a much wider interest in all the rules which actors perceive to be governing behaviour. Rules are socially situated and may differ from player to player. Rules may not be clear to all, they may be understood differently by different participants and may not be followed. Ostrom defines rules as understandings which are held by participants about actions or outcomes which are required, prohibited or permitted (Ostrom, 2005). Rules depend both on enforcement and on the participants' views of their appropriateness. For written laws and procedures to operate as rules (defined as 'rules-in-use' as opposed to 'rules-in-form') they need to be understood and acknowledged by those they govern and those who monitor them. In addition to distinguishing between rules-in-form and rules-in-use, Ostrom makes a distinction between 'rules' which state that participants are obliged to act in certain circumstances or incur a penalty, 'norms' which

incur no institutionally assigned penalties, and ‘strategies’ which incur no institutionally assigned penalties and no necessity of action.

Secondly, the IAD framework has a focus upon a community. Whereas contracts tend to be envisaged as rules agreed between two parties, Ostrom is interested in rules that are agreed across and by a community, including norms of behaviour. Attention is drawn to the wider institutional environment in which interactions take place, and the role institutions have in encouraging co-operation among community members. Ostrom’s framework takes a hierarchical approach and distinguishes between four levels of analysis, ranging from operational situations to metaconstitutional situations involving regional and national structures in which each level decides the rules of the next level (see Figure 2.1). The way the rules are enacted in each level is influenced by the local context, or as Ostrom terms it, the ‘biophysical world’, and the ‘community’. In particular the framework can be used to identify the way institutions can help or hinder ‘innovation, learning, adapting, trustworthiness, levels of co-operation of participants, and the achievement of more effective, equitable and sustainable outcomes at multiple scales’ (Ostrom, 2010, p25).

**Figure 2.1: Levels of analysis (Source: Ostrom 2005, p59)**



Both co-opetition and the IAD framework suggest possible ways to think about real world interactions between organisations that are much more complex than formal games would suggest. Both suggest that co-operation in competitive situations is possible and valuable, and look at the context in which it should be encouraged. The value of both of these frameworks for my thesis is that they offer ways of analysing competitive and co-operative behaviour, in the light of the possible benefits that such a combination might bring. Chapter 4 (Research Methods) describes how these frameworks were used to aid the analysis of data.

## **2.6 Theories of organisational and professional behaviour**

The remainder of the theoretical literature which will be considered in relation to this research is concerned with describing the various approaches which can be used to explain organisational strategy when interacting with other organisations. These approaches will be considered in three groupings: economic approaches to organisational behaviour, economic sociology, and organisational decision-making.

### ***Economic approaches to organisational behaviour***

Firstly, the relevance of economic approaches to organisational inter-relationships will be considered. The transaction cost approach within the school of New Institutional Economics is concerned with the rules and play of the game as established through the institutional environment and the governance structures in operation (Williamson, 1996).

#### Transaction costs

Like Game Theory, New Institutional Economics focuses on the rules and the play of the game, but is specifically concerned with the institutional environment in which the game occurs. Transaction cost analysis is concerned with the costs of conducting organisational relationships. Transaction costs can consist of the cost of bargaining to reach an acceptable agreement between two parties and drawing up and monitoring a contract, or the cost of managing the internal production of a good. Fundamental to this approach is the assumption that the primary objective of the organisation when dealing with inter-organisational relationships is to minimise the costs of transactions in order to maximise profits. Williamson suggests that institutional arrangements evolve in a way which will achieve this, and therefore an analysis of transaction costs allows organisations to identify their most efficient strategy when dealing with other organisations (Williamson, 1985). This has been traditionally imagined as a 'make-or-buy' decision, in which organisations decide whether it is more efficient to provide something themselves or purchase it through the market. This

framework can be extended to a 'make-or-co-operate' decision in which the relative cost of inter-organisational co-operative relationships is also evaluated (Kogut et al., 1992).

Transaction cost analysis encapsulates two important assumptions about behaviour. Firstly, transaction cost analysis encapsulates the notion of 'bounded rationality', which refers to the limits of the capacity of individuals to process information when they are making decisions. Secondly, opportunism, defined by Williamson as 'self interest seeking with guile' (Williamson, 1975) relates to the possibility that individuals will take advantage of circumstances, such as a lack of knowledge in the other party, in order dishonestly to improve their position.

Transaction cost analysis states that the costs of transactions are affected by three characteristics. These are the frequency with which the transaction occurs, uncertainty which relates to the difficulty of predicting all eventualities or possible problems which might occur during the exchange, and asset specificity which refers to whether the assets being used in the transaction can be redeployed. Taken together these transaction characteristics and behavioural assumptions may suggest how organisations should behave in relation to the transaction.

A consideration of transaction costs in relation to the NHS suggests that the cost of organisation through the market may be high (e.g. Roberts, 1993). Health care tends to encapsulate a number of factors such as physical asset specificity (e.g. expensive equipment which is used for very particular purposes) and human asset specificity (e.g. consultant expertise) which require the agreement of compensatory arrangements between the principal (buyer) and agent (provider) should the transaction not complete (Goddard and Mannion, 1998). It might be expected that the level of specialist knowledge required and the uniqueness of resources would lead to bargaining in which there were potentially very few or indeed only one buyer or seller. In order to avoid opportunism in this case, a much more detailed or costly contract would need to be in place.

A further factor increasing the contract complexity, and therefore cost, required to secure co-operation through a contract, relates to the nature of the principal-agent relationship. The high level of expertise and specialisation in the delivery of health services makes it difficult for the principal to know that the agent is fulfilling the terms of the contract. It is possible that due to 'information impactedness' (Williamson, 1975) where one party, in this case the agent, has more technical knowledge, opportunism may occur. An example of this

occurrence in the English NHS is the suggestion that Foundation Trusts are lowering the threshold for NHS treatment for profitable procedures (HSJ, 2005).

It is possible that, in some instances, high transaction costs may be mitigated by the frequency of transactions between NHS organisations. Due to the high entry barriers there is likely to be dense relationships between a limited number of organisations, and rather than being part of a one off transaction, relationships and agreements in the NHS may be ongoing, or part of wider agreements. It may be that organisations are willing to accept higher transactions costs in the light of other transactions already in existence (Tsang, 2000).

If transaction costs are a key factor in NHS organisations' decisions whether to co-operate or compete we would expect, when faced with high transaction costs, that organisations choose not to conduct business through market mechanisms. The first alternative open to them would be to provide services within the boundaries of their own organisation, however, this is not always a feasible option due to the similarly high expense of taking on the provision of new services. The second alternative is to rely on relational contracts (Macneil, 1978, Williamson, 1985). In place of the discrete nature of the complete contract, which is characterised as impersonal, written, specified and measurable, relational contracts are not discrete – they are untransferable, informal arrangements, which are subject to ongoing planning and adjustments (Allen, 2002). Relational contracts may be better viewed as 'relationships over time' (Allen, 2002) similar to a network relationship. The management of risk, which would normally be provided by the contract, is replaced by mechanisms of trust and co-operation. A full discussion of trust and networks in relation to organisational relationships is given below.

There is a number of reasons why adopting a transaction cost approach in isolation may not be a sufficient framework for understanding organisations decisions whether to compete and co-operate.

Transaction costs are based around the idea of organisations organically finding the most effective solution themselves, but health care organisations in the NHS are subject to central control and therefore may not be free to adopt what they consider the most efficient solution (Allen, 2002, Petsoulas et al., 2010, Hughes et al., 2013). In the NHS environment at the time of the fieldwork for example PCTs were required to create an internal separation of their operational provider services, and agree service level agreements for these, based on the same business and financial rules as applied to all other providers (Department of Health,



2007a, Department of Health, 2008a). Furthermore, it can be argued that the norms of behaviour assumed in the transaction cost framework are weakened in the NHS setting. Goddard and Mannion note that whilst the high degree of asset specificity provides scope for opportunistic behaviour, other shared objectives may override the competitive impulse:

*'In the context of the NHS it is not clear that purchasers and providers would necessarily seek to behave in such a way, as they may have some shared objectives relating to achieving maximum health gain, which lead them into co-operative agreements'* (Goddard and Mannion, 1998, p109).

It is possible to criticise economic approaches to inter-organisational relationships for ignoring both the social context of economic interactions and the way in which organisations themselves can affect behaviour. These issues are addressed below in relation to the analysis of theories based in economic sociology.

### ***Approaches related to economic sociology***

This section considers the impact that relationships have on organisations' decisions to compete or co-operate. Explanations of behaviour based in economic sociology suggest that individuals' decisions to co-operate or compete are not based solely on rational economic choices, but may be rational choices based on social structure. Ouchi proposes that transactions between organisations are rarely, if ever, governed completely by the market due to the impossibility of complete information and are 'supplemented' through cultural mechanisms (Ouchi, 1980). Viewed from this perspective, economic approaches are undersocialised conceptions of human action, which pay insufficient attention to the social structure of behaviour. Individuals are embedded in networks of interpersonal relationships and have goals other than economic goals, such as sociability, and gaining and preserving approval and status. Economic sociology focuses on the sustainability of long term social ties which lead to co-operation which may not be in direct economic interests (Uzzi, 1997).

### **Resource based approaches**

Resource based approaches are concerned with decision-making in the light of organisational resources. Resource based approaches have not previously been widely applied to organisational inter-relationships in health systems (Ferlie et al., 2012), but appear to be a relevant approach to aid understanding of organisational strategy in competitive situations. The basis of the resource based approach is that an organisation can be

understood as a collection of assets, which is protected or mobilised in order to gain competitive advantage (Penrose, 1959, Wernerfelt, 1984). The resource based view of organisational decision-making can be seen as an alternative approach to transaction costs. Whilst the basis of the transaction cost argument is that behaviour is decided based on cost minimisation in order to achieve profit maximisation, the extent to which efficiency is the overriding objective in health care organisations is questionable. In the resource based model of decision-making the emphasis moves from the cost minimisation approach of transaction cost analysis, to a consideration of decision-making in the light of organisational resources. The driver for behaviour is value creation rather than cost minimisation, and it can be characterised as an approach which is more focused on possible gains of transacting with other organisations (Tsang, 2000).

The central notion of the resource based view is that organisations make decisions about action based on the resources they have, and the resources of the other party. This includes physical assets, but also skills such as management expertise and other intangible resources such as brand names, reputation or knowledge (Barney, 1991). An organisation would be in a strong competitive position if they had a resource that was difficult for competitors to create for themselves, due to the time and effort which would need to be expended to gain them, and the prerequisite learning which would be required (Gereffi et al., 2005).

It seems very pertinent to consider this approach in relation to the NHS where some assets are knowledge based and difficult to transfer. If both organisations have high cost assets which are complementary in nature they may co-operate for mutual gain rather than choosing to compete.

### Networks and clans

Networks and clans are key concepts within economic sociology. Both focus on the power of social ties to ease economic relations. A key account of this phenomenon is made by Uzzi (1997) who, in his study of dress firms in New York, illustrates that long term co-operative ties between buyers and sellers form more mutually beneficial economic arrangements than those of the market. Uzzi identifies three factors which give social ties superiority over market relationships. Firstly, relationships are built on trust between 'business friends' which result in 'favours', allowing access to rare resources. Secondly, fine grained information transfer based on experience means that there is better quality information available. Thirdly, friendship encourages organisations to go the extra mile in problem solving.

However, Uzzi does not account for situations in which these organisations will be competitors and will need to collaborate. Indeed Uzzi suggests that if strong ties are violated there is a risk of feuds developing.

A connected concept is Ouchi's notion of the clan. Clans are defined as groups with 'organic solidity' which is based on shared objectives due to dependence on each other (Ouchi, 1980). Clans are formed within occupational groups, and may or may not be based in organisations. Ouchi suggests that where transaction costs for market transactions or bureaucratic administration would be high (for instance where performance is difficult to monitor) then a clan is the most appropriate form of co-ordination. Clans operate where there is high performance ambiguity, but where individuals share similar goals. Clan members co-operate because they believe their interests are best served by the interests of the clan, rather than due to contractual obligations or monitoring. Relationships in the NHS have been related to clan culture because of the assumption of goal congruence associated with putting patient values ahead of personal gain (Burke and Goddard, 1990). Whilst in Ouchi's model there is an assumption that the clan is synonymous with the organisation, in the NHS the clan is often associated with the collegial structure of the medical profession (Bourn and Ezzamel, 1986), and links are conceptualised between professional groups rather than between organisations. An associated concept is that of the community of practice. Communities of practice are based around an interest or particular profession, and are associated with mutual learning (Wenger, 2000). Communities of practice can be relational (for example based around a group of organisations or a professional group) or geographically organised. Ferlie et al (2005) found uni-professional communities of practice tended to exist in the NHS context.

### Supply chain relationships

Supply chain relationships are a key mode of organisational co-operation. However, the applicability of supply chain theory to health care is contentious. A supply chain is defined as a network of 'connected and interdependent organisations mutually and co-operatively working together to control, manage, and improve the flow of materials and information from suppliers to end users' (Christopher, 2005, p6). A close concept is that of the value stream, which focuses on the processes involved in the production of a single product for a customer (Childerhouse and Towill, 2006). Whilst much of the analysis of supply chain

performance has focused on industrial dynamics and logistics concerning the physical supply chain, such as inventory management and distribution, supply chain approaches have more recently been extended to outsourcing, management of collaboration and innovation and market management (Allen et al., 2009) and relationships in supply chains (Harland, 1996).

A few attempts have been made to look at the transferability of supply chain literature to the NHS. Allen et al (2009) examine what can be learnt in the NHS from commercial procurement and supply chain management about how to handle reliance on others in a competitive situation. They urge caution when considering the applicability of supply chain learning to the commissioning and provision of services in the NHS due to the differences between the purchasing of commodities and the provision of NHS services, arguing that NHS services are generally of a higher order, with added responsibilities of public duty, and professional-led day to day decisions regarding the use of resources. A similar note of caution is sounded by Keen et al (2006), who point out that there are difficulties applying supply chain analysis in situations where there is 'task uncertainty' where care providers are often not aware of 'the totality of care processes'. This idea appears particularly applicable to long term conditions such as diabetes where there is no single pathway for patients. A further concern is that the concept of value is problematic in relation to health care, as the value added from a patient perspective may be inefficient from a health care provider perspective (Keen et al., 2006, Kahan and Testa, 2008).

A different view is taken by Sanderson et al (2015) who, in their review of the relevance of procurement and supply chain management literature to the NHS, reject the argument for NHS 'exceptionalism' arguing that that the oft cited complicating factors of 'multiple stakeholder involvement, political sensitivities, path dependencies, technical complexities, policy and legal/regulatory constraints, imbalanced commissioning/provider relationships' (p93) are features which are also seen in other industries. In reaching this view of the relevance of the literature to the NHS however the reviewers take a much wider range of disciplinary bases and theories into account in their study, many of which do have an undisputed general applicability to many settings, such as transaction cost economics, resource dependency theory and organisation decision-making theory.

#### Flexible Specialisation and Industrial Districts

A theory associated with supply chain relationships which Keen et al (2006) found to be transferable to an NHS setting is Sabel's notion of flexible specialisation (1994). Flexible

specialisation is based on production of custom made or craft goods rather than mass-produced products, by means of multi-purpose technology and flexible production by skilled workers. As Keen et al (2006) point out, flexible specialisation seems more suited to areas where there is uncertainty in the production process, for instance in the case of a diabetes patient it is not clear at the start of the care process what care will need to be delivered and by whom in the course of his or her care. The key elements of flexible specialisation are the existence of multi-purpose equipment, clusters of small firms, collaboration and interaction between those firms and collective efficiency (van Dijk, 1994). A closely related concept is that of the industrial district. Industrial districts are production systems based in a geographical area in which large numbers of small firms are engaged in the production of a single type of product, and are proposed as the type of environment in which flexible specialisation can occur (Amin and Robins, 1992).

Both the concepts of flexible specialisation and industrial districts suggest that co-operative activity in a frame of long standing ties within producer/supplier relationships can be beneficial for an organisation's performance. This model is an example of how the intrusion of co-operative actions in the competitive environment can lead to innovations and competitive success, through the exchange of tacit knowledge which cannot be traded on the market. It is a model of how co-operation can be achieved without 'formal' integration and in which co-operation and competition seem to coexist (van Dijk, 1994). For instance, in industrial districts it has been observed that competing producers visit each other's shops and discuss problems, communicating beyond the price structure and workers commonly tend to move between organisations (Piore, 1992). Whilst being in competition with each other the firms do not follow strict competitive behaviour, for instance by resisting cutting wages in order to create local stability (Becattini, 1992). The theory of the industrial district seems to suggest that organisations decide whether to compete or co-operate with each other because of their shared interdependencies relating to the industry as a whole and the community they share.

The concepts of industrial districts and flexible specialisation have clear resonance with inter-organisational relationships in the English NHS. Competitive markets within the English NHS resemble the geographically limited nature of industrial districts as NHS provider competition is geographically bounded due to the limitations of patient travel time (Propper et al., 2005). Furthermore the craft production described in flexible specialisation shares

similarities with the need to produce individualised care for patients in health services. Therefore it is possible that, as described in industrial districts and flexible specialisation, co-operation and competition in relation to NHS services can have a coexistence that does not necessarily disrupt each other. However it is not clear how transferable these ideas are to the NHS setting, for example whether the behaviour observed in industrial districts can translate beyond settings in which the industry in question is almost the sole industry for the local workforce.

### Trust

Trust is seen to have many benefits, but trust may be threatened by the intrusion of competition, potentially negatively impacting on the benefits which can be accrued. As discussed in relation to transaction costs, trust is an effective mechanism for cost minimisation, offering an alternative to another form of assurance such as monitoring. Trust is a fundamental element governing relationships within economic sociological models of behaviour, and is important in network relationships. However trust is also seen to have wider benefits. It has also been claimed that trust can improve organisational performance through improved information exchange (Fukuyama, 1995). Lane outlines a number of possible benefits assigned to trust: information is of better quality, including information that would otherwise be considered confidential, and increased openness encourages further collaboration which leads to increases in quality (Lane, 1998). Therefore trust enables co-operation, but also makes organisations more fit for competition. The opposite of trust, distrust, is assumed to have a negative impact, especially on interorganisational co-operation, as the partner is 'relieved of moral obligations and free to act in her own interest' (ibid., p24). However it should also be noted that trust is not a panacea. Too much trust between organisations carries the same risks as too much co-operation. Trust may not always be in consumers' interests as it can lead to anti-competitive practices, as Seal and Vincent-Jones point out:

*'Generally, the positive image of trust that emerges from the literature is based in a tacit assumption that trusting relationships are somehow welfare enhancing. Less obvious are the negative aspects of trust – trust between members of self-serving elites which may flourish in bureaucracies whether they are located in town halls or communist parties.'* (Seal and Vincent-Jones, 1997, p406).

Whilst there are many differing explanations of the functioning of trust, it is common to make a distinction between calculative trust and value-based trust. Calculative trust is trust that emanates from a calculation of the risks and likelihood of defection from agreement, and is therefore a rational decision-making model of trust. Value based conceptions of trust are less rationally based. Trust for Sako relates to a predictability of behaviour. She distinguishes between three types of trust: contractual trust, competence trust or good-will trust (Sako, 1998). Contractual trust is a rational model of trust and exists when governance mechanisms stop opportunism, and when parties have faith in these mechanisms. Competence trust occurs when a party believes that the other is capable of performing their role. Good-will trust is defined as the confidence a party has in the commitment of the other party to continuing the co-operative relationship. These three types of trust are commonly envisaged as a hierarchy in which the first two are necessary for exchange to take place, and the third enhances the quality of the exchange.

A number of issues arise from a consideration of trust in the light of co-operation between competitors. Firstly there is a general question relating to the quality of trust when organisations are both competing and co-operating with each other. It has been noted that paradoxically in situations such as strategic alliances, where organisations need to agree action based on common goals while having different overall objectives, trust is needed to stabilise the relationship but is also threatened by the inherent instability of the relationship between the two parties (Child, 1998). Many academics write about the factors and circumstances which develop or increase trust. Trust is produced and strengthened by action (Sydow, 1998). Gambetta identified certain situations in which one might expect more trust to exist: where there is familiarity through repeated interactions, when it is not considered to be in the interest of the other party to act opportunistically, and where there are coinciding values and norms (Gambetta, 1988). Vincent-Jones notes that trust and co-operation are impeded by 'adversarial or 'hard' contract relations which may be associated with organisations' relationships in a competitive environment (Vincent-Jones, 2006). Whilst some of the difficulties envisaged for sustaining trust between organisations may be reduced in an NHS setting due to the degree of standardisation across the NHS (e.g. shared clinical standards, ethical guidelines etc.) and due to a shared ethos and values, it is not clear what the impact of a combination of competitive and co-operative behaviours may be.

In relation to Sako's three part framework, contractual and competence trust would be unaffected by a combination of competition and co-operation between the same parties,

but it might be expected that good-will trust, as it relates to faith in the continuation of the co-operative relationship, would not be in existence. As it is this type of trust which relates primarily to the quality of the relationship especially the development of new ideas, it may be, in relation to a combination of competitive and co-operative behaviour, that co-operation still takes place but that the quality of the information sharing and the performance improvement possibilities are impaired.

When considering inter-organisational trust a number of different elements may be the objects of trust such as brands, individuals, professionals and organisations (Sydow, 1998). Sydow emphasizes the importance of interpersonal relationships within business relationships, and suggests that it is possible that these relationships can lead to a strong form of trust even when organisations themselves are not perceived to be trustworthy. It has also been proposed that trust is 'task specific', that organisations can be trusted for a specific task, but that this does not indicate a general trust in the organisation (6 et al., 2006).

### ***Decision-making in organisations***

The final group of theories of relevance to this research is theories of decision-making in organisations. A criticism of economic approaches to organisational behaviour is that they treat organisations' decision-making as a 'black box' (Burke et al., 1988), and rely on a rational choice model in which decision-making in organisations replicates the decision-making process of individuals (Zey, 1998). However, organisational theory suggests that organisational decision-making and the differing preferences of individuals who comprise organisations, make organisational behaviour a much more complex subject.

Simon (1957) argues that a rational choice model of decision-making in organisations is problematic for four reasons. Firstly, organisations often make decisions in situations where only incomplete information is available, secondly, problems to be addressed by organisations are often complex, thirdly, organisations may have only limited time available in which to make decisions, and fourthly, organisations may contain multiple decision makers who have differing preferences

Decision-making in organisations is often subject to ambiguity about goals, and/or uncertainty about how to reach those goals (Hatch and Cunliffe, 2006), and depending on the clarity and agreement about goals, organisations are likely to make decisions differently. For example where the means to reach a goal cannot be agreed then incremental decisions may be taken. In situations where both goals and the means to reach them cannot be agreed



then a 'garbage can model' of decision-making may be adopted whereby action is taken in a much more random way (Hatch and Cunliffe, 2006). Instead of exercising rational choice, it may be that decisions are more likely to be based on 'feel and intuition' (Buckley and Chapman, 1997) than a complete evaluation of options and possible outcomes.

The process of making strategy in organisations may also be of relevance when considering the decisions organisations take. Incentives other than those of NHS central policy may also play an important role in influencing organisational decision-making. Public sector agencies are 'multi-principal agencies' that are subject to demands from many stakeholders who themselves have differing aims (Dixit, 2002). In the public sector, workers may derive utility from sources other than salary, for instance they may be motivated by ethical concerns. Whilst policy tends to focus on financial rewards for behaviour, the behaviour of NHS staff may be motivated by both extrinsic and intrinsic rewards (Mannion et al., 2007). Le Grand argues that the motivations of those working in the public services should not be narrowly defined as 'knavish', that is purely self-interested, but other motivations should also be acknowledged including a perceived duty to develop trusting relationships across boundaries (Le Grand, 1999). However it should be noted that structures and incentives can alter these behavioural norms. Allen et al (2012a) for example found that the financial freedoms of Foundation Trusts has led to a more competitive attitude in managers, although interestingly many clinicians were resistant to these incentives.

#### Organisational and professional culture

The behaviour of individuals is potentially complex in the NHS due to the different knowledge bases of the professional groups which work within it (Davies and Mannion, 1999). A common characterisation is that health care managers may be incentivised to balance budgets, and clinicians to maximise health benefits (ibid). Broad differences can be identified between managerial and medical cultures: in the disciplinary bases of the social and natural sciences respectively; in the focus of attention with managers viewing patients as groups and the medical body treating patients as individuals; and in measures of success, with managers focused on efficiency, and medical staff on effectiveness (Davies et al., 2000). These differences may lead to differing rationalities in decision-making, for instance with managers' utility associated with efficiencies and clinicians' associated with effectiveness, which can lead to differing decisions regarding co-operation or competition in the same situation. In addition, professional norms and values, such as the medical code of practice, can impact on co-operative or competitive behaviour. Motivations at an individual basis in an organisation

may be entirely individual such as preservation of professional identity and field of work (Drenth et al., 1998), and it may be that co-operation beyond boundaries is threatening to professionals' discretion and autonomy, and may lead them to defend their own interests (Mur-Veeman et al., 2001).

Additionally, organisational cultures and subcultures can impact on decision-making and behaviour. Organisations are social phenomena and can differ from each other in the beliefs and values of their members. Culture can be viewed as a variable affecting behaviour and decisions in much the same way as other attributes (Mannion et al., 2010). Culture can impact on attitude to risk taking and innovation, degree of central direction within an organisation, team orientation and competitiveness (Davies et al., 2000). It was noted, in relation to an analysis of the quasi-market, that competition was sensitive to organisational and behavioural characteristics of NHS Trusts, such as the role of hospital managers and/or clinicians in decision-making (Propper and Bartlett, 1997). However it is also possible that the use of incentives for competition between organisations providing NHS services in the NHS quasi-market increases the disposition of NHS organisations to compete, regardless of their culture (Mannion et al., 2010).

## **2.7 Empirical studies**

The preceding analysis explored the relevant theoretical context, which consisted of models of co-ordination, game theory and theories of organisational behaviour. The remainder of this chapter will consider the empirical studies which have relevance to the research questions being considered here.

The literature reviewed in this section consists of published studies relating to the impact of incentives for competition and co-operation on the behaviour of health care organisations. The literature was identified through the following means:

- A search of databases (PubMed and Web of Science) using key terms relevant to the research question
- General internet searches
- Citation searching in identified relevant texts to identify potential references
- A search of the publications of relevant research funding bodies (such as the NIHR Service Delivery and Organisation Programme) and authors who had been identified as having an interest in the field.

- Identification of current research by attending seminars and conferences.

The literature has been selected for inclusion here according to its relevance to the research question.

Three main groups of relevant empirical studies were identified. Firstly, a cohort of studies were selected which dealt with organisational behaviour in the NHS in England in the light of the introduction of the quasi-market. Because of the peculiarity of the policy mix in England, it was not considered useful to widen the scope of this element of the empirical review to studies from other health systems, or indeed other sectors. Secondly, a further cohort of studies was identified as relevant. This cohort examined the integration of services between organisations delivering health services in the light of incentives for competition and co-operation and, in relation to this category, studies were included from health systems overseas. Thirdly, a small number of studies were identified which specifically examined the provision of health services from the co-opetition perspective. These cohorts of studies are discussed in turn below.

#### ***Organisational behaviour within the NHS quasi-market***

There are many studies relating to the impact of NHS quasi-market reforms. Some of the research concerning the impact of market-like incentives in the NHS is econometric in nature. The majority of the empirical studies of the 1990s NHS 'quasi-market' relate to the impact of competition on price, quality or equity rather than issues relating to the co-ordination of services (Propper et al., 2008). These studies present a mixed picture of the impact of competition. Propper et al's analysis of the impact of competition in the 1990's quasi-market on acute myocardial infarction mortality rates found that competition reduced quality of outcome (ibid). Feng et al (2015) found that hospital market concentration (as a proxy for competition) appeared to have no significant influence on the outcome of elective hip replacement. However other studies have suggested that competition can lead to better outcomes. A study of the impact of competition in the New Labour reform programme in the English NHS found that competition had a positive effect on clinical outcomes, productivity and expenditure, with patients who were treated in more competitive markets having less likelihood of death and shorter lengths of stay, with no increased cost of treatment (Gaynor et al., 2010). Cooper et al (2011) used acute myocardial infarction mortality data to examine the impact of the expansion of patient choice on hospital quality and found (in contrast to the findings of Propper et al, (2008)) that higher levels of competition were associated with

a faster decrease in 30 day mortality. Cooper et al (2012) showed that NHS providers in competitive environments shortened the length of stay for pre-surgical episodes and overall length of hospital stays. Bloom et al (2014) used both quantitative and qualitative methods in a study which suggested that higher competition was associated with improved hospital performance and a better quality of management.

However studies such as these that attempt to establish a correlation between competition and performance have proved controversial (Bloom et al., 2011, Pollock et al., 2011a, Pollock et al., 2011b). The Office of Fair Trading (2014), in its review of studies of competition, suggested it was not clear whether there was a causal relationship between competition and quality of outcomes, or whether there was simply an associative one. Bevan and Skellern (2011), in their review of studies, point out the difficulty of estimating the causality between competition and outcomes, such as the problematic use of market structure as a proxy for the intensity of competition.

#### Qualitative studies of inter-organisational relationships in the NHS quasi-market

A cohort of studies which is more directly relevant to this study is qualitative studies of NHS inter-organisational relationships in the quasi-market. Some of these studies relate to the quasi-market of the 1990's (Bennett and Ferlie, 1996, Flynn et al., 1996, Allen, 2002), and some to the ongoing reform programme from 2002 onwards (Greener and Mannion, 2009, Dixon et al., 2010, Bartlett et al., 2011, Powell et al., 2011, Allen et al., 2012a, Frosini et al., 2012, Hughes et al., 2013, Porter et al., 2013, Allen et al., 2014a, Naylor et al., 2015, Sheaff et al., 2015). Only one study (Allen et al., 2014a) examines organisational behaviour in the policy environment following HSCA 2012. The applicability of findings from studies from the 1990s is limited by the fact that the incentives used to encourage competition differ from those in place at the time of the fieldwork, as do the governance structures of provider and commissioner organisations.

The findings of these studies relate to the relevant theoretical issues in various ways which will be discussed below. Firstly, some of the findings relate to whether competitive or co-operative behaviour was predominant in inter-organisational interactions. Secondly, some of the studies identified contextual factors which affected how organisations responded to incentives for competition and co-operation. Thirdly, some findings related to the impact of the incentive mix on the relationships between provider organisations when providing services.

A question which has been of concern to many of the studies of organisational behaviour in the NHS quasi-market has been whether competitive or co-operative relationships are predominating organisational relationships. There was some evidence that organisational behaviour in this respect differed depending on the policy mix in place at the time. Three qualitative studies were conducted in relation to the reforms of the 1990's (Bennett and Ferlie, 1996, Flynn et al., 1996, Allen, 2002). Two of these found evidence of a predominance of co-operative relationships at the expense of competitive ones. Bennett and Ferlie's (1996) study of the contracting process for HIV/Aids services examined the behaviour of four purchasing authorities over a two year period (1993 – 1995). The study found an emphasis on co-operation, not just between purchasers and providers, but also between competing providers, which in some cases extended to the creation of cartels by commissioners in order to create seamless services.

In their study of contracting in the 1990's quasi-market, Flynn et al (1996) found a similar emphasis on co-operation rather than competition in organisational behaviour. They conducted three case studies of district health authorities examining the process of contract specification and implementation in relation to the provision of community health services, using a transaction cost analysis. They found that the 'character' of community services created special difficulties for the introduction of a market based approach (and the use of contracts). There were high levels of uncertainty in relation to community health services relating to difficulties in measuring activity (identifying discrete episodes of activity), identifying costs and producing reliable indicators of quality which led to high transaction costs. Flynn et al found that all parties were inclined to pursue co-operation through clan relationships in agreeing and delivering services, rather than enforcing contracts and pursuing competition. They also found that hard adversarial market relations and commodity exchange values were corroding professional networks which depended on co-operation, reciprocity and interdependency, and trust in commissioner/provider relationships.

One later study of organisational behaviour in the quasi-market (conducted following New Labour's renewed emphasis on the quasi-market in the NHS from 2002 onwards), Porter et al (2013), found a similar predominance co-operative behaviour in NHS inter-organisational relationships, and indeed, a lack of competitive incentives. The study focused on the commissioning of services for people with three long term conditions (diabetes, stroke and dementia) in three PCT areas between 2010-12, in order to assess the extent to which commissioners had adopted market oriented (transactional) modes of commissioning.

Allen's case study of contracting for district nursing in a health authority area, suggested that rather than relational contracts functioning in place of complete contracts, instead there was a reliance on hierarchy to control budgets (Allen, 2002). The study findings suggest that, rather than relying on the price mechanisms as would be expected in a competitive market, or establishing co-operative relationships including elements of trust, relationships were more correctly defined as 'continuing relationships in a hierarchy' (p263).

Other studies of organisational behaviour in a similar time frame, however, have found that organisations' willingness to co-operate is being eroded by the competitive incentives in the environment. Bartlett et al's (2011) study of provider diversity in the NHS found that whilst the increasing diversity of organisational forms in the English NHS had brought benefits, the introduction of increased competition in the provision of services had led to a perceived loss of co-operation. Similarly Greener and Mannion's (2009) study based on qualitative interviews exploring the impact of patient choice policy in a single hospital trust found that choice was seen as leading to an increased lack of co-operation between organisations.

Interestingly other studies from this period found that competitive and co-operative behaviour were being combined. Dixon et al's (2010) study of patient choice in the English NHS found examples of organisations competing and co-operating with each other, including the existence of formal agreements between providers to 'carve up' the market.

Frosini et al (2012) found evidence of collaborative relationships at organisational level, specifically that Foundation Trusts identified themselves as having common interests and viewed each other as collaborators. For example, two Foundation Trusts had agreed a Memorandum of Understanding of where they were going to compete and where they were going to co-operate. The study found that organisations co-operated in order to share pathways, staff and facilities. Organisations had more reasons to co-operate in a more market like environment in order to 'collaboratively cope with the challenges a patient choice environment presents' (p22).

Allen et al (2012a) investigated governance in four Foundation Trusts using four case study sites, each consisting of a Foundation Trust. The study found that Foundation Trusts exhibited increased competition for income against local hospitals and were keen to expand their own services to the detriment of other organisations but that this did not necessarily lead to a deterioration in their co-operative relationships with the local health economy, especially when considering actions concerning the quality of patient care.

Sheaff et al (2015) found that local commissioners were drawing on a combination of modes of governance in order to exercise power and control over provider organisations including provider competition, but also approaches based on performance management, discussion and regulatory control.

The second area of interest in relation to this cohort of studies of inter-organisational relationships in the NHS quasi-market is studies with findings which relate to the identification of contextual factors which affect how organisations respond to incentives for competition and co-operation. The theory explored earlier in this chapter in relation to the research question, especially that relating to game theoretic approaches to behaviour, suggests that factors relating to the local environment in which organisations were situated could exert an important influence on organisational and professional reactions to incentives for competition and co-operation, and this suggestion is supported by previous empirical studies of organisational behaviour in the NHS quasi-market. Various aspects of the local context have been identified as significant. Relational elements concerning historical relationships between organisations have been found to be significant, and additionally these relationships have been found to be shaped by the local institutional context. Organisations in competitive environments were found to co-operate if there was a history of collaborative working (Allen et al., 2012a) based on historical loyalties (Frosini et al., 2012), and if there were established relationships and trust (Flynn et al., 1996, Hughes et al., 2011), and existing agreements (Dixon et al, 2010). Dixon et al (2010) also highlighted the importance of the local configuration of providers, and their service portfolios as a factor influencing organisations' reactions to incentives for competition. Both Flynn et al (1996) and Powell et al (2011) found that the economic situation influenced organisations' behaviour. Porter et al (2013) identified that mutual interdependencies between organisations influenced organisational behaviour.

Whilst all the aforementioned qualitative studies relate to organisational behaviour in the quasi-market, only a small number of these include a focus on provider/provider relationships, and a smaller number still focus on provider/provider relationships and the provision of services. The focus of many studies has been on the commissioning process and commissioner/provider relationships (Bennett and Ferlie, 1996, Flynn et al., 1996, Hughes et al., 2013, Porter et al., 2013, Sheaff et al., 2015) rather than looking at the behaviour of providers as they approached their relationships with each other. Some studies did focus on provider/provider relationships (Dixon et al., 2010, Bartlett et al., 2011, Powell et al., 2011,

Frosini et al., 2012, Allen et al., 2014a), but none of these with the exception of Powell et al (2011) focused on provider/provider relationships in relation to a tracer condition. Powell et al (2011) conducted a study to explore how stakeholders regarded the implementation of complex policy initiatives from 2005 onwards within a range of local health economies. The research focused on three tracer conditions (orthopaedics, diabetes and early intervention mental health services) in six local health economies. Whilst the study was not directly concerned with the issue of organisational relationships, or the impact of incentives on these, it found that there was a lack of clarity about the expected dominance of competitive or co-operative behaviour from a policy point of view, and in this confused context commissioners struggled to develop integrated pathways of care.

In summary these studies are useful as they shed some light on inter-organisational behaviour in a policy environment of a similar nature to that in place at the time of the fieldwork. However none of them focus on organisational behaviour in relation to the planning and provision of a specific service, or the impact behaviour has on the co-ordination of services. Furthermore, there is a notable lack of empirical studies which examine inter-organisational relationships in the policy and regulatory environment following HSCA 2012. An exception is Allen et al (2014a) which provides a useful comparator for some of the data collected for this research. However the study differs from my research in two important respects. Firstly, it did not focus on a tracer condition and did not look at the impact of these incentives on the co-ordination of services. Secondly, the main focus of the study was on the use of competition by commissioners.

### ***Co-ordination of services in a mixed incentive environment***

Outside the policy context of the NHS, empirical studies of other health systems which examine inter-organisational relationships in the light of incentives for competition and co-operation, as they relate to the co-ordination of services, are also relevant. Whilst there are often fears cited that competition will lead to the fragmentation of care, there are few empirical studies that directly address this.

Two studies, Muijen and Ford (1996) and Johnson et al (1997) (both cited in (Le Grand et al., 1998) examined the co-ordination of mental health services between health and social care in the managed market of the 1990's. Muijen and Ford (1996) found that the different incentives between purchasers and providers, and health organisations and local authorities undermined the provision of integrated community care for people with the most serious



mental illnesses. Johnson et al (1997) found evidence of fragmented care between health, social services and housing departments. In a study outside the UK, Abelson et al (2004) examined the effect of competitive contracting on the co-ordination of services and organisational working in the home care sector in Ontario. They found that competition was perceived to have led to less collaborative working between organisations, for example competing organisations were inclined to use best practice for competitive advantage rather than share it. They also found that there were concerns from both clients and providers regarding the disruption of care between clients and providers, specifically that trust relationships between clients and providers were disrupted. However this is a concern specifically related to fragmentation due to a change in the contracted provider rather than concerning relationships between organisations in a supply or value chain.

### ***Co-opetition between health care organisations***

Additionally, a small number of empirical studies have been identified which examine how health care organisations deal with the mixed incentives of competition and co-operation through the lens of co-opetition. To date there are three studies of co-opetition in relation to health care.

Peng and Bourne (2009) used a case study approach to examine the interaction between two health care networks in Taiwan. The study focused how organisations and networks managed incentives for competition and co-operation. Whilst other co-opetition research has suggested that competition and co-operation are managed through a division in types of activities, with competition occurring 'downstream' close to customer services, and co-operation occurring 'upstream' in relation to strategic and back office activities, this study found that organisations and networks were co-operating and competing, and were managing these activities by dividing them depending on resources. Organisations and networks co-operated when there was a 'distinctly different but complementary set of resources' (ibid. p393) and competed when they have similar resources in the same limited area.

Two further studies focus on the Italian health care sector. Barretta (2008) studied 'co-opetition' in the Italian health system, specifically examining how health care organisations dealt with the interaction between incentives for co-operation and competition. In this study the regulatory body was found to have a pivotal role in balancing incentives and relationships

and behaviour were strongly influenced by professional staff. In the Italian context this meant that professionals were more likely to compete due to the nature of the incentive structure in place.

A further, quantitative, study of interhospital collaboration and competition in a region of Italy is Mascia et al's (2012) study of interhospital collaboration and competition from 2003 to 2007. The study found that competition among providers did not hinder interhospital collaboration. Reasons for this collaboration, which occurred at a local level, were found to be resource complementarity and differentials in the volume of activity and hospital performance. The study concluded that the formation of collaborative networks among hospitals was not hampered by reforms aimed at fostering market forces.

## **2.8 Conclusion**

This chapter has reviewed both the theoretical literature and empirical studies that are relevant to the research aims, objectives and questions outlined in Chapter 1. The review of the theoretical literature has identified a broad theoretical framework which is of relevance and which includes modes of co-ordination within markets, networks and hierarchies, approaches to analysing organisational behaviour based in game theory, and theories associated with the basis on which organisations make decisions. These theories structure the analysis of the data in later chapters.

The empirical studies reviewed in this chapter show that, whilst there has been a number of studies which examine the behaviour of health care organisations in the quasi-market in the NHS in England, there is in general a lack of research which focuses on the impact of this on service delivery, and none of them has approached the research with a specific interest in the co-ordination of services for a tracer condition. Furthermore, there are very few studies that examine inter-organisational behaviour in the policy and regulatory context following HSCA 2012, and none that do so in relation to the co-ordination of services for a tracer condition.

However the empirical studies, together with the examination of the theoretical context, have led to the identification of a number of key areas of relevance to NHS organisations' behaviour regarding competition and co-operation, and the impact this might have on the co-ordination of services. The areas identified are the impact of local context on the use of incentives for competition and co-operation and on organisational and professional behaviour, the use of coping strategies by organisations to manage competition and co-

operation, and the effect of a combination of incentives for competition and co-operation on organisational and professional relationships. These are discussed below.

Context appears to be important when considering behaviour. Organisational decisions regarding competition and co-operation may be affected by contextual factors, including past and future interactions, perceptions of 'type' of the other party, size of payoffs, and organisational culture. Behaviour may also differ within organisations between professional groups. The empirical studies highlight the important of the interdependencies between organisations and the wider institutional context on the operation of incentives for competition and co-operation. The institutional context which is explored in this thesis includes the regulation of competition itself, and also the broader institutional context which affects the use of competition and co-operation such as pricing structures, organisational structures and the use of contracts.

The theoretical evidence from game theory and from the literature concerning trust in organisational relationships suggests that it will be difficult for organisations successfully to combine competitive and co-operative behaviour. Data from the empirical studies of the 'quasi-market' reforms of the 1990's suggest that co-operation dominated relationships at the expense of competition. However some of the data from studies of the later reform programmes of the NHS from 2002 onwards suggest that a mixture of behaviour is in evidence. However, the literature concerning co-opetition also suggests organisations may employ coping strategies to manage co-operation and competition successfully between the same organisations, such as dividing roles between different departments, activities or individuals, and the role adopted by regulatory bodies, and some evidence from the empirical studies of behaviour in the NHS quasi market suggests that coping strategies are being put in place by organisations (e.g. Frosini et al., 2012).

It is unclear whether the combination of competitive and co-operative behaviour will have positive or negative effects. The literature concerning trust suggests that combining behaviours in interaction between the same organisations may lower the quality of outputs from the interaction. This is supported in part by some empirical studies of organisational behaviour in the NHS quasi market which reflect fears that the sharing of best practice between organisations and goodwill were suffering. Findings from the theoretical literature relating to co-opetition meanwhile suggest that a combination of competition and co-operation can lead to benefits for all. This position is supported by the literature concerning flexible specialisation and industrial districts which suggests that co-operative behaviour can

be included within competitive relationships to the benefit of all parties in certain circumstances.

All of these issues are considered in the thesis in relation to the data gathered. This analysis will commence with a consideration of the institutional context in which organisations were operating at the time of the field work.

## Chapter 3

### Institutional context

#### 3.1 Introduction

##### *Institutions and behaviour*

Institutions are socially constructed systems which are used to structure interaction. They are organising 'prescriptions' in all forms of social structures, from families to government (Ostrom, 2005). Institutions consist of 'formal constraints' such as laws and constitutions, 'informal constraints' such as norms of behaviour and 'enforcement characteristics' (North, 1994). The institutional context defines the incentives which those operating within it are subject to, such as incentives for co-operation and for competition.

In the case of the NHS, a national body consisting of a wide variety of regulatory, commissioner and provider organisations, the behaviour of participants is subject to a complex framework of national and European laws, NHS specific regulation and best practice guidance and professional codes of conduct. The way these nationally set expectations of behaviour affect the behaviour of local provider and commissioner organisations when they plan and provide local services is complex.

A key concept underlying this chapter is an analysis of the institutional context in terms of the 'rules-in-form' as described in Ostrom's IAD Framework (Ostrom, 2005). 'Rules-in-form' refers to the formal rules of behaviour which exist in written statements, and the institutions and structures which are given responsibility for the monitoring and enforcement of the rules. This chapter is concerned with setting out the regulatory and policy framework ('rules-in-form') affecting the competitive and co-operative behaviour of the organisations planning and delivering services at a local level in the NHS at the time of the research. The focus is on the 'rules-in-form' in 'meta-constitutional situations' (national structures), which, together with the local context, impact on the 'constitutional situations' (local commissioner decisions) in the NHS (see Figure 2.1). For Ostrom, rules are socially situated, and it is communities' understanding of rules and norms of behaviour ('rules-in-use') rather than written statements themselves which, together with the attributes of the local context, guide behaviour. The analysis of the interview data gathered in the case study area and discussed in Chapters 5,6 and 7 will help to understand how organisations and professionals in a local health economy interpret and understand the 'rules-in-form' when they are deciding how to

behave in competitive situations, and what 'rules-in-use' exist in terms of organisational and professional behaviour at a local level.

### **3.2 Background**

Before describing the institutional context in place at the time of the research, it is helpful to contextualise this through a summary of market incentives and regulation in the NHS, including the structures which have been established at national, regional and local level, and their relative roles, including the introduction of the market into the NHS and the changes in the institutional landscape which occurred during the period of the research itself.

#### ***Regulation of healthcare markets***

Regulation of behaviour is necessary as the market in health care is imperfect. In a perfect market, there would be no regulation. The perfect market consists of a large number of producers of the same product, which has a large number of potential purchasers. There should be few barriers to entry to or exit from the market, perfect information about price and quality of products should be available to both buyers and sellers, and there should be no disadvantage for new producers (Wonderling et al., 2005). The number of producers and the existence of the informed consumer guards against any producer being able to take advantage of the consumer.

Perfect markets are a largely theoretical construct and in reality markets often need to be regulated due to imperfections such as asymmetries of information or natural monopolies. This is very much the case in relation to health care, where the market is 'almost completely imperfect' (Olsen, 2009, p49). There is a number of reasons commonly given why health is subject to market failure. Firstly, some services are specialist and therefore do not have many suppliers. Secondly, there are problems of asymmetry of information - consumers often do not know what they want to buy, nor do they have the skills to judge the quality of the goods themselves. Thirdly, products are not identical and are therefore very hard to price (Wonderling et al., 2005).

Additionally there are other issues which are problematic in relation to the market. Firstly, there is the need (in the UK at least) to ensure that health care is delivered fairly across the population. Health systems often take measures to ensure that resources are distributed across the population according to a notion of fairness, for example equal access to services for all members of the population. This kind of distribution is not within the remit of the market (Gubb and Meller-Herbert, 2009).

Secondly, it is possible that organisations have objectives which relate to the quality of goods rather than financial outcomes. It is arguable that health care organisations are concerned with the maximisation of health quality and health gains for their population. Crilly and Le Grand for example found in their study of hospital trusts that the dominant objective was to maintain service quality rather than meet financial targets (Crilly and Le Grand, 2004).

Regulation is necessary to guard against these market failures. The aims of regulation are to ensure the quality of the produce (quality regulation) and to control price (economic regulation). However in the case of health care, for the reasons outlined above, whilst regulation of quality and price can improve the market for health care it cannot fully correct it. Indeed there are many other concerns which must be taken into account when regulating health care, not least ensuring that the co-ordination of services is not impeded by the market.

### ***The market in the NHS***

The following section outlines the main elements of the market which have operated in the NHS since market incentives were first introduced in 1990, and highlights which elements were in force at the time the fieldwork was conducted (June 2011 – October 2013).

#### The NHS Internal Market 1990 - 1997

Market forces were first introduced to the NHS by the Conservative Government in 1989. The white paper 'Working for Patients' (Secretaries of State for Health in Wales Scotland and Northern Ireland, 1989) introduced the 'internal market' to the NHS by creating the purchaser provider split, where the state retains control of overall resource allocation but competition is used in the allocation of resources to the providers of services. Purchasing services, or commissioning (as it came to be known in the NHS) consists of deciding what type of services are required and how they are to be provided to best suit the needs of the population in question. Within commissioning the process of contracting consists of negotiating contracts with providers, specifying service design and monitoring performance against the contract. Thus the local bodies responsible for commissioning play a key role in shaping the local competitive environment through the way they choose to commission services. In this period, Health Authorities were responsible for the commissioning of services, and hospitals and community services became 'self governing trusts', with a limited range of freedoms, competing for contracts from health authorities. 'Working for Patients' also introduced the option for GP practices to become fundholders who would directly

purchase certain services (non urgent elective and community services) for their patients. These changes, implemented through the NHS and Community Care Act (1990) first introduced competitive financial incentives to the NHS, with the aim that providers would be given incentives to improve quality and efficiency through competition for contracts.

#### Choice and competition – the NHS market under Labour 1997 – 2010

Whilst the fieldwork for this research commenced in June 2011, after the Labour government had left office, the form of the internal market established by Labour was still operational for the duration of the majority of the fieldwork.

When Labour first came to power in 1997, they abolished GP fundholding and denounced the previous internal market. However they did retain the purchaser provider split, and in 2002 'Delivering the NHS Plan' (Department of Health, 2002a) began the process of developing new market incentives in the NHS.

Competition was stimulated on the supply side of the NHS through an increase in the diversity of providers of care and in the freedom they had to act innovatively. The provision of NHS services was opened up to a variety of accredited providers, including both publicly owned and independent providers, such as NHS Trusts, Foundation Trusts, for-profit independent sector providers and not-for-profit third sector providers. Foundation Trusts, established in 2002, were a new organisational form called public benefit corporations (Health and Social Care Act (Community Health and Standards) 2003, s1). Whilst Foundations Trusts were still owned by the state, they differed from Trusts in terms of their autonomy and regulation (Allen et al., 2012b), and had the freedom to retain surpluses, were not required to break even, and were licenced by Monitor, an independent regulator. Staff and local people could become members and elect a Board of Governors. The introduction of a variety of organisational forms reflected the desire to introduce competition on different fronts, for instance for-profit organisations have incentives to reduce costs, and third sector organisations may be expected to deliver high quality services due to their proximity to the customer (Allen et al., 2011).

Commissioning responsibilities within the NHS lay with PCTs who had responsibility for purchasing services for their local population. In practice, PCTs (and later CCGs) often agreed 'lead' commissioner arrangements, where each PCT led commissioning for a particular provider on behalf of all the PCTs who contracted with that provider (House of Commons Health Committee, 2009, 4.5-4.7). Practices within PCTs were also given indicative budgets



for their population through Practice Based Commissioning. As regional commissioning bodies, PCTs played a key role in shaping the local competitive environment. PCTs had two main courses of action open to them in manipulating incentives for competition. The first of these was allowing providers to enter the market through patient choice, which incentivised competition 'within' the market, and was used when a commissioner wanted to encourage a diversity of provision. From 2008 patients were given a choice of 'any willing provider' (AWP) in England when they were referred into secondary care (Department of Health, 2008b). To be included as a choice, providers need to be registered with the Care Quality Commission, have a PCT or national contract and be willing to provide services at tariff. Together with Payment by Results (PbR), which pays providers according to the number of procedures they carry out, this created competition between providers of elective services (Department of Health, 2002b). PbR is a national tariff rate which is based on the average cost of the episode of care, including after care and overheads for facilities. PbR sharpens incentives for efficiency by encouraging providers to reduce their costs to below the average cost at which the reimbursement is set. Paying by activity resulting from patient choice also incentivises service providers to innovate and provide good quality services in order to attract patients.

The second way of entering the market is through competition 'for' the market by winning contracts to provide services. This process is used when a commissioner wishes to encourage a change in the provision of services, for example moving the provision of a service from acute to community setting.

A third possible course of action open to commissioners does not involve competition. Commissioners can initiate a single tender action for a service, essentially an 'uncontested contract award' (Department of Health, 2010f, 2.39) although this is to be used only where a single possible provider for a service can be identified. Commissioners could also use the option of a Single Tender action if they decide to bundle together a group of services, and there is only one capable provider of these services.

These different courses of action lead to different types of incentives for competition, most notably controlling whether competitive relationships are one off ('for the market') or continuous ('in the market') throughout the provision of services.

The main mechanism set up at national level to manage competition in the English NHS during this period was the 'Principles and Rules for Co-operation and Competition' (PRCC)

(Department of Health, 2010e) which were administered by 'Cooperation and Competition Panel for NHS Funded Services' (CCP). Both the PRCC and the work of the CCP are discussed in sections 3.5 and 3.6 below.

#### The Coalition Government – June 2010 onwards

The field work for this research was carried out in the period following the election of the Coalition Government in 2010 (June 2011 – October 2013). Much of the fieldwork was conducted in the 'shadow' of the new government's NHS reform programme, in the period from the announcement of plans for reform in the White Paper 'Equity and Excellence: Liberating the NHS' (Department of Health, 2010b), through the extensive deliberation of the plans and amendments to the proposed bill, to the passing of the Health and Social Care Bill in March 2012, with the majority of its provisions coming into force on 1 April 2013. As noted above, during the period of the research many of the structures in place affecting competition and co-operation were essentially those of the previous administration. However, some important changes took place in the period ahead of the formal implementation of the legislation in April 2013, and eight research interviews were conducted after April 2013, once the new legislation was in place.

Whilst significant structural change took place during the Coalition administration, the fundamentals of the market put in place by the Labour Government remained in place during the research period (June 2011 – October 2013). The White Paper 'Equity and Excellence: Liberating the NHS' contained plans for large scale structural reform of the NHS, and was described as '*the biggest reorganisation in the 63-year history of the NHS*' (Timmins, 2012, p2), but the Coalition Government retained many of the fundamental market structures put in place by the previous administration. The White Paper restated a commitment to the market (Department of Health, 2010b). The purchaser and provider split was retained. The PbR tariff remained unchanged, as did the drive towards diversity of provision. The growth in the number of Foundation Trusts continued, with a target for all NHS Trusts to become Foundation Trusts by 2014 (Department of Health, 2010b). The White Paper announced that the patient choice based AWP initiative (now known as 'Any Qualified Provider' (AQP)) was to be extended to include community health and other services (Department of Health, 2010b). In July 2011, commissioners were asked to choose three or more services from a list of eight for priority implementation of AQP (Secretary of State for Health, 2011), and to have advertised these opportunities to providers by October 2012. Indeed, not only was the direction of travel retained but the reforms increased the incentives for organisations to

behave as 'market participants' by introducing a clear legal framework to prohibit anti-competitive practices (Davies, 2013).

Whilst the above initiatives, fundamental to the structure of competition within the NHS, were retained the Coalition Government introduced a wide ranging reform of the organisations responsible for commissioning services in the NHS. Whilst these may not directly alter the incentives for competition and co-operation in place, certainly not as directly as the reform of the legislative and regulatory functions contained within the White Paper 'Equity and Excellence: Liberating the NHS' and the subsequent Bill, they are an important factor affecting the environment in which local organisations were planning and providing services at the time of the research. A timeline detailing the changes to the institutional framework in relation to the fieldwork can be found in Chapter 4 (Table 4.1). The key changes to the organisations responsible for locally commissioning and providing services in the NHS were the abolition of PCTs and Strategic Health Authorities and the creation of Clinical Commissioning Groups (CCGs). Whilst these changes were not enacted in legislation until April 2013, towards the end of the fieldwork period, various anticipatory changes took place before this date. PCTs clustered from 151 to 50 from June 2011 (Department of Health, 2011b), and Strategic Health Authorities merged in October 2011 (Department of Health, 2011a) from ten to four. CCGs, local commissioning bodies led by GPs, were created in shadow form. Pathfinder CCGs were established as sub-committees of PCT clusters in phases during 2011 (Checkland et al., 2012). By September 2011 259 pathfinder CCGs were in operation, and, by June 2012, 212 shadow GP commissioning consortia (or 'emerging CCGs') were progressing towards authorisation (Checkland et al., 2012). The shadow consortia were expected to take on as much responsibility as possible locally during the period until formal establishment in April 2013, including responsibility for commissioning (Department of Health, 2011b), and indeed in the case study the CCG was active, either in shadow form or fully established, for the entirety of the field work.

These structural changes affecting the bodies involved in locally commissioning NHS services impacted on the relationships between organisations when planning and providing services, not least creating challenges in terms of changes in local leadership, responsibilities and staffing levels. However, the White Paper 'Equity and Excellence: Liberating the NHS' (Department of Health, 2010b) and the subsequent legislation also introduced a series of changes to the regulation of competition and co-operation. The changes largely required legislation so did not come into force until April 2013, towards the end of the field work

period in October 2013. However, as with the changes in local commissioning arrangements, the field work was conducted in the 'shadow' of the impending regulatory changes, with some early changes put in place. The Health and Social Care Act 2012 (HSCA 2012) itself laid out new rules, relating to the operation of competition and co-operation within the NHS. The implications of HSCA 2012 for competition and co-operation are discussed in more detail in the remainder of this chapter, however a brief summary of the timing of the changes is as follows.

One of the most fundamental changes from April 2013 was the creation of a new economic regulator of the whole NHS, Monitor, previously only the independent regulator of Foundation Trusts. The CCP was dissolved from April 2013, with responsibilities transferred to Monitor. Also from April 2013, the PRCC were subsumed into conditions in Monitor's provider licence (which governs the behaviour of all providers of care to NHS patients) and secondary legislation (e.g. the Procurement, Patient Choice and Competition Regulations No. 2 2013). A new body, NHS England (originally called the NHS Commissioning Board) took responsibility for the commissioning of primary care services and some other nationally based services from April 2013. In order to achieve these changes by April 2013, the NHS England was established as an independent statutory body from October 2012, and assumed responsibility for the establishment of the new commissioning arrangements and the authorisation of CCGs. Monitor took on some new powers from 1 November 2012, and commenced licencing functions from January 2013.

The remaining sections of this chapter describe the 'rules-in-form' which were in place during the period of the research, and clarify the key institutions at national level and their roles in relation to the management of competition and co-operation in the planning and provision of NHS services. This includes an analysis of the regulatory decisions made by the CCP prior to HSCA 2012, and by Monitor and the external regulatory bodies after HSCA 2012. Where relevant, this includes an analysis of the formal (written) rules which were in place, and the relation they appear to have to the behaviour of local organisations with responsibility for the planning and provision of services. The sections will describe: the relevant EU and UK laws and NHS specific laws; the NHS rules and guidance relating to competition and co-operation; the enforcement of rules for competition and co-operation; the operation of contracts and price setting; and the relevance of the regulation of quality to competition and co-operation.

### **3.3 Regulation of competition and co-operation in the NHS – relevant law**

This section examines the European and national laws which have relevance for incentives for competition and co-operation in the planning and provision of local NHS services.

#### ***European Union law***

The European Union (EU) has no jurisdiction to create health law (Hervey and Vanhercke, 2010), and in principle national governments are responsible for their own healthcare (Treaty on the Functioning of the EU (TFEU), 152). However EU law in other areas, such as enterprise and economic policy, has been found to affect health care policy (Hervey and Vanhercke, 2010). Where EU law exists it has primacy over national law. A number of areas may have an impact on the planning and provision of health services. The first, and most directly relevant, is EU competition law. This is discussed below. Other areas may indirectly affect competition in the NHS such as employment law.

#### ***National and European Competition law***

The behaviour of any entity in the UK when engaging in economic activity is governed by The Competition Act 1998 (CA 1998). When economic activity extends to the EU, the behaviour is governed by Article 101 and 102 of the Treaty on the Functioning of the European Union (TFEU) (as amended by the Treaty of Lisbon 2007).

This legislation regulates two aspects of behaviour to ensure that competition is not impaired. Firstly it prohibits anti-competitive behaviour, and secondly it prohibits abuse of dominant market position. Chapter 1 of CA 1998 (and 101 of TFEU) regulates anti-competitive agreements between businesses, and guards against agreements which fix the price charged for goods/services, limit or control production, markets, technical development or investment, share markets or sources of supply, which set dissimilar conditions for similar transactions, or which make contracts subject to supplementary obligations. Chapter 2 of CA 1998 (and Article 102 of TFEU) relates to abuse of dominant position in a market. It prohibits a dominant party from directly or indirectly imposing unfair purchase or selling prices to exclude other competitors, limiting production, markets or technical development against the interest of consumers, applying dissimilar conditions to similar transactions with similar customers and making the conclusion of contracts subject to acceptance of supplementary obligations.

In the UK at the time of the field work competition law was enforced by the Office of Fair Trading (OFT), which had responsibility for investigating suspected breaches and enforcing Chapter I and II of CA 1998 and Articles 101 and 102 of TFEU (the OFT, and the role of the Competition Commission, was taken over by the Competition and Markets Authority from April 2014). The OFT had the power to apply both the UK and EU competition law in the UK. When applying CA 1998, the OFT was required by Section 60 of CA 1998 to act consistently with UK law (CA 1998). If the OFT found that CA 1998 or Articles 101 and 102 of TFEU have been breached then it could impose penalties such as fines of up to 10% of turnover. Third parties were able to bring damages claims against the business, individuals could be fined and imprisoned, and directors could be disqualified for up to 15 years (Office of Fair Trading, 2005).

The Enterprise Act 2002 (EA 2002) specified the circumstances in which the OFT should refer investigations to the Competition Commission (CC). The CC was an independent public body which existed to ensure healthy competition between businesses in the UK. EA 2002 gave the OFT responsibility for reviewing all mergers between distinct 'enterprises', meaning undertakings carried out for 'gain or reward' (EA 2002). HSCA 2012 confirmed that mergers involving Foundation Trusts were subject to EA 2002, but the opinion of the OFT was that mergers between NHS Foundation Trusts and NHS Trusts may also be subject to review under EA 2002 (Monitor, 2013b). The OFT could refer mergers and market investigations to the Competition Commission. Mergers were referred when the OFT investigations suggested that there was a realistic prospect that the merger would lead to a substantial lessening of competition (Competition Commission and Office of Fair Trading, 2010). If, after an in-depth investigation, the Competition Commission found that the merger had or would lead to a substantial lessening of competition, it could take action to remedy this including preventing the merger from going ahead or requiring a company to sell off part of its business. Similarly, if the OFT was concerned that there were competition problems in a particular market they could refer the matter to the Competition Commission for in depth investigation. If the Competition Commission found that there was an issue it must seek to remedy this by introducing measures itself or instructing others to do so.

The applicability of competition law to the NHS is a question of increasing relevance, in light of the drive to increase the variety of providers of NHS services through for instance the extension of the AQP initiative, and the distancing of Foundation Trusts from the state. EU and UK competition law applies to any 'undertaking' which is carrying out economic activity

in a market. As the applicability of competition law depends on the definition of an 'undertaking' which is itself dependent on the assessment of any particular activity, rather than for example a specific organisational form, it is not possible to give a definitive assessment of how the activities of NHS organisations may be subject to competition law. The judgement that an organisation is acting as an 'undertaking' does not depend on the legal status of the organisation, the way it is financed, or the volume or value of a particular transaction (Office of Fair Trading, 2011b), it is dependent on the particular activity in which it is engaged. Activity which is purely social is excluded from the legislation. The social definition was described by the OFT as based on the following principles:

*'The activity must be **exclusively** social – an activity that is fundamentally 'commercial' but also pursues some public service objectives will still be an economic activity. Activities which by their very nature could not – even in principle – be carried out for profit without State support have previously been characterised as being 'exclusively social'.'* (Office of Fair Trading, 2011b, p15)

Additionally entities are unlikely to be considered as engaged in economic activity if they provide services on a universal or compulsory, rather than optional, basis and if financial disparities existing between entities are addressed through a redistribution mechanism (Cooperation & Competition Panel for NHS-funded services and Office of Fair Trading, Undated).

The OFT stated that it is for public bodies themselves to assess on a case by case basis whether they are acting as undertakings (Office of Fair Trading, 2011b). Indeed in December 2011 the Department of Health wrote to the OFT to seek clarification about the application of UK and EU competition law to Foundation Trusts after questions were raised in Parliament in relation to the impact of the Health and Social Care Bill (Office of Fair Trading, 2011a). As there is little case law in relation to competition law in health care it is not clear to what extent competition law may be applicable (Odudu, 2011, Lear et al., 2010). However EU case law can be used to provide examples of how judgements have been made in the past. These examples distinguish between bodies managing health care schemes (which would include bodies responsible for commissioning services) and those providing health care services. In the case of the commissioners of health care services, case law suggests that competition law does not apply as the activity is based on solidarity and subject to state control (NHS Confederation, 2009, Sauter and van de Gronden, 2010). Most commonly cited is the case of

FENIN in which hospitals in the Spanish NHS (who were funded from social security and other state funding and provided services free of charge) were found not to be subject to EU competition rules when purchasing goods as they operate in the spirit of solidarity (Case C-205/03 P, *Federación Española de Empresas de Tecnología Sanitaria (FENIN) v Commission* [2006] ECR I-6295). This may mean that the activities of bodies when they are engaged in commissioning services, including both CCGs and hospitals, are not subject to competition law.

However, case law in respect of the providers of health care services is very different, and suggests that where goods and services are provided in competition or where competition is possible, providers are acting as undertakings carrying out economic activity (Sauter and van de Gronden, 2010). This is based on the *Ambulanz Glöckner* case in which the Court of Justice of the EU ruled that German ambulance companies are undertakings, because ambulance services are not necessarily always provided by public services or medical aid organisations and can be provided by private operators (*Ambulanz Glöckner v. Landreis Sudwetpflaz* Case C-475/99 [2001] ECR I-8089 (Sauter and van de Gronden, 2010)). This is an argument which would seem to suggest that all providers of a particular service are undertakings and therefore subject to competition law if the service could be provided by private healthcare organisations (Sauter and van de Gronden, 2010). In this assessment it would appear likely that some of the activities of organisations providing NHS services could be subject to UK and EU competition law. There is therefore a potential disjoint between the commissioning of health services, which is not subject to competition law, and the provision of services which is (van de Gronden and Szyszczak, 2014).

EU competition law identifies 'services of general economic interest' as exempt from the application of competition laws, where these laws would obstruct the performance of their tasks (TFEU 106 (2)). If an undertaking is found in violation of competition law, the courts will evaluate whether the anti-competitive mechanism was justified to facilitate the public interest objective, for example that a service provider has been entrusted to give access for all to an essential service (Mossialos and Lear, 2012, van de Gronden and Szyszczak, 2014). In the *Ambulanz Glöckner* case cited above, the Court of Justice of the EU found that an ambulance service should be granted rights for the monopoly provision of services in a rural area, as it would not be financially feasible to provide emergency services without cross subsidy from routine patient transport. This and similar judgements are seen as providing



some protection for health services on the principle of universal service obligations (Mossialos and Lear, 2012).

Whilst it appears that the NHS, particularly organisations providing health services, are subject to competition law, this has yet to be tested in court. There is the possibility that health services are exempt from competition law, but this depends largely on the definitions of solidarity and public service obligations. In practice, until HSCA 2012, issues of competitive behaviour in the planning and provision of NHS services were largely dealt with by means of Department of Health rules and guidance. When the Department of Health sought clarification from the OFT regarding the application of competition law to Foundation Trusts, it confirmed that any judgement would need to be made on a case by case basis. Interestingly though it also confirmed that any fines imposed on a Foundation Trust for a breach of competition law would take into account the impact that this would have on the provision of health care services (Office of Fair Trading, 2011a).

A further important factor in the application of competition law to health care purchasing and provision relates to State Aid. Articles 107 – 109 of the Treaty on the Functioning of the European Union prohibit illegal state aid. State Aid is defined as ‘any aid granted by a Member State or through state resources in any form whatsoever which distorts or threatens to distort competition by favouring certain undertakings or the production of certain goods, shall, in so far as it affects trade between Member States, be incompatible with the internal market’ (TFEU, 107, (1)). State Aid, essentially a subsidy, risks giving some undertakings an advantage over others. It is permitted in order to achieve ‘specified community objectives’, but not to make payments from the public purses for public services ‘*if there is a risk of overpayment and the recipient is in a position to compete with others*’ (Department for Business Innovation and Skills, 2009, p1). State aid measures are banned unless they are approved by the European Commission. However, an exception is made for costs relating to the ‘Public Service Obligation’ of the provision of ‘Services of General Economic Interest’, and these do not need to be notified. The conditions which must be met for the Public Service Obligation to be accepted is that the undertaking is charged with a public service obligation, that the compensation is established in an objective and transparent manner and is not beyond what is necessary and that the compensation equates to the costs of a well run company (van de Gronden and Szyszczak, 2014).

### ***Procurement law***

The procurement of NHS services, supply and work is subject to UK and EU public procurement law. The relevant law in England is the Public Contracts Regulations 2006. These regulations implement the European Commission's 'Consolidated Directive on Public Procurement' (2004/18/EC). The scope of the law covers procurement activity carried out by 'contracting authorities'. A contracting authority in relation to the NHS is the Department of Health (government body) or Secretary of State for Health (minister of the state), and any corporation or group of individuals, acting together to meet the 'general interest', without an industrial or commercial character, which is financed wholly or mainly by another contracting authority or has more than half of the board of directors appointed by another contracting authority. This definition encompasses the procurement activities of NHS commissioners (PCTs and CCGs), and NHS Trusts and Foundation Trusts.

Procurement law differentiates between Part A and Part B services. Part A services are subject to a rigorous procurement regime, which requires each contract to be advertised and that one of four tender processes are followed for awarding the contract. Part B services are subject to a less prescribed procurement process with no particular procedure that should be followed. Health and social care services fall within the Part B categorisation, with the exception of computer related purchases, accounting services, architectural and consultancy services (including commissioning support services) which fall within Part A. Part B services do not require prior advertising or competitive tendering, but must satisfy the general obligations to treat 'economic operators' equally and in a non discriminatory way and act in a transparent way (Public Contracts Regulations 2006, s 4). Therefore, as this research is focused on the planning and provision of clinical services, Part B rules and processes will be of relevance. Some fieldwork was conducted after April 2013, when the procurement and contracting of health services became subject to the Procurement, Choice and Competition Regulations No.2 (2013). The implication of these regulations for procurement is discussed in section 3.4 below.

### **3.4 NHS specific legislation**

In addition to EU and UK law, competition and co-operation between local organisations planning and providing NHS services is also subject to NHS specific legislation. This is an area which has been subject to considerable change during the period of the research, with the introduction of HSCA 2012 and the Procurement, Choice and Competition Regulations No.2 (2013).

### ***The NHS Act 2006***

For the majority of the research period (June 2011 – March 2013), the main piece of NHS specific legislation affecting competition and co-operation was The NHS Act 2006. The NHS Act 2006 gives all NHS bodies, including Foundation Trusts, a statutory duty to co-operate (NHS Act 2006, s72). In 2009 NHS Directions were issued which placed a legal requirement on PCTs to ensure that patients were offered a choice of secondary care provider, including the duty to promote and publicise choice (The Primary Care Trusts (Choice of Secondary Care Provider) Directions 2009). NHS Directions are legally binding instruments issued by the Secretary of State under powers from primary legislation, in this case NHS Act 2006.

Other guidance regarding the operation of competition existed, such as the PRCC (see below), but these were not legally enforceable until April 2013 with the introduction of HSCA 2012. The NHS Act 2006 was also amended when the provisions of HSCA 2012 came into force.

### ***Changes to The NHS Act 2006***

NHS Act 2006 was amended by HSCA 2012. In the main the changes to NHS Act 2006 were to reflect the revised duties of the Secretary of State for Health, the establishment of NHS England and CCGs, and the abolition of Strategic Health Authorities and PCTs. In terms of the roles of NHS England and CCGs, NHS Act 2006 was amended to include the duties of both bodies to enable patients to make choices (13 (1) and 14 (v)) and to promote integration (13 (N) and 14 (z)). Both bodies are required to support integration where this would improve quality of services, reduce inequalities with respect to people's ability to access services, and reduce inequalities between persons with respect to the outcomes resulting from the services.

### ***Health and Social Care Act 2012***

HSCA 2012 which came into force on 1 April 2013 (towards the end of the fieldwork period) contains more specific regulations relating to competitive and co-operative behaviour. HSCA 2012 gives commissioning bodies (CCGs and NHS England) the duty to enable patients to make choices in relation to the health services provided to them (HSCA 2012, s75). Additionally, it gives commissioning bodies (CCGs and NHS England) the duty to promote integrated working by securing integration where this would improve quality, reduce inequality of access and reduce inequality of outcome (HSCA 2012, s1).

Monitor, the designated health care sector regulator from April 2013, must act to prevent anti-competitive behaviour which is against the interests of service users, enable services to be integrated where this would improve quality, reduce inequality of access and reduce inequality of outcome, and must not 'cause a variation in the proportion of services provided by persons on the basis of whether they are public or private' (HSCA 2012, s62). Additionally Monitor must act bearing in mind the desirability of co-operation between the providers of health care services (HSCA 2012, s66). A full description of Monitor's new duties is given in section 3.6.

***The NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012***

These regulations came into force on 1 April 2013. They are a replacement in part of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administrative Arrangements) (England) Regulations 2002, and make provision for CCG and the NHS England's responsibilities for commissioning. These responsibilities include authorisation for NHS England to draft a standard contract, and to require CCGs to use it. The NHS Commissioning Board and Clinical Commissioning Groups Regulations 2012 provide the legal basis for three patient rights set out in the NHS Constitution. One of these Standing Rules is particularly relevant to competition as it refers to a duty 'to ensure persons are offered a choice of health service provider' (s39). In addition to the right of patients to choose secondary care provider for elective referral these regulations also include the right to choose a named clinician ('any clinically appropriate team led by a named consultant who is employed or engaged by that health service provider' (s 39 (2)), and choice of a named professionals-led team at referral to secondary care mental health services (s39 (4)).

***Procurement, Choice and Competition Regulations No.2 2013***

From April 2013 the procurement and contracting of health services have been subject to the Procurement, Choice and Competition Regulations (2013), which were produced to 'govern matters of due process in determining who should deliver services' and to ensure that commissioners deliver patients' rights to make choices (Department of Health, 2012d). The Regulations relate to sections 75-77 and 304 (9) and (10) of HSCA 2012. The Regulations include elements of existing guidance that previously were not subject to statutory regulation, including the PRCC and NHS Procurement guidelines. They also mirror EU and UK public procurement law.

The second version of the Regulations replaces the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 (SI. 2013 No.257), which were made on 11 February 2013. They were amended in the light of public concerns and political pressure regarding their implications for the competitive environment within the NHS, most specifically that CCGs would be required to use competitive tenders in all circumstances.

The Regulations cover a number of areas affecting competition and co-operation. They address procurement behaviour, including the basis on which procurement decisions should be made, and the means of achieving quality and efficiency which should be considered by commissioners. Commissioners (both NHS England and CCGs) are not allowed to discriminate between providers, particularly on the basis of ownership (Procurement, Choice and Competition 2013 s3 (2)). Procurement decisions must be made on the basis of capability of delivering quality and efficiency and providing best value for money (s3(2)) and taking into consideration the use of integration, provider competition and choice of provider as a means of achieving quality and efficiency (s3(4)). Additionally commissioners must not prevent, restrict or distort competition against the interests of patients (s10(1)), and must not 'include any restrictions on competition that are not necessary for the attainment of intended outcomes which are beneficial for people who use such services' (s10(2)). A comparison of the Regulations with the PRCC is given in Table 3.1.

The regulations also cover the more processual aspects of the NHS procurement, including how and where contracts must be advertised and decisions recorded. Of most direct relevance to the management of competition is section 5 of the Regulations which state:

*'A relevant body may award a new contract for the provision of health care services for the purposes of the NHS to a single provider without advertising an intention to seek offers from providers in relation to that contract where the relevant body is satisfied that the services to which the contract relates are capable of being provided only by that provider.'* (Procurement, Choice and Competition Regulations (2013) s5)

Section 6 of the Regulations clarifies that the criteria for services that are capable of being supplied by a single provider are 'technical' reasons, reasons connected with the protection of 'exclusive rights' or for reasons of 'extreme urgency'. Section 10 (3) states that UK/EU law should take precedence over the regulations where they are in contradiction.

These NHS specific legal instruments clarify the legal footing of competitive behaviour, and remove doubt about the legal status of competitive behaviour by providing more obvious legal obligations for behaviour. Interestingly whilst competition law, if it applied, was thought not to apply to the commissioners of health services on the basis of solidarity, HSCA 2012 imposes restrictions on commissioners not to engage in anti-competitive behaviour (s75 (1)). However in addition to strengthening the framework prohibiting anti-competitive behaviour, it also upholds the need for the protection of competition to be balanced against the use of integration to achieve quality and efficiency.

Details of how these laws affecting competition and co-operation in the NHS are enforced are found in section 3.6 below.

### **3.5 NHS rules and guidance relating to competition and co-operation**

In addition to the legal instruments affecting the competitive and cooperative behaviour of NHS organisations, a wide range of NHS guidance was in existence during the research period. Before HSCA 2012, the main NHS specific rules governing the operation of competition and co-operation were laid out in the NHS procurement guidelines and the PRCC.

#### ***Procurement rules within the NHS***

NHS Commissioners have some freedom over the nature of the competition for NHS contracts when procuring clinical services. The Department of Health issued guidance to NHS bodies to help decide which procurement approach to use for health services, bearing in mind the legal requirement for equality, non discrimination and transparency, and that processes should be 'defensible to scrutiny'. The guidance in place for the majority of the research period (June 2010 onwards) was the 'Procurement guide for commissioners of NHS-funded services' (Department of Health, 2010f). This guidance was replaced by the Procurement, Choice and Competition Regulations No.2 2013 when they were issued in February 2013 (Monitor, 2013g).

Options open to NHS commissioners range from use of the formal procedures applicable to Part A services (e.g. single tender action, open tender process etc.), to 'contract management' in which an existing contract is negotiated to secure incremental improvements, to the use of the AWP model (a 'call off' contract). The Procurement Guide recommended that whilst there was no requirement to advertise Single Tender Actions, it would be advisable to do so (Department of Health, 2010f)

An important element of procurement within the NHS is the requirement for proportionality. This is an acknowledgement that the resources available to commissioning activity within the NHS are limited, and that therefore the resources used for any particular process should be *'proportionate to the value, complexity and risk of the services contracted'* (ibid. 1.27). The NHS Procurement Guide acknowledged that contracts for public procurement are usually based on value for money criteria rather than cost. However the guide also stated that it is possible for commissioners to decide to seek competition on cost for non-tariff services with minimum quality standards (ibid. 3.4). The standard NHS contract is three years with a one year option to extend, but can be up to between five and seven years.

The NHS Procurement Guide specified some of the behaviour expected of commissioners in relation to the requirements of transparency, non-discrimination, equality of treatment and an additional NHS specific requirement of proportionality. Of particular note is the expectation that commissioners state their commissioning intentions on their websites, and on the NHS Supply2Health website, highlighting those procurements which are single tender and which will use competitive procurement. It is also mandatory for commissioners to advertise procurements and contract awards over a specified amount on the NHS Supply2Health website (£100,000 at the time of the fieldwork), and on the Official Journal of the European Community website (£156,442 at the time of the fieldwork). The requirements also necessitate other behaviours such as retention of an auditable documentation trail providing accountability and clear documentation of criteria used for the evaluation of tenders.

As the legal requirements for Part B services are general rather than specific, prior to April 2013 it was for Strategic Health Authorities to agree the local processes for governance of procurement and dispute resolution, and for commissioners to approach Strategic Health Authorities with potentially contentious issues. The NHS Procurement Guide (Department of Health, 2010f) was replaced by the Procurement, Choice and Competition Regulations No.2 2013 when they were issued in February 2013. Supplementary explanatory guidance about procurement processes was published by NHS England for CCGs (NHS Commissioning Board, 2012). Notably, there was no corresponding process for local dispute resolution in the supplementary guidance, as the hierarchy of organisations at a local level had been removed.

Commissioners are also encouraged to have a policy on the management of conflicts of interest. Before 2013, the main guidance for commissioners was found in The Procurement Guide (Department of Health, 2010f) which outlined the steps commissioners should take.

HSCA 2012 contains requirements for the management of conflict of interest by CCGs (s140). It might be expected that conflicts of interest would become an increasingly relevant issue as CCGs become active, and a guide to CCG requirements for the management of conflicts of interest has been issued by NHS England (NHS Commissioning Board, 2013a). In addition to procurement law GPs are also governed by the General Medical Council 'Good Medical Practice 2006' which requires them to tell the patient and purchaser at the point of referral about any conflict of interest (General Medical Council, 2006, para 7).

### ***Principles and Rules of Co-operation and Competition***

A set of NHS specific rules 'The Principles and Rules of Co-operation and Competition' (PRCC) (Department of Health, 2007b) were introduced in 2007 (see Table 3.1 below). The PRCC were in place for the vast majority of the research period (June 2011 – March 2013). The PRCC were not enshrined in law. A breach in the PRCC could be raised with the NHS CCP, who would, in their advisory role, make recommendations to the relevant regulatory body for commissioners and providers, either the local Strategic Health Authority or Monitor, and to the Secretary of State for Health. A small number of interviews was conducted after March 2013 when the PRCC were abolished and replaced by other mechanisms, including the Procurement, Choice and Competition Regulations No.2 (2013), and conditions in Monitor's provider licence (see section 3.6 below).

The PRCC were grouped around four areas: obligations on commissioners, co-operation and agreements, conduct of individual organisations and mergers and vertical integration. There were ten principles, and each principle was supported by a rationale, summary of expected behaviour/action and rules.

Whilst CA 1998 prohibits anti-competitive behaviour, and abuse of dominant market position, the tenor of the PRCC was that both competition and co-operation were desirable, and the PRCC took other concerns into account in addition to competition. In some aspects the protection of competition was blunted. Various principles addressed the need to ensure a competitive environment. Commissioners were required to commission services from the most appropriate providers (principle 1), commissioning was required to be transparent and non-discriminatory (principle 2), patient choice was required to be promoted (principle 5), commissioner/provider agreements should not restrict choice against patient and taxpayer interest (principle 6), promotional activity was encouraged (principle 9) and mergers should



not restrict choice and competition against patients' and taxpayers' interests (principle 10) (Department of Health, 2010e). However, in addition to addressing competition, the PRCC also emphasised other considerations, some of which related to co-operative behaviour. Organisations were expected to co-operate to ensure service improvement and seamless and sustainable care (principle 4). Within the rules of this principle NHS bodies were reminded of their statutory duty to co-operate, and that they should co-operate to maintain patient safety and improve quality of care, ensure a seamless patient experience regardless of organisational boundaries and ensure service continuity and sustainability. They were also reminded that they should share best practice.

In relation to those principles which protected and promoted competition, the detailed rules in the PRCC provided important caveats. Decisions regarding mergers were not to be considered simply in relation to the protection of choice and competition as they would be in a market, but also in the light of patients' and taxpayers' interests such as whether they will 'deliver significant improvement in the quality of care' (principle 10).

The PRCC were subject to two sets of revisions after they were issued (March 2010 and July 2010), both occurring before the start of the fieldwork in June 2011. A substantial change in the PRCC was the inclusion of two new principles (numbers 6 and 7), both of which sought to protect choice and competition, and incorporate some aspects of CA 1998. Principle 6 emphasised the need to ensure competition and choice was not restricted against taxpayers' and patients' interests, in line with the provision in CA 1998. Essentially this principle aimed to prevent commissioners and providers reaching agreements which reduced choice and competition, for example a group of providers agreeing to refer patients to a single provider. Principle 7 also sought to promote competition by ensuring a diversity of provision. It stated that providers should not 'unreasonably refuse' to supply a service where this restricted choice and competition.

### **3.6 Enforcement of rules for NHS competition and co-operation**

#### ***Cooperation and Competition Panel***

At a local level compliance with the PRCC was overseen by various bodies, but there was a clear expectation that issues regarding competition and co-operative behaviour should be discussed and resolved at a local community level whenever possible. Prior to the regulatory changes of the HSCA 2012, NHS Trusts' and PCTs' compliance was overseen firstly by their

own Boards and then by the regional Strategic Health Authority. For NHS Foundation Trusts, compliance with the PRCC was required by Monitor, the independent regulator of Foundation Trusts, as part of its terms of authorisation. The PRCC were intended to apply to all providers of NHS funded services, including private and third sector providers (Department of Health, 2010e). Compliance with the PRCC was written into the NHS Standard Contracts (until 2013/14), so if any complaint had been upheld regarding the PRCC in relation to any services an organisation provided through an NHS Standard Contract, this would have constituted a breach of contract. At a national level, until April 2013, the CCP was responsible for ensuring that all providers and commissioners of NHS funded services, whether they were public, private or third sector organisations, abided by the PRCC. The CCP had no enforcement power. It had a duty to investigate cases which may infringe the PRCC and to advise the Secretary of State for Health and Monitor (for Foundation Trusts) and the local Strategic Health Authority (for NHS Trusts), who then decided what action should be taken. The remit of the CCP covered an assessment of all mergers, investigation of complaints regarding organisational behaviour, including if organisations had not worked together to provide co-ordinated care to patients, procurement disputes and advertising disputes.

It was anticipated that any issues arising concerning possible infringement of the PRCC at local level should firstly be dealt with locally and informally between the relevant parties. If these discussions failed to resolve the issue, the matter was to be brought to the attention of the PCT, and then escalated to the Strategic Health Authority if necessary. If after Strategic Health Authority intervention the issue remained unresolved it should be referred to the CCP for investigation. The emphasis therefore, was on local resolution wherever possible.

### ***Monitor's regulation of competition and co-operation***

From April 2013 Monitor assumed the role of economic regulator, and the PRCC were subsumed and expressed as 'conditions' in Monitor's provider licence (which covers all providers of NHS funded services) and through secondary legislation (the Procurement, Patient Choice and Competition Regulations No. 2 (2013)) (Cooperation and Competition Panel, 2013). As will be discussed in the section, Monitor emphasised the role of commissioners in deciding how to use flexibilities locally (Monitor, 2013e).

HSCA 2012 endowed Monitor with the following general duties. Firstly, a general duty to protect and promote the interests of health services users by promoting provision of health care services which is economic, efficient and effective, and maintains or improves the quality of the services. (HSCA 2012, s62 (1)). Secondly, Monitor must act to prevent anti-competitive behaviour in the provision of health care services which is against the interests of people who use such services. (HSCA 2012, s62 (3)). Thirdly, Monitor must exercise its functions with a view to enabling NHS services to be provided in an integrated way where it considers that this would achieve the improvement of quality or efficiency of services, reduce inequality of access to services and reduce inequality of outcome (HSCA 2012, s62 (4)). Monitor was also given the general duty to exercise its functions with a view to enabling the NHS health care services to be integrated with the provision of health-related services or social care services where this would achieve the improvement of quality or efficiency of services, reduce inequality of access to services and reduce inequality of outcome (HSCA 2012, s62 (5)). Additionally, Monitor is required have regard to the desirability of co-operation between NHS service commissioners and providers in order to improve the quality of services (HSCA 2012, s66 (2)).

A key mechanism in Monitor's regulatory responsibility required by HSCA 2012 is the provider licence. Monitor is responsible for issuing provider licences to all providers of NHS funded services. Licences are a key mechanism in the regulation of competitive and co-operative behaviours. These were issued to Foundation Trusts from April 2013 and other providers required a licence from April 2014 (Cooperation & Competition Panel for NHS-funded services and Monitor, 2012). From April 2013 NHS Trusts were required by the NHS Trust Development Authority to comply with standards equivalent to licence conditions regarding integrated care, choice and competition and pricing conditions. Monitor assumed responsibility for the investigation of suspected breaches, including those of NHS Trusts. In the case of breaches by NHS Trusts, Monitor provides advice to the NHS Trust Development Authority (Monitor, 2013c). Presumably until other providers, such as independent providers, were required to be licenced in April 2014, they were not subject to any of the conditions of the licence. However, they were of course be subject to the legal framework governing competition and procurement.

The licence conditions address Monitor's statutory duties: pricing licence conditions, choice and competition licence conditions, integrated care licence conditions, continuity of services licence conditions and special Foundation Trust conditions. There are two licence conditions

relating to choice and competition, one to patient choice and the other to anti-competitive behaviour. These are 1) the protection of a patient's right to choice between providers by requiring licencees to make information available to support choice (Provider licence condition C1 – The right of patients to make choices), and 2) the prevention of providers from entering into or maintaining agreements that prevent or distort competition against the interests of health care users (Provider licence condition C2 – Competition oversight). The condition relating to anti-competitive behaviour is intended to mirror the requirements of CA 1998, in order to ensure that the same requirements apply to organisations and activities which do not fall within the jurisdiction of the Act (see section 3.3 above) (Monitor, 2013g). A further licence condition relates to integrated care, and requires that licencees 'shall not do anything that could reasonable be regarded as detrimental to enabling care', including anything which would be against the interests of people using health care services by impeding integration and co-operation with other licencees (Provider licence condition IC1 – Provision of integrated care). A mapping of the way the licence conditions relate to the PRCC can be found at Table 3.1.

Monitor issued enforcement guidelines for the licence in March 2013 (Monitor, 2013d). This guidance describes the range of enforcement mechanisms as ranging from 'obliging' providers to take action to ensure compliance, requiring providers to return to the position before the breach or to make the provider pay a penalty. In exceptional circumstances, Monitor can revoke a licence, essentially preventing an organisation from providing NHS services. Additionally, Monitor may, in respect of Foundations Trusts add in new licence conditions and may remove, suspend or disqualify one or more of the Foundation Trust Directors or Governors. A description of Monitor's responsibility for price setting is given in section 3.8 below. In addition to these formal interventions, Monitor may also take informal action in relation to breaches.

Monitor has also issued separate guidance for its enforcement of the Procurement, Patient Choice and Competition Regulations No.2 (2013) (Monitor, 2013e). Under the powers of these regulations Monitor can investigate potential breaches, and declare arrangements for NHS health care services ineffective. Monitor can require commissioners to put in place measures to prevent breaches, remedy or mitigate the effects of breaches, withdraw or vary arrangements for the tender of services and change the way services are provided. As is the case with the enforcement of the provider licence, Monitor may also decide to resolve

breaches of the Procurement, Patient Choice and Competition Regulations No.2 (2013) informally.

Investigations by Monitor relating to either the provider licence or the Procurement, Patient Choice and Competition Regulations No.2 (2013) are triggered by complaints. These can be raised by provider organisations, commissioning organisations, patient groups, representative bodies or individual health service users (Monitor, 2013f). Monitor's role in considering complaints is to enforce the legal framework of the regulations. In its guidance Monitor stresses that it is the role of commissioners to decide when and how to use the flexibilities open to them in order to secure services in the best interests of service users (Monitor, 2013e).

### ***Office of Fair Trading***

HSCA 2012 gave the OFT concurrent responsibilities with Monitor relating to anti-competitive functions, by allowing Monitor to apply CA 1998 concurrently with the OFT. HSCA 2012 also states that mergers involving two or more NHS Foundation Trusts should be reviewed by the OFT under Part Three of the Enterprise Act 2002 (HSCA 2012, s79). EA 2002 defines enterprise as the '*activities, or part of activities, of a business*' and defines a business as '*undertakings carried out for gain or reward or services/goods which are not supplied for free*' (EA 2002, s129). The OFT has taken the view that mergers of NHS Foundation Trusts and NHS Trusts are also subject to investigation under EA 2002. Under EA 2002 the OFT will investigate any mergers which have resulted or may result in the lessening of competition (Office of Fair Trading, 2013). Monitor will take an advisory role in relation to the benefits of the merger for patients. If the OFT reviews a merger and decides that it has resulted or will result in a lessening of competition then the case is referred to the Competition Commission. The Competition Commission has the power to prohibit the merger in full or partially.

**Table 3.1- A comparison of the regulation of competition and co-operation before and after HSCA 2012**

December 2007	March 2010	July 2010	New arrangements April 2013 Procurement, Patient Choice and Competition Regulations 2013 and Monitor provider licence conditions
<p>1. Commissioners should commission services from the providers who are best placed to deliver the needs of their patients and populations.</p>	<p>1. Commissioners must commission services from the providers who are best placed to deliver the needs of their patients and populations</p>	<p>1. Commissioners must commission services from the providers who are best placed to deliver the needs of their patients and populations</p>	<p><b>PPCC regs</b></p> <p>2) General objective that commissioners ‘must act with a view to a) securing the needs of the people who use the services, b) improving the quality of the services, and c) improving efficiency in the provision of services</p> <p>3(2) Commissioners should treat providers equally and in a non-discriminatory way, including by not treating a provider, or type of provider, more favourably than any other provider, in particular on the basis of ownership.</p> <p>3 (3) The relevant body must procure the services from one or more providers that— (a) are most capable of delivering the objective referred to in regulation 2 in relation to the services, and(b) provide best value for money in doing so.</p> <p>7(1) Commissioners must act transparently and fairly when qualifying providers for patients 7(2) Commissioners must not refuse to qualify an appropriate provider, except where a limit to numbers has been reached</p>

<p>2. Providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability</p>	<p>4. Commissioners and providers must cooperate to improve services and deliver seamless and sustainable care to patients.</p>	<p>4. Commissioners and providers must cooperate to improve services and deliver seamless and sustainable care to patients.</p>	<p>Provider licence condition IC1 – Provision of integrated care – 2 and 3</p>
<p>3. Commissioning and procurement should be transparent and non-discriminatory</p>	<p>2. Commissioning and procurement must be transparent and non-discriminatory and follow the PCT Procurement Guide</p>	<p>2. Commissioning and procurement must be transparent and non-discriminatory and follow the Procurement Guide issued in July 2010</p>	<p><b>PPCC regs</b>  3 (2) Commissioners should act in a transparent and proportionate way,  3 (3) The relevant body must procure the services from one or more providers that—  (a)are most capable of delivering the objective referred to in regulation 2 in relation to the services, and  (b)provide best value for money in doing so.</p>
<p>4. Commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare.</p>	<p>5. Commissioners and providers should encourage patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare.</p>	<p>5. Commissioners and providers should promote patient choice, including – where appropriate – choice of any willing provider, and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare.</p>	<p>Provider licence condition C1 - The right of patients to make choices   Provider licence condition C2 – Competition oversight</p>
<p>5. Appropriate promotional activity is encouraged as long as it remains consistent with patients’ best interests and the brand and reputation of the NHS</p>	<p>9. Appropriate promotional activity is encouraged as long as it remains consistent with patients’ best interests and the brand and reputation of the NHS.</p>	<p>9. Appropriate promotional activity is encouraged as long as it remains consistent with patients’ best interests and the brand and reputation of the NHS.</p>	<p>Provider licence condition C1 - The right of patients to make choices</p>

6. Providers must not discriminate against patients and must promote equality	8. Commissioners and providers must not discriminate unduly between patients and must promote equality.	8. Commissioners and providers must not discriminate unduly between patients and must promote equality..	Provider licence condition C1 - The right of patients to make choices
7. Payment regimes must be transparent and fair	3. Payment regimes and financial intervention in the system must be transparent and fair	3. Payment regimes and financial intervention in the system must be transparent and fair	No direct equivalent, but the principles of transparency and are stated in Part 2 of the Procurement, Patient Choice and Competition regulations
	7. Providers must not refuse to accept services or to supply essential services to commissioners where this restricts commissioner or patient choice against patients' and taxpayers interests.	7. Providers must not refuse to accept services or to supply essential services to commissioners where this restricts commissioner or patient choice against patients' and taxpayers interests.	Provider licence condition C2 –Competition oversight 1(b)
8. Financial intervention in the system must be transparent and fair	NO DIRECT EQUIVALENT		
9. Mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible when demonstrated to be in patient and taxpayers' best interests and there remains sufficient choice and competition to sure high quality standards or care and value for money.	10. Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' and taxpayers' interest, for example because they will deliver significant improvements in the quality of care.	10. Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' and taxpayers' interest, for example because they will deliver significant improvements in the quality of care.	<p><b>PPCC regs</b></p> <p>10 (2) An arrangement for the provision of health care services for the purposes of the NHS must not include any restrictions on competition that are not necessary for the attainment of intended outcomes which are beneficial for people who use such services</p> <p>Other regulations</p> <p>OFT review of mergers involving NHS Foundation Trusts under Part 3 of the Enterprise Act 2002 with advice from Monitor of customer benefits (Section 79 (5) HSCA). Monitor must also enable NHS services to be provided in an integrated way</p>



			<p>where this would achieve the improvement of quality or efficiency of services, reduce inequality of access to services and reduce inequality of outcome (HSCA 2012, s62(4)).</p> <p>Monitor advice to NHS Trust Development Authority on the competition implications of mergers under review involving only NHS trusts (Monitor, 2013b)</p>
<p>10. Vertical integration is permissible when demonstrated to be in patient and taxpayers' best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money.</p>	<p>NO DIRECT EQUIVALENT</p>		
	<p>6. Commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients' and taxpayers' interest</p>	<p>6. Commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients' and taxpayers' interest</p>	<p><b>PPCC regs</b></p> <p>10 (1) When commissioning health care services for the purposes of the NHS, a relevant body must not engage in anti-competitive behaviour which is against the interests of people who use health care services for the purpose of the NHS.</p> <p>Provider licence condition C2 – Competition oversight</p>

### **3.7 Decisions taken in relation to the regulation of competition and co-operation**

The complaints made to the CCP and Monitor and their subsequent recommendations, and the general investigations which they carried out, are particularly interesting in the context of this thesis as they, firstly, illustrate the 'rules-in-use' which are being employed by local organisations in competitive situations, and the difference between this behaviour and the written 'rules-in-form', and secondly, illustrate the interpretation of the 'rules-in-form' made by the regulatory bodies.

#### ***Recommendations made by the Cooperation and Competition Panel***

The decisions that the CCP made suggest that the need to protect and promote competition was balanced with other concerns, such as the achievement of better services, cost savings, quality and safety benefits and optimisation of estate. In the time period it was active as a standalone organisation (2009 -2013) the Panel reviewed 54 merger cases, 11 conduct cases, 4 procurement cases and no advertising disputes. A summary of the cases investigated by the CCP in its lifetime is given in Table 3.2.

**Table 3.2: Summary of decisions taken by the CCP (2009 -2013)**

	<b>No. of cases investigated</b>	<b>No. found to be inconsistent with PRCC</b>
<b>Mergers</b>	54	7
<b>Conduct</b>	11	5
<b>Procurement</b>	4	0
<b>Advertisement</b>	0	0

The work of the CCP was tempered by concerns about the use of public money. In 2010 it issued a Prioritisation Criteria stating that its activities would be shaped by the impact on patients and taxpayers, including likely future deterrence of non compliance with the PRCC, strategic significance including how likely the activity would be to help organisations in their future behaviour and future outcomes, and likely impact on available resources (Cooperation and Competition Panel, 2010).

## Merger cases

The most frequent investigations by the CCP were merger cases. The CCP investigated both horizontal mergers between organisations providing similar portfolios of services and vertical mergers across organisations providing primary, community and secondary care. The CCP assessed merger cases to ascertain whether sufficient choice and competition would remain post-merger. The CCP's recommendations often referred to the merger proposals' consistency with Principle 10 of the PRCC which states that 'mergers between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' and taxpayers' interest, for example because they will deliver significant improvements in the quality of care' (Department of Health, 2010e). Between its establishment in 2009 and its disestablishment in March 2013, the CCP concluded reviews of 54 mergers. In the vast majority of cases that were found to be inconsistent with the PRCC rules, arrangements were agreed that mitigated the loss of patient choice and competition, and the mergers were eventually approved.

In October 2010, the CCP issued fast-track guidance relating to the merger cases they reviewed. This was a reflection of the experience to date that certain types of mergers were very likely to be consistent with the PRCC. These consisted of temporary mergers with a duration of up to two years, mergers between non-competitors, transactions where the merger had previously been approved by the CCP and a change in the degree of control of one party over another was taking place, and other mergers where consistency with the PRCC were very likely, such as certain mergers involving providers of community health services (Cooperation & Competition Panel for NHS-funded services, 2010c). The CCP aimed to identify such cases through informal discussions with the merger parties, and in such cases the CCP would give their recommendation within ten days. The CCP carried out a total of 23 fast track reviews.

Due to the volume of potential merger cases relating to the transfer of PCT provider arms of other organisations arising from the Transforming Community Services initiatives, the CCP decided in 2010 to limit the resources it allocated to such cases. As the majority of mergers reviewed up to that point had been consistent with the merger provisions of PRCC or had become so following assurances and/or remedies regarding the preservation of patient choice, the CCP agreed with the Department of Health that it would not provide formal recommendations on Transforming Community Services mergers as long as the merger

parties completed a letter confirming detailing of the transaction and giving assurances regarding patient choice.

#### Horizontal mergers

In its lifetime (April 2009 – April 2013) the CCP concluded reviews of 32 horizontal mergers of Trusts. These occurred between a variety of organisations, including acute Trust mergers, Ambulance Trust mergers and community services mergers. The CCP found 26 of these horizontal mergers to be consistent with Principle 10 of PRCC. The remaining six proposed mergers were found to be inconsistent due to the potential loss of patient choice and competition which would be incurred, but in all cases remedies were agreed to enable the mergers to proceed.

In one case, that of the Nuffield Orthopaedic Centre NHS Trust and Oxford Radcliffe Hospitals NHS Trust, in which the CCP made its recommendations in September 2011, the Panel found that whilst the merger would result in a loss of commissioner choice and competition in relation to routine elective orthopaedic services, and give rise to additional cost for patients and taxpayers, the benefits (better services, out of hours care improvements, improvements in medical research, PFI cost savings and optimisation of estate) would outweigh these costs.

In three cases, the CCP recommended that the mergers were consistent with the PRCC as long as ‘safeguards’ which had already been agreed with the merger parties and commissioners were put in place.

In the first case, in April 2011 (Outer North East London Community Services and North East London NHS Foundation Trust), the CCP recommended that a particular service (Redbridge health visiting) be transferred to the Council as, if it was part of the merged organisation, the merged entity would only face competition from an ‘insufficient number of effective competitors’ (two or fewer) for the health visiting service in the local area (Cooperation & Competition Panel for NHS-funded services, 2011f). In another, the transfer of NHS Barking and Dagenham community health services business to North East London NHS Foundation Trust in 2009, the CCP found the merger was unlikely to impose material cost on patients or taxpayers by reducing the scope for patient choice or competition, but there was a risk that the arrangement would delay the development of patient choice and competition in community services (Cooperation & Competition Panel for NHS-funded services, 2009b). It

was therefore recommended that NHS Barking and Dagenham work with the London Strategic Health Authority to develop a commissioning strategy to minimise this risk.

The second case, in December 2011, involved a merger of three NHS Trusts (Barts and The London, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust). This proposed merger was found to be inconsistent with Principle 10 as it would result in a material cost to patients and taxpayers through a loss of patient choice and competition (Cooperation & Competition Panel for NHS-funded services, 2011d). However, agreement was reached that the merger could go ahead subject to safeguards, consisting of a requirement that the merger parties agree with the CCP a set of quality indicators to be included in the NHS Standard Acute contract entered into with the merged organisation. This was expected to 'reflect a higher level of quality than we would have expected to exist in the absence of the merger' (Cooperation & Competition Panel for NHS-funded services, 2012d). The CCP recommended that they include quality visits by commissioners, commitment for the merged organisation to meet certain national quality measures at site, and, on occasion, departmental level. Additionally the CCP expected the merged organisation to achieve the claimed benefits of the merger (improvements in length of stay, improvements to pathology services, improvements to cancer care and improvements to paediatric consultant rotas). Locally agreed details of these safeguards were to be agreed by the CCP. The Panel also proposed that if these safeguards were breached, the merged organisation would be at risk of losing its service contracts and commissioners could select a new service provider which would have access to the estate of the merger parties in order to provide the services which had deteriorated in quality.

In making this recommendation the Panel noted a number of factors which in its view took precedence over the need to ensure that competition and choice was preserved: that the commissioners were in favour of the merger, that the financial problems facing two of the Trusts could only be solved by merger and that, whilst there was a potential alternative merger partner for one Trust, the nature of the NHS was such that a 'hostile' takeover would not be practical (Cooperation & Competition Panel for NHS-funded services, 2012d). These recommendations illustrate a clear desire to take into account the local situation and preferences of local stakeholders.

Interestingly, in this case, the Secretary of State for Health did not agree with all of the recommendations of the CCP. The recommendation that commissioners should select a new service provider which would have access to the estate of the merger parties in order to provide the services which had deteriorated in quality was not adopted, and instead the Secretary of State stated that a neighbouring Trust, Homerton University NHS Foundation Trust, should provide services on the Newham site if service quality was to decline to an unacceptable standard, as assessed by the commissioner (Secretary of State for Health, March 2012).

The third of these involved Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust. In this case, the CCP concluded that the merger would give rise to costs for patients and taxpayers as a result of reduced patient choice and competition in relation to two clinical specialities (Urinary Tract and Male Reproductive System Procedures and Disorders) (Cooperation & Competition Panel for NHS-funded services, 2012f). It found that the benefits of the proposed merger cited by the merger parties either would not benefit patients and taxpayers or would not only come about due to the proposed merger. It was agreed that safeguards to mitigate the loss of choice and competition should be firstly, the promotion of patient choice by the commissioners, secondly that service quality indicators for the two services should be measured by commissioners with action to address decline, including retendering if necessary, and thirdly that the benefits of the merger should be delivered in a timely fashion.

There were two further cases of horizontal merger which were found to be inconsistent with the PRCC.

The first of these cases, for which the CCP made recommendations in February 2011, involved the merger of three community provider services (provider arms of South Birmingham PCT, Heart of Birmingham PCT and Birmingham East and North PCT). The CCP found this merger was not consistent with Principle 10 of the PRCC as it was likely to lead to a reduction in patient choice and competition in several areas (Cooperation & Competition Panel for NHS-funded services, 2011g). Whilst the three organisations provided community services, there was also an issue relating to the gatekeeper function in relation to acute elective dental services provided by the provider arm of South Birmingham PCT and the

dental services provided by the provider arm of Heart of Birmingham, where the Heart of Birmingham service referred onwards to acute dental services.

After consultation on remedies, the recommendation to the Secretary of State was to put in place behavioural remedies to safeguard the gatekeeper function for dental services (Cooperation & Competition Panel for NHS-funded services, 2011h). These consisted of the provision of impartial advice about choice to community dental patients requiring direct referral to acute dental services, and that the PCTs should monitor referral patterns and the quality and impartiality of the advice being offered to patients. The CCP noted that no further remedies could be put in place regarding their concerns relating to patient choice and competition as the merger had already taken place.

In the second of these cases, the CCP was unable to identify any remedies which it felt would mitigate the adverse effects of the proposed merger. In March 2011, the CCP reviewed a single case relating to the merger of two Mental Health Trusts (Norfolk and Waveney Mental Health NHS Foundation Trust and Suffolk Mental Health NHS Partnership Trust). The Panel found that the proposed merger was likely to have a material adverse effect on patient choice and competition, which was not outweighed by benefits to patients and taxpayers (Cooperation & Competition Panel for NHS-funded services, 2011e). The Panel was not able to identify any remedies to address this concern, and recommended to Monitor that this merger should not go ahead. Monitor's Board subsequently found that the merger would be in patients' interests, particularly in relation to quality and safety, and decided to address the risks to patient choice and competition through a package of remedies including the retendering of a proportion of contracts, ensuring access to estate for new providers and the publication of information to promote transparency (Monitor, 2011). It should be noted that Monitor's decision followed the presentation of new evidence not considered by the CCP. This is the only merger that Monitor intervened in counter to the CCP recommendation.

#### Vertical mergers

In 2009 -2013 the CCP reviewed 22 mergers involving vertical integration. Seven of these were found to be consistent with the PRCC. Of these, in one case, that of the merger of NHS Warwickshire provider services arm (consisting of three GP practices) with George Eliot NHS Trust in 2011, the merger was found to be consistent with the PRCC by the CCP, but the Secretary of State then asked the merging parties for reassurance regarding the management of potential conflicts of interest between GPs as provider and commissioners

(Cooperation & Competition Panel for NHS-funded services, 2011i). In 14 mergers, the CCP found that the mergers were consistent with the PRCC as assurances had been given by the merging parties regarding the protection of patient choice in acute services.

In one case, the proposed merger of Lewisham PCT provider services arm with Lewisham Hospital NHS Trust in 2010, the CCP again found a potential risk of reduced patient choice for referrals to acute elective care (Cooperation & Competition Panel for NHS-funded services, 2010d). In this case rather than resolving the issue with assurances regarding the preservation of patient choice, a series of remedies were agreed. These consisted of the commissioner monitoring referrals, outpatient attendances and the quality of choice being offered to patients. Furthermore the PCT was to specify where in the pathway choice should be offered to patients, and by whom.

In summary, the CCP merger recommendations indicate a desire to take a wide variety of factors into account in addition to concerns about the preservation of competition when making decisions. The CCP was not only considering whether the merger would bring benefits to patients such as better quality of care, but also looking at the wider factors influencing the merger proposal. This occurs most clearly in the case of the proposed Barts merger where factors which took precedence over the preservation of competition as described in the PRCC included the fact that the financial problems which faced the organisations could only be resolved by means of a merger, and that a 'hostile takeover' was not a workable solution (Cooperation & Competition Panel for NHS-funded services, 2012e). This suggests that there are 'rules-in-use' in operation in the decisions of the CCP which are additional to the formal rules of the PRCC. Furthermore, where it was necessary for the CCP to recommend remedies to counter the issues it had identified which were inconsistent with the PRCC, the emphasis was on consulting with local stakeholders to find an agreeable solution.

It is also noteworthy that it appears that all the proposed mergers which were reviewed by the CCP went ahead, suggesting that all other options would be exhausted before a proposed merger was not supported. In the vast majority of proposed mergers reviewed by the CCP, it is not clear what decisions the Secretary of State made following CCP recommendations, as these decisions do not appear to have been published. The exceptions are the proposed merger Barts and The London, Newham University Hospital NHS Trust and Whipps Cross



University Hospital NHS Trust reviewed above, and the case of a proposed merger between NHS Warwickshire Provider Services arm (consisting of 3 GP practices) with George Eliot NHS Trust in 2011, when the Secretary of State intervened to ask for reassurance regarding the management of potential conflicts of interest between GPs as providers and commissioners (Cooperation & Competition Panel for NHS-funded services, 2011i).

#### Procurement cases

In addition to the review of proposed mergers, the CCP had responsibility for reviewing procurement cases and conduct cases. In the period 2010 – 2013, the CCP reviewed 4 procurement cases, one in 2010, one in 2011 and two in 2012. A review of a further case commenced in 2010, but was subsequently withdrawn as the procurement process ceased. All four complaints related to alleged breaches of Principle 1 of the PRCC, that commissioners must commission services from the providers who are best placed to deliver the needs of their patients and populations, and Principle 2, that commissioning and procurement must be transparent and non-discriminatory and follow the Procurement Guide issued in July 2010. The complaint reviewed in 2011 related to a procurement process which took place pre 2010, so the review was based on the earliest version of the PRCC. All four complaints related to procurement processes of NHS Trusts or Foundation Trusts, and the complainants were unsuccessful bidders from the independent sector. The cases involving the Foundation Trusts were referred directly to the CCP, which made recommendations to Monitor. One case involving an NHS Trust, the NHS North Tyne procurement appeal of October 2010, was referred to the CCP following the local dispute procedure involving the PCT and the Strategic Health Authority. The second case involving an NHS Trust, the Nottingham University Hospitals, was referred straight to the CCP, as the dialysis tender under discussion was commissioned directly by the Trust without PCT or Strategic Health Authority involvement. In all cases the CCP concluded that the decisions of the organisation leading the procurement process were within the range of decisions that could reasonably have been taken, and did not breach the Principles (Cooperation & Competition Panel for NHS-funded services, 2010e, Cooperation & Competition Panel for NHS-funded services, 2011c, Cooperation & Competition Panel for NHS-funded services, 2012i, Cooperation & Competition Panel for NHS-funded services, 2012a). In three of these cases, whilst making this decision, the CCP noted that there were aspects of the procurement process which could have been improved, but which did not constitute a breach of the Principles.

This suggests that, in the cases reviewed, whilst local commissioning organisations were adhering by the formal rules set out in the PRCC, they had not in all cases adopted the best practice guidance that was outside the remit of censure. It is not immediately clear why all the complaints reviewed were submitted by independent sector organisations, but this may be indicative of differing relationships between commissioners and potential service providers dependent on organisational type, or may suggest a different understanding of the 'rules' in operation in the independent sector as opposed to NHS organisations. The relatively small number of procurement cases which were referred to the CCP (including the joint conduct and procurement cases discussed below) is also interesting, and suggests that either the PRCC relating to procurement processes were understood very clearly at local level and were fully embraced when the vast majority of procurements were conducted, that issues arose but were resolved at local level, or that issues arose, were not resolved, but were not referred to the CCP. A further possibility is that providers did not have sufficient motivation to pursue complaints relating to procurement.

#### Conduct cases

The CCP reviewed 11 conduct cases in the period 2009 – 2013. None of these cases related to problems with the co-ordination of care between competing organisations. Four of these were accepted as both conduct and procurement cases. In five of the conduct and conduct/procurement cases the commissioning organisations were found to have breached the PRCC. The CCP's guide to conduct complaints states that complaints can relate to 6 of the PRCC (Cooperation & Competition Panel for NHS-funded services, 2010b). These are: principle 1, that commissioners must commission services from the providers who are best placed to deliver the needs of their patients and populations; principle 2, that commissioning and procurement must be transparent and non-discriminatory and follow the Procurement Guide issued in July 2010; principle 3, that payment regimes and financial intervention in the system must be transparent and fair; principle 5, that commissioners and providers should encourage patient choice, including choice of Any Willing Provider, and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare; principle 6, that commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients and taxpayers' interests; and principle 8, that commissioners and providers must not discriminate unduly between patients and must promote equality.

Two conduct cases were commenced and subsequently withdrawn by the complainant. One of these is particularly interesting. In March 2010 the Association of Chief Executives of Voluntary Organisations and NHS Partners made a complaint in relation to the conduct of NHS Great Yarmouth and Waveney. NHS Partners is an association which represents a range of independent sector providers of NHS services including acute, diagnostic, primary and community care. The nature of the complaint was that the PCT had breached Principles 1 and 4 of the PRCC (December 2007 version) by commencing a tender process for community services, and subsequently taking the decision to restrict potential bidders to NHS organisations or NHS led consortia. The PCT took this decision in the light of a speech from the Secretary of State for Health, and a subsequent letter to NHS Chief Executives, suggesting that a policy of 'NHS as preferred provider' was to be developed (Nicholson, 2009). The CCP investigation of this complaint was halted by the subsequent decision of the Department of Health that all PCTs in the East of England area should cease any ongoing procurement processes for community services, and that '*PCT Boards are required to review their plans for future provision of community services and secure DH 'approval in principle' on direction of travel for their preferred option, against published criteria*' (Department of Health, 2010c).

Five conduct complaints were upheld by the CCP.

In 2009, NHS Kingston was found by the CCP to have breached Principle 4 Rule 2(December 2007 version) (that providers, referrers to and commissioners of NHS services must not restrict choice via collusive behaviour or any other action) by deciding not to let Churchill Medical Centre provide NHS services from a new branch surgery. The CCP recommended that the Department of Health and London Strategic Health Authority should allow the new branch surgery to proceed (Cooperation & Competition Panel for NHS-funded services, 2009a). The Department of Health was reported to have carried out its own investigation into the case and also asked NHS London to carry out a separate review before agreeing that the GP practice could proceed with the planned branch surgery (Health Service Journal, 2010).

In 2010, the CCP found that the North West Specialised Commissioning Group had breached Principles 1 and 4 of the Principles and Rules of Cooperation and Competition (December 2007 version) in its decision to enter into two four year framework agreements for secure mental health services on an exclusive basis restricting choice and competition and giving

rise to material net costs for patients and taxpayers (Cooperation & Competition Panel for NHS-funded services, 2010a). The complaint was made by Hanover Healthcare Ltd (a company which operated an independent mental health hospital). In remedy the Department of Health agreed with the CCP recommendations that the Commissioning group should in future: firstly, acquire services from providers whether or not they were part of the Framework agreements based on value for money considerations and should make a public statement to reflect this; secondly, refrain from entering long term framework agreements in the future; and thirdly, publish on its website the details of the contracts it has entered into.

In 2011 the CCP upheld elements of a complaint from Circle Health Care that Wiltshire PCT was seeking to impose restrictions on providers through contracting which were inconsistent with the PRCC. The CCP found that the PCT had breached Principles 3 and 5 by imposing a minimum waiting time before patients could access Circle Health (thereby distorting choice and reducing competition), restricting the routine elective care services which Circle could offer to NHS patients (again reducing patient choice and restricting competition) and requiring Circle to bundle first and follow-up appointments and pre-operative services into tariffs paid for procedures (payment regime not transparent and fair) (Cooperation & Competition Panel for NHS-funded services, 2011b). In these areas, the CCP did not accept that the benefits cited by Wiltshire PCT would outweigh the costs to patients and taxpayers of the breaches. One argument cited by the PCT for the imposition of a minimum waiting time was that they did not want to encourage competition on the basis of waiting time as patients would choose the shortest waiting time (typically an independent provider), thereby undermining emergency and complex care services (typically provided by NHS providers). Other benefits cited by the PCT included that the restriction on the providers of routine elective care services ensured that sufficient patients would choose UK Specialist Hospitals for routine elective care, for whom the PCT had already made the minimum guaranteed payment.

The CCP recommendations were accepted by the Department of Health. They included that Wiltshire PCT should not require that providers comply with uniform waiting times prior to treating patients, that Circle should be given the opportunity to provide services previously commissioned under to Extended Care Network and that pre-operative assessments and follow up appointments should be paid at national tariff (Cooperation & Competition Panel

for NHS-funded services, 2011a). Additionally the CCP required that the PCT should stop distorting patient choice by influencing the behaviour of GPs and local providers to transfer activity to any preferred provider.

In 2012 the CCP reviewed two conduct cases both of which were found to be in breach of the Principles and Rules. In the first case, 3well Medical (a limited company formed by a group of GPs) complained that Peterborough PCT had breached the PRCC in relation to the possible reconfiguration of primary and urgent care services in the Peterborough area. The CCP accepted the case as both a conduct and procurement review and upheld part of the complaint, that the clinicians involved in the decision-making regarding the reconfiguration were subject to a conflict of interest as they were associated with providers who would be directly affected by the decision and might gain as a result (a breach of the terms of the Procurement Guide, and accordingly their actions were not consistent with the PRCC) (Cooperation & Competition Panel for NHS-funded services, 2012c). The CCP recommended that an independent panel of clinicians review the clinical case and report to NHS Peterborough Board and that the PCT should put measures in place to ensure conflicts of interest are appropriately managed (Cooperation & Competition Panel for NHS-funded services, 2012b). In this case however, Earl Howe for the Department of Health did not agree with the CCP recommendation to require the PCT to take advice from an independent panel of clinicians on the basis that *'I do not believe that this is necessary or likely to materially affect the outcome'* and instead asked the Board members with a conflict of interest to abstain from the vote (Department of Health, 2012c).

In the final conduct case reviewed by the CCP in March 2012, Assura East Riding LLP (a partnership of 13 GP practices and Virgin Care) complained that York Hospitals NHS Foundation Trust and North Yorkshire and York PCT acted inconsistently with the PRCC for the procurement of a Musculo Skeletal (MSK) and Orthopaedic clinical assessment, triage and treatment service. Assura accused the PCT of acting unfairly in awarding the contract for the service to York Hospitals NHS Foundation Trust, and argued that the Trust had deliberately priced its services too low. This is the first example of a complaint of predatory pricing made to the CCP. The CCP however, did not uphold the predatory pricing complaint, but found that the PCT had acted inconsistently in relation to Principle 5 of the PRCC regarding the promotion of patient choice, as York Hospital would be referring patients in its gatekeeper role as the MSK provider and would also be competing for referrals for the same

patients (Cooperation & Competition Panel for NHS-funded services, 2012g). The CCP recommended that safeguards of either the employment of an independent health care adviser to advise patients about choice or that GPs register and record patient choices before a referral was made to the MSK service (Cooperation & Competition Panel for NHS-funded services, 2012h).

The conduct complaints upheld by the CCP cover a variety of principles. Some of these concern issues covered in relation to merger complaints, such as the need to protect choice and competition through the retention of clear gatekeeper arrangements for referrals. However conduct complaints also gave some new interpretations of the way the PRCC should be applied. The issues raised by the Circle Health complaint against Wiltshire PCT are perhaps most interesting. There is a clear difference between the 'rules-in-form' which are cited by the CCP, and the justification of the proposed commissioning agreement by the PCT, illustrating their interpretation of the rules regarding competition in the local NHS ('rules-in-use'). The issues upheld in the Circle complaint against NHS Wiltshire suggest that commissioners' actions to distort choice and competition would not be accepted where there was not clear evidence (rather than anecdotal evidence) that the benefits of this interference would outweigh the costs to patients and taxpayers.

#### Advertising Disputes

During the life of the CCP, no advertising disputes were reviewed.

#### General Investigations

Additionally the CCP undertook investigations as directed by the Department of Health or Monitor. These were general investigations of practice within the NHS, rather than investigations of specific organisations.

One investigation requested by the Department of Health and Monitor and conducted in July 2011 concerned the operation of the 'Any Willing Provider' initiative (Cooperation and Competition Panel, 2011). The review found that practice by PCTs varied considerably and whilst there were examples of good practice, there were also examples of PCTs acting against the PRCC by 'excessively constraining patients' ability to choose, and providers' ability to offer routine elective care services'. The most frequent PCT practice constraining choice was to influence GP referral decisions and to limit or distort choice through processes in referral

management centres. PCTs were found to restrict providers' ability and/or incentive to offer elective care through the imposition of caps on the number of patients a provider would be paid for treating. Other constraints included the imposition of uniform minimum waiting times before treatment. The CCP reported that it was likely that this type of activity was inconsistent with the PRCC, and urged providers to raise any concerns they might have. The CCP acknowledged that there may be good reasons for adopting some of these practices, but that these should be identified and recorded in a transparent manner.

### ***Decisions made by Monitor, the Office of Fair Trading and the Competition Commission***

From April 2013, the Competition and Cooperation Directorate within Monitor has dealt with breaches of the regulations within Monitor's remit where they relate to competition and cooperation. By the completion of the field work in October 2013 Monitor had completed three merger reviews.

Monitor was engaged in the review of two organisational mergers (Royal Free NHS Foundation Trust and Barnet and Chase Farm Hospitals NHS Trust, and part of University Hospital Bristol NHS Foundation Trust and North Bristol NHS Trust) which were completed as CCP reviews under the PRCC as the reviews began whilst the CCP was still in existence. One of these (Royal Free NHS Foundation Trust and Barnet and Chase Farm Hospitals NHS Trust) was approved. In the other (part of University Hospital Bristol NHS Foundation Trust and North Bristol NHS Trust) Monitor decided the benefits of the merger did not outweigh the reduction in patient choice and competition (Monitor/CCP, September 2013). However, no action was taken as the merger had already occurred.

During the fieldwork period the review of the proposed merger of Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospital Foundation Trust by Monitor, OFT and the CC commenced. This is the only merger to date (July 2015) which has been rejected. In February 2013 Monitor advised the OFT that it was not satisfied that some of the envisaged benefits of the merger would occur, or would occur only through merger (Monitor, 2013a). The OFT referred the case to the CC in January 2013, who confirmed that the merger was subject to HSCA 2012 s79 (1) and the turnover test. The Competition Commission found in October 2013 that, counter to the merger parties arguments that the merger would result in benefits which would outweigh a lessening of competition, the proposed merger was likely to result in a significant lessening of

competition in 55 clinical service areas (Competition Commission, October 2013). The Competition Commission rejected the merger parties arguments regarding the benefits of the proposed merger on the grounds that there was a lack of detailed plans to support the claims, a lack of commissioner support, a lack of evidence that the benefit would not occur without the merger, a lack of evidence about the form some savings would take and a lack of detailed implementation plans of these savings, and a lack of evidence that savings would not occur without the merger.

The Competition Commission rejected a behavioural remedy proposed by the merger parties based on the use of NHS Friends and Family Test (which asks patients whether they would recommend services to friends and family) to monitor service quality, accompanied by a retendering of contracts should service quality drop. The Competition Commission ruled that there was insufficient evidence from the behavioural remedies previously implemented by the CCP that such a remedy would be successful in respect of such a significant lessening of competition (SLC), and furthermore, suggested that it did not find behavioural remedies acceptable as they would *'by its nature only remedy, mitigate or prevent the adverse effects of the SLCs; it would not address the SLCs at source by restoring competition'* (Competition Commission, October 2013). The Competition Commission suggested that competition itself would be more effective in achieving quality in services.

### **3.8 Contracts and price setting**

Contracts and price setting are important mechanisms for use by commissioners to influence provider behaviour, and are an important part of the structuring of incentives for competition. Both mechanisms are set partially at national and partially at local level.

#### ***NHS Contracts***

All commissioners are required to use the NHS Standard Contract when agreeing the allocation of services to providers. The NHS Standard Contract is a legally binding agreement between the commissioner and Foundation Trusts, the independent sector, the voluntary sector and social enterprises. An identical contract (the 'NHS Contract') exists between commissioners and NHS Trusts, but this is not legally binding. The contract performs other roles in addition to providing a formal agreement for the purchase of services, for example, it is used to set quality standards. The contract is altered and developed each financial year. The information here is based on the contracts of 2011/12 and 2012/13 which were in place at the time of the research.



The contract performs a number of regulatory functions in relation to competition and co-operation.

Guiding principles are issued to commissioners and providers to bear in mind when agreeing contracts. Some of these specifically relate to co-operation between parties. These include that the agreements support co-operative behaviour that benefit all parties, and that parties understand their mutual dependencies (Department of Health, 2012b). The contract itself specifically states that parties should co-operate to ensure a high standard of care and that a co-ordinated approach is taken across care pathways spanning more than one provider.

More generally the contract specifies how pricing should be set (see section below) and how financial risk should be allocated. In addition the contract sets out how payment disputes, including those regarding low quality services should be resolved.

Large elements of the contract are mandatory and nationally set, however elements can be added for local agreement. These include variations to tariff prices (see section below) and sanctions for low quality.

### ***Price setting***

An important part of governing competition at a national level is price setting. Providers can be reimbursed for services in three ways: by the national tariff (Payment by Results), block contract agreement and local variations to tariff. These payment systems contain differing incentives for organisational behaviour.

Until 2013 the Department of Health was responsible for setting the national Payment by Results tariff. This is essentially a national setting of prices for procedures, which is based on average costs. Up to 2012/13 the national tariff covered the majority of acute hospital activity, but did not include community and mental health activity. The national tariff prices for activity are fixed nationally and whilst local variations to tariff can be agreed between the commissioner and provider, this can only be agreed in exceptional circumstances. In 2010, the Department of Health specified the criteria required for local flexibilities to be implemented. These are that the flexibility supports the provision of care that is better for the patient and the NHS, the flexibility supports service redesign, the flexibility is the product of local agreement, the flexibility is clearly established and documented, and the flexibility should be time limited and subject to review (Department of Health, 2010d). HSCA 2012 gives Monitor the flexibility from 2013, in conjunction with NHS England, to devise pricing

strategy, including allowing local modifications to national tariff, if a provider can provide evidence that it cannot provide services at that price (Frontier Economics Ltd, 2012).

Where the national tariff does not exist, commissioners and providers can agree a local tariff for activity. This local tariff is recorded in the service contract and operates on the same basis as the national tariff (i.e. payment is made for volume of activity undertaken). The terms of the NHS Contract allow commissioners either to agree to pay providers for the actual activity undertaken, or agree monthly payments which can then be revised retrospectively for over or under performance.

The tariff payment has many aims, among them is the facilitation of plurality and contestability by enabling funds to go to any NHS accredited provider on the basis of patient choice (Department of Health, 2012a). The tariff payments are a key element of the competitive environment for NHS services and are thought to incentivise organisational behaviour in two key ways. Firstly, for those providers receiving tariff payment for procedures, it encourages volume, even where this is not in the best interest of the patient. Secondly, a criticism made of the incentives of the tariff system is that it does not include any funds recognising the cost of co-ordinating care across organisational boundaries (Appleby et al., 2012) and indeed does not encourage providers to work together to improve care. This is especially relevant in relation to long term conditions such as diabetes, where a number of organisations are involved in care. The potential negative impact of the tariff on the co-ordination of care between organisations can be mitigated by the 'bundling' of tariffs. This is a process whereby commissioners can encourage co-ordination between organisations providing acute services by 'bundling' tariffs together which include all of the episodes a patient has with the NHS for a care pathway. In these arrangements, a lead organisation might receive a tariff payment for a diabetes pathway and then subcontract other organisations to provide parts of the service as necessary.

Whilst the 'bundling' flexibility can be used by commissioners to encourage the co-ordination of pathways using tariff payments, they may also choose, conversely, to 'unbundle' tariffs where they want to encourage diversity of provision in an element of care, for instance separating payment for a diagnostic activity from the tariff for an inpatient or daycase procedure.

The Department of Health issues an annual Code of Conduct for commissioners and providers of services. This guide notes that, whilst the tariff incentivises providers to attract

more patients, it is 'not a mandate for providers to undertake activity' (Department of Health, 2012a, 2.4), and indeed the NHS Contract stipulates that commissioners and providers should conduct their contractual relationships to 'find and support win/win solutions' (Department of Health, 2012b) and commissioners and providers should remain mindful of the overall cash limits of the local system. The Code also states that commissioners and providers share responsibility for demand management where this is required (8.1.2). If the provider exceeds the agreed level of activity and does not implement agreed remedial actions, the NHS Contract for 2010/11 and 2011/12 states that a commissioner can 'in its reasonable discretion' refuse to pay the provider for activity above the forecasted amount (schedule 3 (1) para 6). Interestingly this provision did not appear in the 2012/13 acute standard contract. Recent research suggests that commissioners and providers were discouraged from letting payment disputes reach a formal level (Allen et al., 2014b).

For those services not captured within the national tariff or a locally agreed tariff, services may be paid using a block contract. Block contracts represent a fixed price for the treatment of a population of patients. Block contracts, and any links to activity and quality outcomes are negotiated locally. Unlike PbR, the block contract does not incentivise organisations to carry out higher volumes of procedures, as the NHS Standard Contract does not allow for reconciliation of costs when a block contract has been agreed. Block contracts are commonly associated with community and mental health services, where the national tariff has not yet been implemented. The divide between national tariff payments in acute settings and the use of block contracts in community services can create disincentives for organisations to facilitate the shift of activity from acute to community settings, even when both services are provided within a single organisation. The split between payment structures for acute and community services is therefore particularly relevant in the light of the move to shift care for conditions such as diabetes from the hospital to the community in line with best practice models. In the case of an organisation which provided both types of care, the financial incentive would be to retain activity in the acute setting, and to carry out as much of it as possible, rather than transferring to the community.

A report for Monitor suggests that, whilst the number of services subject to the PbR tariff is increasing, the proportion of services delivered through local negotiation rather than tariff is increasing (23% on 2007/08 to 28% in 2010/11) (PriceWaterhouseCoopers, 2012).

Furthermore, the report finds that approximately 50% of providers acknowledged deviating from the rules of PbR in negotiations with commissioners. The report also suggests, based on a sample of 69 NHS Trusts, that a common practice is 'cross subsidisation' between tariff and non tariff activities, where non tariff income for providers decreases or increases in proportion to tariff income so provider income remains constant from year to year. Further research, based on data gathered between March and August 2012, suggested that some commissioners lack the budgets to pay for PbR activity and are instead using block contracts and limits on activity paid at full tariff to manage financial risk (Allen et al., 2014b). This suggests that in practice some commissioners and providers are reaching local arrangements about overall pricing structures. From 2013/14 price setting is the responsibility of NHS England and Monitor, who will design and apply the methodology for pricing of services. NHS England leads on the scope and design of currencies, and the variation rules to the National Tariff. Monitor leads on the methodology for setting prices, local modification and rules for local price setting (Monitor, 2012)

### **3.9 Quality regulation**

The following section describes the bodies which were involved in the regulation of quality in relation to NHS services at the time of the fieldwork. These bodies have relevance to competition and co-operation in terms of how their regulations may affect organisational behaviour, however the policy and regulatory framework relating to quality is not directly concerned with issues of competition and co-operation, and consequently there are fewer rules to explore.

#### ***Care Quality Commission***

The quality and safety of services is monitored by the Care Quality Commission which is the independent regulator of health and adult social care services in England. All providers of healthcare must register with the CQC. One of the standards against which the CQC assesses providers' compliance with quality concerns 'cooperation with other providers' (Care Quality Commission, 2010). Providers are required to ensure that care is safe and co-ordinated when more than one provider is involved or patients are moved between services. In order to comply with the regulation, providers are required to: cooperate with others involved in the care, treatment and support of a person who uses services when the provider responsibility is shared or transferred to one or more services, individuals, teams or agencies; share

information in a confidential manner; work together to respond to emergency situations; and support people to access the other health and social care services they need (ibid.)

Following HSCA 2012, providers have a joint licence which is overseen by both Monitor and the CQC in order to both maintain safety and quality standards and to ensure effective competition and the continuity of services (Department of Health, 2010a).

### ***Professional behaviour***

All doctors in the UK must be registered with the General Medical Council (GMC). Other health professionals must also be registered with their professional bodies, for example, nurses must register with the Nursing and Midwifery Council. Registration with professional bodies is subject to standards governing professional behaviour regarding the rules, standards and ethics by which members must abide. In the case of the GMC, some of these standards relate to the way doctors should behave in relation to competitive and co-operative behaviour. Firstly, doctors registered with the GMC have a general duty of co-operation by which they must '*work with colleagues in the ways that best serve patients' interests*' (General Medical Council, 2006). There is more specific guidance relating to financial transactions, requiring that doctors must be honest and open in any financial arrangements with patients, and in honest in financial and commercial dealings with employers, insurers and other organisations or individuals. In particular doctors are required to declare relevant financial and commercial interests to patients. Additionally doctors are not allowed to let financial or commercial interests in organisations providing healthcare affect their treatment or referral of patients, and must tell patients and commissioners of any financial or commercial interests in organisations to which they refer patients.

There are other additional drivers for co-operation between professionals and between organisations in order to ensure the quality of clinical services. Medical training is organised through 'Foundation Schools', groups of institutions including medical schools, the local deanery, trusts (acute, mental health and PCTs), and training for junior doctors is shared across a variety of organisations in the school.

Across the NHS various clinical networks are in place, often used in areas where care spans a number of different types of provision, across primary, secondary and tertiary care, across organisational boundaries and can involve a wide range of professionals. Networks have responsibility for training, spreading best practice and are encouraged to develop a

relationship beyond the transfer of patients which is based in partnership working (Department of Health and Welsh Office, 1995). The National Service Framework for Diabetes recommends that care should be co-ordinated through managed clinical networks (Department of Health, 2001a), and networks have become a prominent model of service co-ordination in diabetes (National Diabetes Support Team, 2007).

### **3.10 Conclusion**

As stated in the introduction to this chapter, the rules affecting competition and co-operation in the planning and provision of NHS services are complex, spanning both legal regulation and best practice guidance. During the research period itself the institutional context changed significantly, and signalled a move towards a more legal footing for rules governing competition and co-operation in the NHS. Whilst the increasing legal requirements regarding the nature of competition and co-operation in the NHS suggest stricter regulation of organisational behaviour, the enforcement mechanisms in place during the research period also suggest that the operation of co-operation and competition in the NHS remains, wherever possible, a matter for local governance within health communities, who are encouraged to agree local rules of behaviour, which Ostrom would term 'rules-in-use'. Both the CCP and its replacement, Monitor, state their intention that it is for commissioning organisations themselves to decide how best to interpret rules and where possible to resolve issues through informal discussions in their own communities. The relatively small number of complaints referred to the CCP during its lifetime suggest that many health communities were resolving issues that arose locally, without resorting to formal regulatory structures. Furthermore, both pricing and contractual mechanisms contain within them the possibility of local flexibilities.

That said, there has been a number of cases of high level arbitration of issues concerning competition which have taken place. Most of these cases were considered by the CCP, however more latterly, issues have been considered by Monitor, the OFT and the Competition Commission. Under the CCP the majority of the decisions taken, particularly those concerning mergers (which represented the largest section of the CCP workload) were pragmatic in nature. All of the mergers reviewed by the CCP were agreed, and in doing so, in some cases acknowledging that other matters took precedence over the preservation of competition. However, it appears that this may be changing with the involvement of non health specific bodies, and the new legal framework. The analysis of the case study data in

Chapters 6 and 7 explores how this policy and regulatory framework was being enacted at a local level by commissioners and providers respectively.

## Chapter 4

### Research Methods

#### 4.1 Introduction

This chapter discusses how the research design addresses the objectives of the study, and includes a discussion of the potential limitations of the research design and execution and how, where possible, these were mitigated. The chapter begins by discussing the selection of a case study method, and the implications of using a single case study design. The rationale underlying the choice of case study site is detailed, and the methods used to gather and analyse data are described. The procedures which were undertaken to gain ethical approval for the study are also described. The chapter closes with a critical reflection on the methods used in the research, and how they and my own identity may have influenced the process of data collection and the research findings.

#### 4.2 The research design – use of a tracer condition

The aim of this study, as explained in Chapter 1, is to examine the way health care organisations and health care professionals in the English NHS understand the current policy and regulatory environment, including incentives for competition and co-operation, and to examine how this understanding affects their relationships as they plan and provide services.

In order to address the study aim it was necessary to select a tracer condition. The use of tracers in research about health care systems was introduced in the 1970s by Kessner, Kalk and Singer (1973) who advocated the use of tracer conditions as a means to assess the quality of health care within an organisation. It was envisaged that the tracer condition would be used as a frame within which a sample of patient records was taken for audit to review the process and quality of care which patients had received in the treatment of that condition. The tracer condition acts as a proxy for care across all conditions, and is used to assess the process of care rather than the outcome. Tracers are used widely within health service research, particularly to assess the quality of the provision of services by tracing the patient journey through services (e.g. Joint Commission on the Accreditation of Healthcare Organizations, 2008). The use of tracer conditions is well established in studies of this nature (e.g. Bennett and Ferlie, 1996).

In this case, a tracer condition approach was adopted in order to provide a proxy focus for the way organisations dealt with competition and co-operation across the range of their



services. It was necessary to select a tracer because it would be simply unmanageable to try to conduct detailed research across the breadth of services provided by an organisation. Diabetes was selected as the tracer condition to be studied, and the research focused on the way organisations planned and provided diabetes care, and the diabetic patients' experiences of the co-ordination of services.

Diabetes was thought to be a suitable tracer condition, not simply because it was a 'proxy' condition which could be used to stand for all or any services provided by a health organisation, but also because diabetes care incorporated services which were thought to be particularly interesting in relation to incentives for competition and co-operation. Firstly, due to the high level of complications people with diabetes were likely to suffer, they were likely to access a variety of services. Secondly, diabetes services could be provided across primary and secondary care, and thirdly, there was a drive in the UK to move care for people with diabetes from a hospital to a community setting. These factors suggested that it was likely that incentives for both competition and co-operation would be active in the commissioning and provision of diabetes services. As there was debate about the best organisational settings for the provision of diabetes services, commissioners may have wanted to open up competition between service providers in order to encourage the establishment of different service models, including the shift of services from secondary to primary care settings. Given this it was likely that the co-ordination of diabetes services would be affected by provider competition. Furthermore, given the need for co-ordination to provide the spectrum of services required by people with diabetes, it was likely that productive inter-organisational relationships would also be encouraged. More information about the nature of diabetes and the organisation of diabetes services in the English NHS can be found in Chapter 1 (Introduction) and Chapter 5 (Provision of diabetes services in the case study area).

### **4.3 The research questions**

The research questions were formed by the findings of the literature review and the theoretical review, and were:

- 1) How do organisations planning and providing NHS services understand the policy and regulatory environment, including incentives for competition and co-operation, and how does this understanding affect their objectives?

- 2) What are the objectives of professionals, particularly managers and clinicians, involved in the planning and provision of NHS services in the current environment, and how do these objectives affect their behaviour?
- 3) In the current environment, how do those organisations and professionals approach their relationships with each other in relation to the planning and delivery of care for diabetic patients?
- 4) What is the patient experience of the co-ordination of services in this environment?

#### **4.4 The use of a case study design**

The research was conducted using a case study approach, which incorporated qualitative methods. Whilst there are various definitions of case study research (e.g. Yin, 1994, Ragin, 1999, Cresswell, 1998), at its most basic a case study is a research 'strategy' (Yin, 1994) characterised by the use of multiple sources of data to explore a single phenomenon. It can incorporate a variety of different methods, both qualitative and quantitative, and can focus on a single case, or incorporate comparison of a number of cases.

The selection of a case study methodology to explore the research questions can be defended on a number of fronts.

Firstly, the research is clearly suited to a largely qualitative rather than quantitative approach. Quantitative methods are suited to research where variables can be grouped into clear categories prior to the research being conducted, and where clear hypotheses exist to be tested by the research, resulting in data which indicates the prevalence of a characteristic. Qualitative research, meanwhile, is based on data generation methods which are 'flexible' (Mason, 2002), and in which categories are not fixed prior to research but are expected to alter in response to the data which is gathered. The aim of qualitative research is to explore theories ('analytical generalisation'), rather than to prove or disprove hypotheses based on frequencies ('statistical generalisation').

The analysis of the theoretical and institutional contexts relevant to this research, as described in Chapters 2 and 3 of this thesis, illustrate the complexity of the environment health care organisations operate in, and, furthermore, suggest that this complex environment may influence organisations' competitive and co-operative behaviour. For

example, game theory suggests that factors such as governance structures (Williams, 1988, Frey and Oberholzer-Gee, 1997), previous organisational interactions (Axelrod, 1984, Burke et al., 1988), the expectation of ongoing future interaction (Parkhe, 1993) and notions of the 'type' of the other player (Gauthier, 1986) may all influence the behaviour of organisations. Case study designs are thought to be particularly sensitive to exploring 'contemporary phenomenon within its real life context' (Yin, 1994, p13). The multiple methods create a number of perspectives on the same phenomenon, giving a more rounded exploration and understanding of context than could be gained from a single method such as a collection of interviews. The flexibility of research methods within the case study approach creates the opportunity to choose specific research methods to address the multiple foci of the study, and to use flexible methods which address the complexities of organisational behaviour and its impact (Green and Browne, 2005).

Case studies are thought to be suited to exploring 'how' and 'why' questions (Yin, 1994), in this instance the question of how health care organisations behave in relation to particular incentives, and how this affects the co-ordination of services. There are, of course, other ways to approach 'how' questions, most obviously by means of conducting an experiment. It is clear that an experiment does not represent a feasible or appropriate way of addressing the research questions. Even if it were possible to control the environment in which organisations operate, there are too many possible variables affecting behaviour which would need to be taken into account, making the environment too complex for a research design based around an experiment or survey.

The literature review found a lack of research which addressed the impact of competitive behaviour on the co-ordination of services. Asking these questions within this environment can only be achieved through a method of enquiry suited to gaining an in depth understanding of how organisations work in circumstances that are not well documented (Bryman, 1989, p173). Furthermore, case study methodology is a recognised method in research about organisational behaviour in the NHS (Keen, 2008), suggesting that the case study has previously been found to be a useful approach and that using the same form again would increase the ease of comparability with existing studies.

#### **4.5 The definition of the case**

An important element of case study research is the identification of the unit of analysis (the 'case'). In this instance, as indicated by the research questions, the phenomenon of interest

was the relationships between organisations and professionals. Therefore the 'case' consisted of those organisations and individuals who were involved in the planning and provision of diabetes services to a specific population.

The purpose of the sampling approach in relation to case studies is to select case study sites on the basis of the research question rather than seeking a sample that is statistically representative (Silverman, 2000). This type of 'theoretical sampling' approach aims to 'specify the conditions and process that give rise to the variations in a phenomenon' (Liamputtong and Ezzy, 2005, p50) and seeks to understand the case in depth rather than look for typicality and representativeness (Stake, 1978).

In terms of defining the particular case which will be selected, the researcher may want for instance to select a case which represents an extreme example of a phenomenon, or alternatively may want to find an 'atypical' case. In this instance the aim was to select a typical case, in which the study of the phenomenon (the relationship between organisations) was of more importance than any particular characteristics of the case itself. However, whilst it would have been possible to select any group of NHS commissioner and providers, the theoretical context discussed in Chapter 2 and the practicalities of conducting research resulted in the identification of a number of characteristics which were taken into account when choosing the case. Firstly, it is suggested that trust may have an impact on behaviour, particularly in relation to history of interaction between organisations, and likelihood of further interaction. Therefore a case study area was sought in which there were new entrants to the market, who had a more limited history of interaction with other local organisations. Secondly, it was anticipated that incentives for competition would be more relevant in areas in which a variety of organisations existed in a concentrated area. Thirdly, it was practical to select an area which was relatively cost and time effective to access.

The boundaries of the 'case' were not solely defined geographically. Selection and definition of a 'case' also involved decisions based on other criteria. Firstly, a 'tracer' condition was selected (see section 4.2 above). Secondly, the case also required a definition of the organisations which would be included within its scope. In this instance, the boundaries of the case were defined by the commissioner, and consisted of the organisations with which they had agreements to deliver diabetes care to the local population. Organisations involved in the planning and provision of diabetes services within the case study consisted of the commissioning organisation themselves (PCT/ shadow GP commissioning consortia in the first instance, and CCG from April 2013) and local hospitals, local intermediate bodies

(screening services, community services etc.) and GP-led services. Thirdly, the case study was defined temporally. As the research question was to a large extent triggered by a drive to introduce competition to the NHS through NHS policy initiatives, the research focused on organisations' behaviour at the time of the fieldwork. The fieldwork was conducted from June 2011 to October 2013.

In practice, it was found that the boundaries of the case were not fixed, and altered as the research progressed. The changes were organisational (see section 4.8 below) and temporal (see section 4.9 below).

#### **4.6 The use of a single case study site**

Qualitative research generally, and case study research in particular, tends to take a small sample. Case study research does not seek to make an inference about the prevalence of a particular characteristic across a population as would a quantitative study. The research used a single case study design, encompassing one NHS commissioning area and the organisations identified by the commissioning body responsible for that area as involved in the delivery of NHS diabetes care to their local population. The case study also included a small number of adult patients with Type II diabetes who were receiving care for their diabetes from case study providers. The choice of a single case study design is not uncomplicated, and like any research design, carries risks and weaknesses which need to be mitigated through the way the research is designed and executed.

The adoption of a single case study design was a largely pragmatic decision in this instance. Securing permission from organisations to participate in research can be a time consuming process, and in this case the research aim of examining inter-organisational and professional behaviour meant that a number of organisations constituted a single case. It was estimated before fieldwork commenced that approximately seven organisations would form the case study (in actuality nine organisations participated). It was important in terms of the credibility of the research to gain access to the majority of organisations within the case study, and therefore it was decided that efforts should be focused on gaining completeness in a single site, rather than risking partial recruitment across multiple case study sites.

The weakness of single case study designs relates to the issue of generalisation (e.g. Verschuren, 2003), namely the concern that one cannot generalise from findings concerning a single example. Multiple case studies may be thought to have the advantage of more valid analytic conclusions, robust findings and greater replicability (Yin, 1994). It can be argued

that such criticism is not valid (e.g. Flyvbjerg, 2006). It is possible, for instance, that a single case study can be sufficient to disprove a theory. Furthermore, as the aim of case study research is to expand and generalise theory, not to make generalisations across the population, the empirical findings of a single case study can be compared with previously developed theory to develop and add to understanding.

The use of a single case study was mitigated for in the following ways. Firstly, whilst only one case study was conducted, interviewees at times referred to dealings with commissioners, provider organisations and professionals who operated outside the case study area. This data allows an element of comparison of provider and commissioner behaviour within the case study area with that of organisations outside the case study area. Whilst this data is not sufficient to allow a full comparison of behaviour within the case study area to that without it, the data is very helpful in situating organisational behaviour in a wider context.

Secondly, by giving a full description of the methods used within the case study to collect the data, including full information of the research methods used, the questions asked of interviewees and the way the data was analysed, it is anticipated that the research has increased power of replicability (Yin, 1994), and therefore could become more generalizable by being repeated in other settings.

Thirdly, Chapter 8 (Discussion) considers the findings of the case study in relation to other empirical studies which address similar issues, thereby allowing a consideration of the extent to which the findings of this study agree or disagree with the findings of other studies.

#### **4.7 Selection of the case study site**

The case study site was identified in April 2011 and field work was conducted between June 2011 and October 2013. Organisational interviews were conducted throughout this period, and patient interviews were conducted from January – April 2013.

A shortlist of possible case study sites was drawn up in March 2011. The shortlist was compiled based on the criteria outlined in section 4.5 (i.e new entrants to market, variety of organisations in concentrated area, ease of access and cost of access). Identification of commissioning organisations to be considered and approached was limited to organisations operating in the London area. This was partly to allow ease of access, and also because the concentration of population in the London area meant that there was likely to be a variety of organisations providing services to the population of one commissioning organisation.

A complicating factor to the selection of the case study site was that the shortlisting of lead commissioning organisations coincided with a transition in commissioning arrangements between PCTs and CCGs (see Chapter 5 – Provision of diabetes services in the case study area). In March 2011 shadow GP commissioning consortia were being established with ‘pathfinder’ status across the country, and PCTs were being dismantled. In London, interim arrangements were in place in which PCTs were grouped together to provide leadership arrangements in the transitional period. In this climate it was important to select a case study commissioning organisation which had some clarity regarding future management arrangements at the time the case study was selected, as this would enable ease of identification of the right person to approach regarding participation in the research.

Considering the factors above, the shortlist was reduced to two commissioning organisations. Both of these areas had the added advantage of an ethnically diverse population. This was considered to be an advantage as such areas tend to have high levels of diabetes and therefore it was likely that diabetes provision would be an important service for the population. The preferred case study area was chosen due to the fact that the Director to be approached had participated in a London School of Hygiene & Tropical Medicine (LSHTM) study previously, and it was hoped this previous contact would encourage participation in research once again.

#### **4.8 Securing access to case study organisations**

An initial approach was made to a Director within the interim management structure for the commissioning organisation. An initial meeting was held with this Director in which formal organisational sign up was secured. This meeting was also used to identify the main providers of diabetes services to the PCT population and used to establish contacts within the PCT, shadow GP commissioning consortium and the provider organisations.

As a result of this meeting, once the necessary organisational research governance approval was in place, an initial interview was held with the PCT manager with responsibility for diabetes services to map the organisations in the local health system involved in the provision of diabetes care, and the patient pathways.

Five providers were identified at these meetings which were then approached to see if they would participate in the research. The initial mapping interview had identified predominantly secondary care providers who were the main providers as defined by the size of the commissioning budget given to them, but during interviews a further three relevant provider

organisations were identified and subsequently approached for participation. One of these was a private provider of part of the diabetic pathway. The other two were NHS community organisations. Both these community organisations provided part of the diabetes pathway for secondary providers who were already part of the study. They were approached to participate in the study as they were examples of an organisational type (standalone community NHS Trusts) which were not at that point represented in the study, and which had been identified during fieldwork as sites which were particularly interesting in relation to incentives for competition and co-operation in relation to diabetes services.

Provider organisations were approached by means of a letter which was emailed to the Chief Executive. This was followed by a chasing email within approximately two weeks, which was then followed by a telephone call. All organisations approached to take part in the research agreed to participate.

Securing the agreement of organisations to participate in the research was in some cases a lengthy process, in the most extreme case taking over a year from the original request (although this does include a break in fieldwork for maternity leave). Often the request was deferred by the Chief Executive to others in the organisation who would be directly involved in the research, such as the diabetes consultants or to a further manager. One difficult-to-reach organisation was entered via snowballing from an interviewee in an outside organisation who agreed to the use of their name. At one point when organisational recruitment had stalled, an approach was made to an individual known in the health community who also had a role within LSHTM for their assistance. This individual contacted the remaining organisations to recommend participation in the research.

Interviewees within organisations were, in the main, identified by those who acted as organisational gatekeepers. Further interviewees were identified via snowballing during fieldwork.

#### **4.9 The timeframe of research**

Interviews were conducted in two blocks: June 2011 – August 2011 and July 2012 – October 2013. The two year period during which the fieldwork was conducted was a period of great national policy and regulatory change, and local organisational change in the case study area itself. The commissioning organisation changed from a PCT to a CCG in April 2013, but the transfer of responsibilities to the shadow GP commissioning consortium began in April 2012, before field work commenced. The CCG became fully operational during the second period



of fieldwork (July 2012 – October 2013). In the time between the two research periods, two of the case study provider organisations began a merger consultation with each other which was approved by the NHS Cooperation and Competition Panel (CCP) just before fieldwork recommenced. Additionally, during the second fieldwork period a consultation on a central reorganisation of acute providers in the wider area took place, which proposed to downgrade the major hospitals in the area from nine to five. Alongside these local changes, the national policy environment in relation to competition was also changing (see Chapter 3 – Institutional Context), most notably the introduction of the provisions of HSCA 2012 in April 2013. These changes not only complicated the process of conducting fieldwork, but also altered the incentives for competition and co-operation. For a timeline of interviews and national and local policy mapped against periods of fieldwork see Table 4.1.

The existence of two periods of fieldwork, spanning in total just over two years, gave the case study a temporal aspect. It was possible, during the second period of fieldwork, to incorporate a degree of reflection from interviewees regarding the changes in the environment and incentives for behaviour which had occurred over time. Later in the fieldwork period, where possible, interviewees were asked about the way incentives for competition and co-operation had altered during the entire fieldwork period, and two key individuals were interviewed in both the first and second fieldwork periods to gain a sense of how issues and behaviour had altered over time with the changing environment. The timeframe also enabled interviews with both the outgoing PCT and the incoming CCG to gain data regarding how incentives and organisational relationships had changed with the change in commissioner. In all, interviewees referred to activity across three contracting years: 2011/12, 2012/13 and 2013/14.

**Table 4.1: Timeline of key national and local changes to the institutional context and organisational interviews**

<b>Date</b>	<b>Event in case study area</b>	<b>Interviews</b>
<b>April 2011</b>	<i>Provider A becomes an Integrated Care Organisation</i>	
<b>May 2011</b>		
<b>June 2011</b>		- PCT Director - PCT Diabetes Manager
<b>July 2011</b>		-Provider A General Manager - Provider A Diabetes Consultant 1 - Provider A Diabetes Consultant 2
<b>Aug 2011</b>		- Provider A Director (Strategy)
<b>Sept 2011</b>		
<b>Oct 2011</b>		
<b>Nov 2011</b>	<i>Outline business case for merger of Provider A and Provider D produced</i>	
<b>Dec 2011</b>		
<b>Jan 2012</b>	<i>Pan CCG organisational reconfiguration programme consultation launched</i>	
<b>Feb 2012</b>		
<b>Mar 2012</b>		
<b>April 2012</b>	<i>Case Study CCG starts works in shadow form</i>	
<b>May 2012</b>	<i>Full Business Case for merger of Provider A and Provider D produced</i>	
<b>June 2012</b>	<i>CCP approves merger of Provider A and Provider D</i>	
<b>July 2012</b>	<i>Pan CCG organisational reconfiguration programme consultation on proposals and preferred option begins</i>	- PCT Diabetes Manager -Provider A Director (Community Services)
<b>Aug 2012</b>		
<b>Sept 2012</b>		- PCT Project Manager
<b>Oct 2012</b>	<i>Pan CCG organisational reconfiguration programme consultation ends</i>	-Provider B General Manager
<b>Nov 2012</b>		-Provider C Director (Strategy)
<b>Dec 2012</b>		- PCT GP and Clinical lead
<b>Jan 2013</b>		-GP -Provider B Director (Strategy) -Provider C Diabetes Nurse - Provider D Director (Strategy) -Provider E Director
<b>Feb 2013</b>	<i>Joint Committee of PCTs accept recommendations to implement Pan CCG organisational reconfiguration programme</i>	
<b>Mar 2013</b>		
<b>April 2013</b>	<i>Case Study CCG goes live. PCT disestablished. Health and Social Care Act live.</i>	-Provider A Director (Strategy) -Provider D Diabetes Consultant -Provider F Director (Strategy)
<b>May 2013</b>		-Provider G Manager
<b>June 2013</b>		-Provider F Diabetes Consultant - Provider G Manager (Contracts)
<b>July 2013</b>		
<b>Aug 2013</b>		-CCG Vice Chair
<b>Oct 2013</b>		- Provider H Director (Strategy)

#### 4.10 Summary of methods in the case study

The research used a combination of qualitative methods. The following section outlines the methods which were used firstly, in relation to the organisational data and secondly, in relation to data concerning the patient experience of the co-ordination of services.

Generally the use of various methods within the case study is not seen as problematic (e.g. Ragin, 1999), although it is of course necessary to have clear justification of integrating different methods within research whether this involves combining qualitative and quantitative approaches, or indeed mixing qualitative methods (Mason, 2002). The value of case study research is in not dealing with pieces of data in isolation when conducting analysis, but to look at the collection of data as a whole (Yin, 1981).

The case study combined semi structured interviews with NHS staff, documentary analysis, observation of NHS staff meetings, and semi-structured interviews with patients (see Table 4.2). The research design was amended during fieldwork in response to the data that had been gathered.

**Table 4.2: Overview of research methods**

Research method	Details
Semi structured interviews	Interviews with NHS staff involved in planning and provision of diabetic services (n = 25) Interviews with patients to discuss their experience of the co-ordination of services for people with diabetes (n=8)
Documentary analysis	Documents available in case study organisations relating to planning and provision of diabetic services
Meeting observation	Non participant observation of meetings held during period of data collection relating to planning and provision of diabetic services

It was originally intended to conduct patient focus groups to establish patients' views of the factors which contributed to well co-ordinated services, and the use of a patient questionnaire to assess the patient experience of the co-ordination of services was considered. The use of the patient questionnaire was rejected before fieldwork commenced because it was not considered a useful way to find out patients' views on the issues in question, as there was no routine dataset which would supply information about the aspects of patient experience needed for the study. The focus groups were removed from the case study design during the fieldwork itself, as following reflection on the data gathered at that point (February 2013), it was clear they would not add value to the research findings, and that patient interviews would instead be more effective.

The recruitment method for patients was changed during the fieldwork, prior to the commencement of recruitment. Details are given in section 4.12 below. This change in recruitment method was necessitated due to the difficulty experienced in recruiting GP practices to the study. Originally it was anticipated that two GP practices would participate in the research, and that participation would involve, firstly, interviews with a GP in each practice, and secondly, the recruitment of diabetic patients for interview from patients who had recently attended a diabetes clinic at the practices. However it was not possible to identify practices from the commissioning area who were willing to participate in the research. Recruitment was attempted by firstly approaching 'research friendly' practices identified by the PCT, and secondly by an email sent to all practices in the area. Whilst this approach resulted in one interested GP practice, they withdrew when told that there would be no payment for participation. Two GPs were eventually recruited for interview but this was too late in the fieldwork to aid the patient recruitment. Advice on recruitment of patients was sought from Diabetes UK who recommended recruitment in person from outpatient clinic waiting rooms, and this was the recruitment approach adopted.

The relation of the methods used to address the research questions is summarised in Table 4.3.

#### **4.11 Research methods used to gather data relating to inter-organisational and professional interactions**

This section describes the methods used to gather data relating to the organisations and professionals involved in the planning and provision of diabetes services in the case study area.

##### ***Semi structured interviews***

Semi-structured interviewing is well suited to examining local context and understandings as respondents have a high degree of autonomy about the data produced (Green and Thorogood, 2004). The interview presents a very flexible method of research which has an 'emphasis on depth, nuance, complexity and roundedness' (Mason, 2002, p65). The use of semi structured interviews was to establish the structure of diabetes services in the case study area, and also to explore interviewees' understanding of the regulatory environment in which they were operating and its impact on their objectives and behaviour when planning and providing services.

**Table 4.3: Matching of research questions with methods of data collection**

<b>Research question</b>	<b>Methods</b>
<i>How do organisations planning and providing NHS services understand the policy and regulatory environment, including incentives for competition and co-operation, and how does this understanding affect their objectives?</i>	Semi structured interviews - one senior member of staff per organisation who has an overview of strategy Document analysis - publicly available documents from each organisation outlining their strategic direction and objectives.
<i>What are the objectives of professionals, particularly managers and clinicians, involved in the planning and provision of NHS services in the current environment, and how do these objectives affect their behaviour?</i>	Semi structured interviews - managerial and clinical service leads for diabetes in each organisation Interviewees asked to share any service level planning documents concerning diabetes care.
<i>In the current environment, how do those organisations and professionals approach their relationships with each other in relation to the planning and delivery of care for diabetic patients?</i>	Initial meeting with PCT diabetic lead to map the provision of diabetic care in each PCT Map used in other interviews to explore the reasons care is provided as it is. Non participant observation of meetings which are associated with the planning of diabetes care.
<i>What is the patient experience of the co-ordination of services in this environment?</i>	Semi structured interviews to establish patient experience of the co-ordination of services.

A summary of the anticipated interviewees prior to fieldwork is given in Table 4.4 below. Prior to recruitment it was anticipated that in the commissioning organisation I would interview the commissioning manager and a board level manager in the PCT, and lead GPs for diabetes if the shadow GP commissioning group had established them at the time of the fieldwork. In each provider organisation participating in the case study I intended to interview the lead clinician for diabetes, lead nurse for diabetes, business/service manager for diabetes and a Board level manager who could provide a strategic overview for the organisation. Additionally, as described in section 4.10, I intended to interview two GPs about their participation in the planning and provision of diabetes services.

All interviews followed a semi structured topic guide developed from the research questions, and informed by the theoretical framework. As the topic guides were only loosely structured, there was the opportunity in each interview to discuss issues of interest freely and fully as they arose. Interview topic guides can be found at Appendix 3.

**Table 4.4 : Anticipated interviewees from commissioners and providers**

Organisation	Interviewees	Total number of interviewees
PCT	Commissioning Manager Diabetes Board level manager	2
Shadow GP Consortia	Lead GPs with responsibility for diabetes	1
Providers	Board level manager Business/service manager with responsibility for Diabetes Lead Clinician Diabetes Lead Nurse Diabetes	4 per organisation
Primary Care providers	GPs providing diabetes care	2

Interviews were conducted between June 2011 and October 2013, in two blocks June 2011 – August 2011 and July 2012 – October 2013. 25 interviews were conducted with 23 people for this element of the research. A summary of the recruitment of interviewees is given below, and a list of all interviews can be found at Appendix 4. 23 of these interviews took place at the interviewees' workplace in a location which allowed confidential discussion. 2 interviews were conducted over the phone. 24 interviews were recorded and full verbatim transcripts produced. In one interview notes were taken as the interviewee felt they would not be able to speak freely if comments were recorded.

Interviews lasted between 30 minutes and 100 minutes.

The temporal element of interviews is significant. There was over two years between first and last interviews. Later in the fieldwork period, where possible, interviewees were asked to reflect on the way incentives for competition and co-operation had altered during the entire fieldwork period. I also returned to the commissioning organisation and the main provider organisation at the start of the second block of interviews and re-interviewed the key individuals for the second time to establish what had changed in the interim (as indicated in Table 4.5).

#### ***Commentary on organisational interviews***

Recruitment in organisations was particularly difficult as the posts of interest were often ones with a single incumbent, or a very small pool of incumbents. If a particular individual declined to engage with the research there was at times no other individual who could be approached in their place.

**Table 4.5: Commentary on recruitment of interviewees**

Organisation	Interviewees	Comment on recruitment
Case Study PCT/ Shadow GP Consortia	PCT Director GP and Clinical Lead for PCT PCT Diabetes Manager (2 interviews)	Difficulty recruiting GPs due to lack of response
Case study CCG	Case Study PCT Project Manager Vice Chair, CCG GP	
Provider A	Director (Strategy) (2 interviews) Director (Community Services) General Manager Diabetes Consultant 1 Diabetes Consultant 2	Unable to secure interview with any of 3 nurses approached. Two did not respond, one unable to provide date for interview.
Provider B	Director (Strategy) General Manager	Consultant suggested did not respond to requests. No contact for nursing forthcoming from organisation.
Provider C	Director (Strategy) Diabetes Nurse	Consultants did not respond. Service Manager declined
Provider D	Director (Strategy) Diabetes Consultant	General Manager declined interview. No nurse identified.
Provider E (Independent Sector provider)	Director	No other individual approached
Provider F	Director (Strategy) Diabetes Consultant	Access secured to Director, who suggested consultant. No service manager or nurse identified.
Provider G	Manager (Contracts) Manager	No response from consultant. One nurse responded, agreed to interview, but then cancelled and did not provide replacement date.
Provider H	Director (Strategy)	No other individuals approached

**Director level interviews** were conducted in all organisations participating in the research. Gatekeepers were asked to identify the Board level individual who could discuss the strategy of the organisation. Interviews with Board level staff followed a topic guide which included questions about what incentives for competition and co-operation existed at an organisational level, and influenced relationships with other organisations, how decisions regarding service development and strategy were made, and what roles each organisation had in that process.

**Business Manager / Service Manager interviews.** The aim was to identify the operational manager with responsibility for the diabetes service in the organisation. The nature of this role depended on the organisational structure and the individual identified by the

gatekeeper varied from those in senior general manager posts with responsibility for a wide spectrum of services to individuals holding posts with smaller areas of responsibility. Out of the five managers identified and approached for the study, two declined as they felt they did not have sufficient knowledge about the diabetes service. Interviews with staff involved in the planning and delivery of diabetic services explored the way this activity was affected by incentives for competition and co-operation, for instance decisions about where care should be delivered and how patient pathways were agreed, including who made decisions and how they were made. Where the roles of interviewees were general rather than focused solely on diabetes, interviewees were asked about strategy and competition in relation to all services provided by the organisation. This approach allowed broader examples and a more nuanced analysis of the way that incentives for competition and co-operation differ within the different services.

**Lead consultant interviews.** Consultants were approached for interview in 6 provider organisations. Interviews were secured with four consultants in three organisations. In the other organisations the consultants did not respond to repeated requests. Interviews followed a similar topic guide to service managers (see Appendix 3).

**Lead nurses interviews.** Recruitment of nurses was problematic. Successful recruitment was often predicated upon the recruitment of consultants or the lead manager, who would then identify potential interviewees from the nurse team. Furthermore, nurses were often reluctant to agree to interviews. More extensive efforts may have been made to recruit nurses, had it not become apparent during the fieldwork that nurses did not appear to operate at the right level in organisations to be affected by incentives for competition. The single interview conducted followed a similar topic guide to that of consultants and service managers (see Appendix 3).

Whilst interviews followed the topic guides, there was an increasing emphasis on organisational behaviour across the spectrum of services provided rather than concentrating specifically on diabetes. This was because firstly, many interviewees had a remit wider than diabetes, and secondly because in some organisations competition existed in relation to services other than diabetes.

### ***Observation***

Observer techniques are acknowledged to provide rich 'holistic' data sources (Denscombe, 1998, p157). In this study, participating organisations were asked to allow me to observe



meetings associated with the planning of diabetes care and which took place during the period of data collection. The aim of meeting observation was to provide supplementary evidence of the data regarding the decisions made about the planning and provision and diabetes services which were described in the semi structured interviews. Observed behaviour is an important data source to triangulate with interviewees' descriptions of the environment in which they are operating and the 'rules' governing their behaviour wherever possible as sometimes individuals are not aware of or cannot articulate the rules affecting their behaviour (Ostrom, 2005, p139).

During the fieldwork period the commissioner established a diabetes redesign board to steer the development of diabetes services in the health community. I attended these meetings, of which there were two (September 2012 and October 2012) during the field work period. I also attended a shadow GP commissioning consortia led workshop on public engagement in organisational strategy in 2011. Due to the timing of the fieldwork it was not possible to observe contract negotiation meetings concerning diabetes. However, the nature of these negotiations was discussed in depth at interviews.

Detailed notes were taken of the meetings, recording the matters discussed, attendees and other relevant observations.

### ***Documentation***

Documents were an important source of data for this research. The main advantage of the use of documentation as a data source within the case study is that the documents are readily available information sources, which can be easily accessed and stored. Unlike data gathered through interviews, documentation is seen as irrefutable and 'stable' (Yin, 1994), especially when it is publicly available. However, it is important to remember that documentation is also socially constructed and situated, and can act as an 'agent' in its own right, (Prior, 2007) a fact that is especially pertinent when considering the official documentation which organisations produce for public consumption, which, like any other source of data, may only reflect an account of a particular viewpoint (Abbott et al., 2004). Indeed, in researching a potentially sensitive area for organisations, such as competitive strategy, much of what is interesting in relation to organisational behaviour and strategy is left out of official documentation due to commercial sensitivity. For instance organisations were not willing to share tender documentation. Whilst documents are generally viewed as 'stable', policy documents in particular reflect a snapshot of policy at a particular time, and,

as was found to be the case with documents regarding competition in the NHS, are subject to a process of continual revision.

Documentation was used within the research both to track policy regarding competition nationally, and to identify local strategy. A distinction could also be made between the 'rules-in-form' (official rules of behaviour) conceptualised by Ostrom (2005) and represented in official documentation, and the 'rules-in-use' which were more apparent in interviews and observation.

The types of documentation which informed the research were as follows:

- National policy documents relating to policy initiatives concerning competition and co-operation
- Planning and policy documentation relating to organisational strategy generally in the wider health community in which the case study organisations were situated
- Planning and policy documentation relating to the provision and organisation of diabetes services in the wider health community in which the case study organisations were situated
- Planning documentation and local policy documentation relating to the provision and organisation of diabetes services in the case study area

Documentation was obtained by a variety of means. National policy documentation was widely available through the Department of Health website. I searched the website firstly for policy documentation directly affecting competition in NHS in the period of the field work, and then followed up the references in these documents to other relevant documents. I also searched the Department of Health website for guidance relating to the provision of diabetes services which affected the planning and provision of diabetes services within the period of the fieldwork. Other documents were mentioned by interviewees.

Interviewees were asked to share local documents relating to the planning and provision of diabetes services and searches were conducted of the publicly available documentation on each organisation's websites, including minutes of Board meetings for each organisation. NHS organisations publish annual strategy documents, which include plans for diabetes, and these were gathered. Commissioning organisations also produce annual strategic commissioning documentation which were also gathered.

#### **4.12 Research methods used to gather data relating to the patient experience of the co-ordination of services**

The research used interviews with diabetes patients to explore the co-ordination of services across organisations from the patient point of view. The data relating to the patient view of the co-ordination of services was to provide an important point of comparison with the data gathered about organisational relationships and the provision of services, to establish what the patient experience of services was in the environment.

Eight adult patients with Type II diabetes were interviewed for the research. The patient recruitment and interviews took place mid way through the fieldwork (January – April 2013). This allowed for organisational service mapping to take place beforehand. It also allowed for a refinement of the research instruments in relation to patient data. The research design originally included the provision of two focus groups and, as a supplementary tool, the administration of a questionnaire. The reason for the rejection of these methods is detailed in section 4.10 above.

##### ***Recruitment***

It was originally envisaged that adult patients with Type II diabetes would be recruited via two GP surgeries. However, despite various attempts at engaging practices, it was not possible to identify practices who were willing to assist with this aspect of the research. After consultation with Diabetes UK regarding most successful methods of patient recruitment it was decided to recruit patients for interview via attendance at diabetes outpatient clinics. Recruitment took place at a hospital diabetes clinic and at a community diabetes clinic. Both these clinics were run by a single organisation. Whilst the interviews only provide data from patients attending clinics of one single provider (Provider A), this was the provider who provided the vast majority of the services to the case study area population. An additional patient was recruited via their membership of the Diabetes Redesign Board run by the case study commissioner.

Patients were given the choice of an interview face to face in their homes, or over the telephone. One interview (Patient A1) was conducted face to face, the rest were conducted by telephone. All interviews were fully transcribed.

Recruitment ceased when the interviews did not appear to be generating fresh data in relation to the themes, and the types of pathways which were identified.

**Table 4.6: Recruitment of patient interviewees**

<b>Interviewee identifier</b>	<b>Gender</b>	<b>Age</b>	<b>Where recruited</b>	<b>Date of interview</b>
Patient A1	Male	61-70	Diabetes forum	31/1/13
Patient A2	Female	51-60	Community clinic	19/3/13
Patient A3	Female	51-60	Hospital clinic	26/3/13
Patient A4	Female	31-40	Hospital clinic	27/3/13
Patient A5	Female	51-60	Hospital clinic	27/3/13
Patient A6	Male	61-70	Hospital clinic	28/3/13
Patient A7	Male	51-60	Hospital clinic	28/3/13
Patient A8	Male	51-60	Community clinic	3/4/13

***Interview topic guide***

Patients were recruited for interview to discuss their pathway through the diabetic services within the past year, and to provide information about their diagnosis and the general co-ordination of the services they accessed. To gain further data about the co-ordination of services across organisations patients were asked questions to ascertain their experience of continuity of care. Continuity of care refers to patients' experiences of the co-ordination of services. The questions patients were asked to explore their experience of continuity of care were based upon a selection of the questions in a patient questionnaire devised by Gulliford et al (Gulliford et al., 2006a, Gulliford et al., 2006b) to measure diabetic patients' experience of continuity of care. Gulliford produced a 19 item measure of experienced continuity of care for diabetes (Gulliford et al., 2006b), which was developed from 25 qualitative patient in-depth interviews exploring patients' experiences and values with respect to continuity of care. Gulliford found that patients' experiences of continuity of care could be characterised across four dimensions. These were experienced longitudinal continuity (regular monitoring of the patient over time), experienced relational continuity (relationship over time with professionals), experienced flexible continuity (the extent to which clinicians respond to patients changing needs over time) and experienced team and cross boundary continuity (concerning the degree of consistency and co-ordination of care between different care settings and different individual clinicians) (ibid.).

The questions developed by Gulliford to measure team and cross boundary continuity were particularly appropriate for use in this research as it was this aspect of continuity of care which was concerned with co-ordination across organisational boundaries. The questions asked in relation to team and cross boundary continuity of care can be found in Appendix 3. They relate to: patients' experiences of co-ordination in general; the provision of

complementary advice and information by professionals; knowledge of medical history across professionals; knowledge of diabetes treatment; knowledge and sharing of patients' treatment plans across professionals.

### ***Commentary on patient interviews***

As explained previously the recruitment strategy for patients changed during the course of the fieldwork from recruiting patients from GP clinic lists, to recruiting patients from outpatient clinics. This change in recruitment strategy was made due to the difficulty in recruiting GP practices to the study, and following advice from Diabetes UK about their experience of successful methods of recruiting patients to research. This approach was successful in recruiting patients for interview, however the disadvantage of this approach was that the patients who were recruited were all under the care of a single provider (Provider A). This can be seen as limiting the data gathered as all the patients' experiences related to care with a particular provider. However the data suggests that the patients interviewed did have experience of care across organisational boundaries. Furthermore Provider A was the main provider of diabetes services to the case study population, so it is not unreasonable that the patients recruited for interview reflected this organisational arrangement.

### **4.13 Analysis of data**

The research took an 'analytic generalisation' approach which draws on theory in the analysis of data, and seeks to expand theory through its findings. In addition, the research sought wider resonance through a comparison with relevant aspects of other case studies (Hammersley, 1992). Much of the recent research examining organisational behaviour in the NHS has used case study designs, which suggests that the analysis of the data can be situated within the learning from other case studies of organisational behaviour.

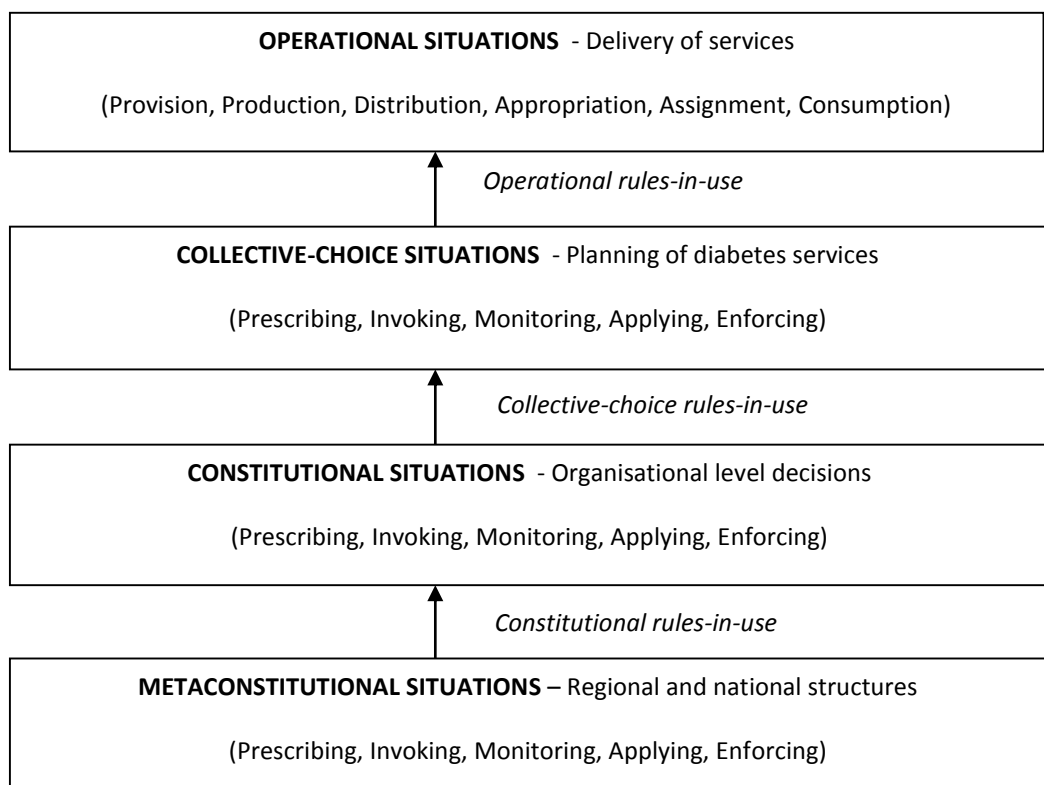
My approach to the analysis of data mixed both deductive and inductive elements. In part, the framework for my analysis of the organisational data was set through the use of the co-opetition (Brandenburger and Nalebuff, 1996) and Ostrom's IAD framework (Ostrom, 2005) as described in Chapter 2 (Theoretical context). Both theories suggest analysis frameworks which can be applied to organisational interactions.

Co-opetition suggests situations should be conceptualised as a 'Value Net' which consists of customers, suppliers, competitors and complementors. A key mechanism for changing the

rules of the game in the co-opetition framework (and thereby creating win/win situations) is the flexibilities in the terms of the contract between two parties. Co-opetition is a framework which is focused on transactions in the market, and therefore its direct applicability to the case study data was limited due to the predominance of hierarchical relationships in the case study area. Due to the weak market incentives in the case study it was not appropriate to directly apply the Value Net framework. However, at the points where incentives for competition were deployed, co-opetition was used as a more general concept to aid analysis of how organisations and professionals were dealing with the need to both co-operate and compete with each other.

The framework which proved the most helpful in relation to the case study was Ostrom's IAD framework, and in particular the conceptualisation of levels of analysis and outcomes, and the associated notion of the 'rules-in-form' and the 'rules-in-use'. The multiple levels of analysis are based in the view that 'all rules are nested in another set of rules that define how the first set of rules can be changed' (Ostrom, 2005, p58). The multiple levels of analysis is a particularly helpful model to consider the rules in place within different levels of the NHS hierarchy. For example, operational rules concern day to day decisions, and collective choice rules affect operational activities. Constitutional choice rules affect collective choice activities. It was found to be useful to consider the rules in place regarding national regulation and policy, and local decision-making within this framework (see Figure 4.1).

**Figure 4.1: Levels of analysis applied to the case study ( from Ostrom 2005)**



These game theory based frameworks were used to help understand and compare theories of behaviour from economics, economic sociology and organisational theory to identify the 'rules-in-use' in the local context.

The data from the interviews with organisations and observation notes from meetings were organised through a computerised database (NVivo). The theoretical and empirical literature gathered had generated some broad categories which were initially used to guide the data analysis (themes such as 'trust', 'clan relationships' and 'historical relationships'). However the data analysis process was largely inductive, and the analytic categories were refined as the data was analysed, for example to include nuances of interpersonal relationships such as 'gift exchange' and 'definitions of business relationships'. New themes were identified throughout the process of data analysis. The most significant new theme which was identified related to the role of hierarchy in the coordination of organisations' activity. An interim analysis of data was conducted after the first two months of data collection, which drew on interviews with the commissioner and with staff working in Provider A, and at this point it was clear from the way the provider described their relationship with the commissioner and the commissioner deployment of incentives for competition, that the use of hierarchy was an significant motivator of behaviour. Partly, this conclusion was reached as it was clear that the categories concerning competitive strategies and provider/commissioner relationships were not sufficiently capturing the provider explanations of their relationship and interaction with the commissioner. At this point the analytic categories were further refined to include 'hierarchy' and subcategories such as 'parent/child relationships'. During the process of data analysis, the earliest interviews were reanalysed in the light of the refined categories.

Documents were gathered relating to the case study research. These documents were a combination of publicly available documents relating to the organisations' competitive strategies and the planning and provision of diabetes services which were accessed via the case study organisations' websites (17) and documents supplied by case study interviewees (1). All the documents gathered were within the public domain. Two approaches were taken to documentary analysis. Firstly, a data collection sheet was produced which noted: the document which had been gathered; its stated purpose; who it was produced by; and, if clear, who it was produced for. A free text section of the data collection sheet was used to analyse the documents in the light of the themes used for analysis of interview data. The documents were also used to check against the data gathered through interviews and

meeting observation, particularly to establish the details regarding the structure of diabetes services in the case study area.

The analysis of the patient interview data was informed by Gulliford's conceptualisation of aspects of continuity of care, and by issues relating to the co-ordination of services which had been highlighted during the theoretical review.

The data from the organisational interviews, observation of meetings and documentary analysis was synthesized through the production of narratives based on each main analytic category. Once these narratives had been completed, the process of the construction of the overall argument took place.

#### **4.14 Ethical issues**

Formal ethical approval was sought from the LSHTM Ethics Committee. NHS Ethics Committee approval was gained before starting work with NHS staff and patients (NRES Committee London- Central Ref 11/LO/0445). Each organisation identified as relevant by the commissioners was approached separately to obtain consent to participate in the study. Local Research Governance was sought from each participating NHS organisation following local guidelines and procedures.

In addition to gaining the formal permissions necessary to conduct the research, ethical issues remained 'live' throughout the research. Three ethical issues are particularly important in qualitative research: anonymity, confidentiality and informed consent (Goodwin, 2006).

In relation to anonymity, all participants in the research, both organisations and individuals, were not named, and are referred to by pseudonyms, both in the thesis and in the transcriptions and notes of interviews. Generic job titles were used for organisational participants, standardised across the organisations where possible. However in order to describe the data in sufficient detail and to situate the case study contextually, it was necessary to disclose some details which may make the case study site and organisations within it identifiable to some readers. In order to describe the case study it was necessary to give details about the organisations contained within it, the nature of the demography etc. Furthermore it was not possible to keep the identity of the organisations participating secret within the case study itself. As my selection criteria for the study was not random,



participants may have been able to guess who the other organisations participating were, and the identity of individual interviewees in other organisations.

Confidentiality was an important issue. It was important to assure participants that, whilst comments they made during interviews were 'on the record' and could be reported verbatim in this thesis, the contents of interviews remained confidential and were not divulged to any other participants of the research. This was particularly important as I was asking organisations and individuals to divulge competitive strategies which could be viewed as highly confidential. The meaning of confidentiality in relation to the study was explained in the Participant Information Sheets (Appendix 1), and was also discussed with participants ahead of each interview. When meeting observation took place, the nature of confidentiality was discussed with the permission giver ahead of the meetings. In some cases participants chose to make comments that they wished to remain 'off the record'. In such circumstances, the information was used to inform my understanding of the case study, and was not referred to directly in the data.

Issues of informed consent were addressed in the main through the explanation of the research given in the Participant Information Sheet (Appendix 1), Consent Form (Appendix 2) and the opportunities for discussion of the study with participants that were built into the consent procedure. Consent to take part in the research was formally obtained through the signing of a consent form, which sought permission for the use of quotations in the study and the recording of the interview. Issues concerning the potential identification of the case study area and participating organisations and individuals were discussed with organisations and individuals prior to the interview.

When my research included attendance at meetings I took steps to ensure that each attendee received an information sheet explaining the research beforehand. In all situations I followed established best practice by being as overt as possible when making notes (Goodwin, 2006).

All interviews were recorded and transcribed. Field notes were taken during non participant observation of meetings. A field diary was kept throughout the research which included details of all contact with organisations and interviewees, and thoughts about the progress

of the research. All electronic data was stored on the School's server and was password protected where appropriate.

In some circumstances, particularly in data gathering which involved patients, it was possible that patients would raise questions about their care, or become concerned about aspects of their care. Whilst this situation did not arise in practice, I was resolved to advise patients to raise their concerns with their GP practices if the situation occurred.

#### **4.15 Commentary on methodology**

It is important that in conducting research the researcher can exhibit 'sensitivity to the ways in which the researcher and the research process have shaped the data collection' (Mays and Pope, 2006). All research, whether consciously or not, has a philosophical underpinning and is shaped by the researcher's view of the world. Whilst this bias cannot be avoided, it can be mitigated through critical reflection about the assumptions made within the research and the extent to which the researcher may have unconsciously shaped the research (Mason, 2002).

A starting point for critical reflection is the identification of the researcher's epistemological and ontological position. Epistemology refers to the researcher's understanding of what constitutes knowledge and how it can be acquired. These assumptions influence the type of research questions we ask, which methods are viewed as reliable, and how they are justified. Much qualitative research belongs to the 'interpretativist sociological tradition' which is concerned with finding out how the social world is understood and experienced, rather than seeking to discover a single 'truth' about the way the world is constructed (Mason, 2002). In terms of this research my epistemological approach is most accurately characterised as one of 'subtle/critical realism' (Hammersley, 1992). The approach of critical realism is that phenomena have an existence outside the interpretations of the social world, but that it is not possible to gain direct, unmediated access to this phenomena. Critical realism therefore denotes a belief that knowledge is socially produced. In conducting my fieldwork I was of the view that my data was socially produced, and therefore seen through the lens of interviewees' own understanding of the world. However that is not to say that a reality, for example the 'true' nature of organisational relationships, does not exist beyond the various understandings of it which are apparent in the data. To hold that no reality exists beyond the account of individuals would be problematic in relation to research of an applied nature that seeks to gain insights of use to a body such as the NHS (Mays and Pope, 2006). Instead, the

role of the researcher who takes a 'critical realism' view of the world is to attempt to weigh the different perspectives and accounts against each other when analysing data.

A further connected philosophical underpinning research is that of ontology. Ontology is concerned with questions about what entities exist, in other words, the way social life is organised. The researcher's ontological approach controls what entities are thought to be the route to understanding the phenomena in question. A researcher could be interested, for example, in individual psyches, in words, in identities or perhaps in feelings (Mason, 2002, p15). In terms of this research I am interested in the interactions between organisations and the impact of the wider institutional structure upon these interactions. Within this approach, I am interviewing individuals, but I am interested in their responses as members of organisations.

Whilst qualitative research, by its nature, steers away from the notion of 'correct' findings, it remains important to ensure that research is 'valid', and to ascertain 'the extent to which the account accurately represented the social phenomena to which it referred' (Pope and Mays, 2008, p87). The use of multiple methods in the case study approach allows the triangulation of multiple data sources. Triangulation is recommended as a means of improving the validity of the study (see for example Yin, 1994). The triangulation of data in this research offers different perspectives of organisational behaviour as a route to comprehensiveness, for instance observation of meetings generates data about behaviour in competitive situations and interviews generate data about participants' understanding of the incentives for competition and co-operation in their environment. It has been noted that triangulation should not be used as a method to reach an 'overall truth' (Silverman, 2000). In this case the data generated is being compared to reveal different aspects of the phenomena being observed.

A further technique to improve the validity of qualitative research is to provide a clear account of the methods used to gather data and how the analysis was conducted. This enables the reader to judge whether the methods used were sound and whether the data supports the interpretation made. I have attempted to achieve this by keeping a field diary recording key thoughts and learning during the fieldwork period, keeping audio recordings and transcriptions of the interviews, keeping a record of all documentation used and keeping a written record of all contacts made with case study organisations. In addition, within this chapter I have attempted to make clear the methods followed, and the reasons the field work was conducted as it was.

Additionally, the validity of the research is increased by an awareness of how my identity as a researcher may have impacted on the research process.

Prior to my career as an academic researcher, I worked as an NHS Manager and have experience of working in both planning roles and in service management roles. As the research progressed I found this to be important in various ways. Firstly, I felt that my previous 'insider' knowledge of the NHS was helpful in enabling me to navigate within organisations to gain access to interviewees. Secondly, my background as a manager had relevance in the interviews themselves. Interviews are essentially social occasions, and the data generated at interview is the result of an interaction between the interviewer and the interviewee. Based on my preconceptions about staff groups within the NHS, I felt that my first hand prior experience of NHS services as a manager would be an asset in some interviews and a hindrance in others. In the interviews with NHS operational managers in particular I revealed my previous work experience as I thought it would build a rapport with my interviewees. On some occasions I feel it may have encouraged interviewees to be more frank with me as I was 'one of them'. Conversely, I was less keen to reveal this work history in interviews with clinicians. During interviews with clinicians it was often the case that they felt there were different incentives in place between managers and clinicians, and I was concerned my work history would place me in the management camp in their minds and led to a less open response. However it may be that my assumptions in this situation were erroneous.

Thirdly, a further possible consequence of my previous work history on the collection of interview data, particularly in the interviews with managers, was the risk of an assumption on my part (and also on the interviewees' part if they knew my background) that I had an insider's knowledge of the functioning of NHS organisations, for example a pre-existing knowledge of the commissioning cycle, or the functioning of NHS budgets and so forth. Indeed whilst I may have a degree of pre-existing knowledge, it does not necessarily follow that these processes within the case study organisations were the same as the ones I had previously experienced. I realised during the interviews that these assumptions risked reducing the depth of explanation in the data, and guarded against revealing my background unless I judged in the interview that it would be necessary in order to establish rapport.

#### **4.16 Conclusion**

This chapter has discussed how the research design allowed the research to address the research questions. It has outlined the potential limitations of the case study design and the way it was executed, and has indicated how these limitations were mitigated wherever possible. The next three chapters of this thesis will discuss the data that was collected in relation to the research aims and objectives.

## Chapter 5

### Provision of diabetes services in the case study area

#### 5.1 Introduction

This chapter describes the way services for adults with Type II diabetes were provided in the case study area. The nature of services for patients with Type II diabetes, as described in Chapter 1 (Introduction), necessitates the involvement of a number of organisations and health care professionals in the provision of services, who are required to work together to plan and provide comprehensive services for patients. The aim of this chapter is to describe the organisations and health care professionals involved in the planning and provision of services for adults with Type II diabetes in the case study area, and the way in which services were organised during the field work period.

The majority of this chapter focuses on a description of the organisations and professionals involved in the provision of services for adults with Type II diabetes in the case study area, their roles within local diabetes pathways, and the best practice models which were being used by commissioners to shape the provision of services during the case study period. As described in Chapter 3 (Research Methods), the field work spanned over two years (June 2011 – October 2013) and the provision of diabetes services changed significantly within this period. This chapter clarifies the change in provision during this time.

Whilst the focus of this thesis is to explore the impact that incentives for competition and co-operation are having on the behaviour of organisations and health care professionals, a subsidiary objective of the research is to examine how patients in the case study area experienced the co-ordination of services between organisations and professionals. The second section of this chapter therefore draws on data from interviews with a small number of diabetic patients in the case study area to describe how patients were experiencing the provision of care from a variety of organisations.

The chapter describes the organisation of services for patients with diabetes across primary, community, and secondary care and various providers as 'pathways'. 'Pathways' describe the 'expected route of care for a patient within a specified setting' (O'Brien and Hardy, 2003). Whilst there is of course no single pathway through services, within the case study area there were several pathways which had been established by commissioners which aimed to encompass all the services an adult patient with Type II diabetes within the population might need to access. It is worth noting that this chapter, and the thesis as a whole, takes a

deliberately 'organisation-centric' view of services and pathways. There is, of course, a very wide range of services which people with diabetes might need to access for reasons connected or unconnected with their diabetes. People suffering from diabetes are at risk of a number of other complications. Some of these, such as a greatly increased risk of suffering from damage to the eyes (diabetic retinopathy) have their own dedicated services. Others, such as the increased risk of kidney damage, are managed within mainstream services (National Institute for Health and Care Excellence, 2015). People with diabetes may also of course need to access health services for reasons unconnected to their diabetes (such as a broken leg for example), but for which their diabetes becomes a relevant concern during treatment. Whilst the patient pathway, and patient experience of their journey through all the services they encounter is very important, what is of interest here are those services identified by commissioners as specifically for people with diabetes.

## **5.2 Diabetes services - the organisational pathways**

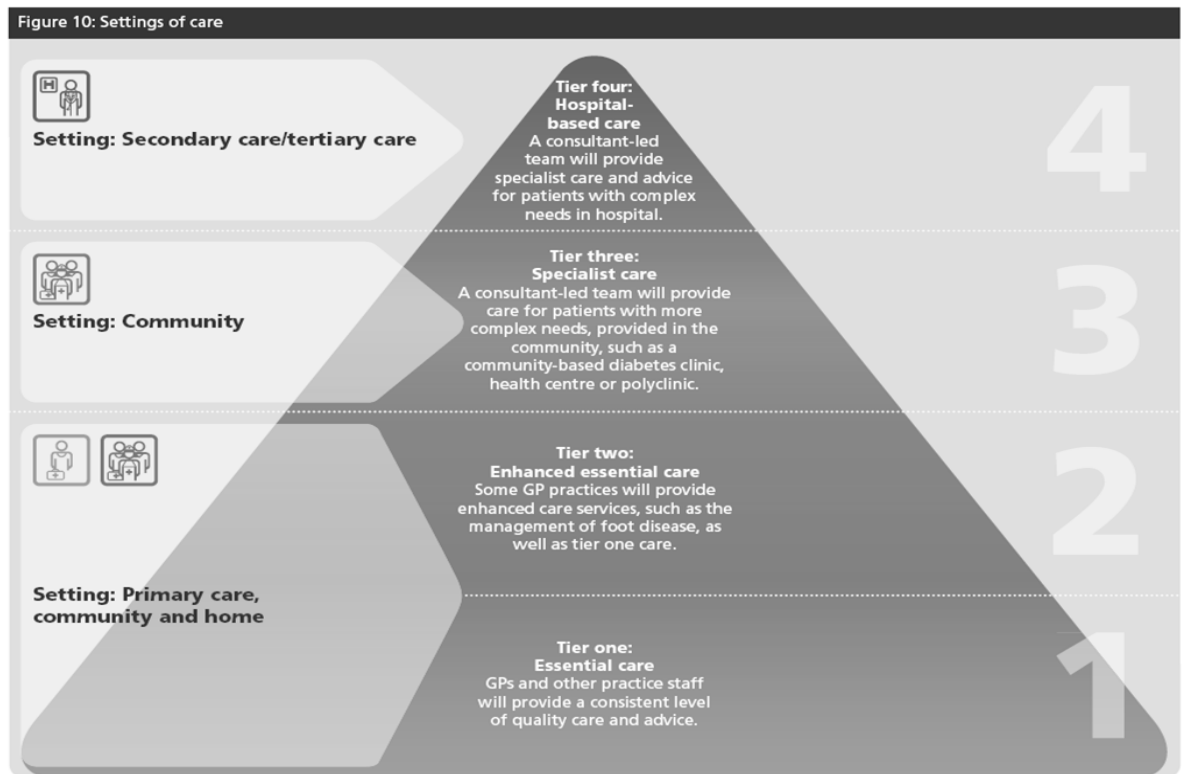
This section discusses the diabetes services identified by the organisations and professionals interviewed, and described in case study documents, in order to outline the roles the case study organisations played in the provision of services as part of the pathway for patients with Type II diabetes in the case study area. This analysis will refer to all the pathways which were identified as available to the case study population, however it will concentrate in detail on the pathway involving Provider A. Like many commissioners (House of Commons Health Committee, 2009), the commissioning organisations in the case study area had established lead commissioner arrangements. The Provider A pathway was the pathway which the case study commissioner was directly responsible for commissioning, and therefore is the pathway for which data is available from both the commissioner and provider perspective.

### ***Diabetes models of care***

In order to understand the different pathways and organisational configurations in place in relation to services for adults with Type II diabetes in the case study area, it is helpful to clarify the models of care in place. The commissioning of diabetes services in the region in which the case study commissioner was situated was influenced by a best practice model devised by Healthcare for London (2009) which envisaged the organisation of diabetes services in a tiered fashion. The diabetes model of care was based on four tiers of care provided in three settings: primary care, community health services and in hospital (see Figure 5.1 below).

Figure 5.1: Best practice model of provision of diabetes services

Source: Healthcare for London, 2009



The tiered care was organised as follows:

**Tier 1** care consisted of essential care provided by GPs and other practice staff in a primary care setting. It could also include other enhanced services such as care planning and email/telephone support.

**Tier 2** care consisted of essential and enhanced diabetes care. This was defined as treatment escalation: for example, insulin initiation in people with Type II diabetes, following accredited training; structured education programmes for patients and carers. It was envisaged that these type of services would be carried out as enhanced care in the primary care practice by primary care staff who had undertaken appropriate training. However if this was not possible, services could also be provided by intermediate diabetes teams.

**Tier 3** referred to the provision of specialist care and consultant-led advice in a community setting for patients with complex needs. Care could be provided in a polyclinic, community-based diabetes centre or health centre.



**Tier 4** care concerned the provision of specialist care and advice in an acute setting for patients with complex needs who were either unsuitable for other settings, or who required more specialist care than that provided in Tier 3.

This model was accepted as best practice by the case study commissioner, and was reported to have been adopted in all community/secondary care pathways, with the exception of the Provider A pathway at the start of the field work period. Importantly, when considering the relationships between organisations and professionals in the diabetes pathway and incentives for competition and co-operation, within the best practice model there were services at Tier 2 and Tier 3 level which could be provided by a variety of providers. Services and organisational relationships could function quite differently depending how these services were organised locally. For example, the GP's role could be expanded to provide services of Tier 2, or these services could be provided by community services. Tier 3 services could be managed by GPs or community trusts with provision for consultant input, or conversely these services could be provided by secondary care using a 'step down' model.

#### ***The provision of diabetes services in the case study area***

##### Self Management

The case study commissioner was working to encourage people with diabetes to become more engaged in the management of their condition. A key mechanism employed by the case study commissioner to achieve this was the introduction of the Year of Care model.

At the start of the field work period about a third of the practices were working to the principles and practices of Year of Care (Diabetes UK et al., 2008). The programme was described by the commissioner as a means of empowering patients to look after themselves. It involved establishing a more proactive process of care planning with the patient in the primary care setting, to provide a more personalised approach. In diabetes, the annual surveillance review conducted in primary care was replaced with a more collaborative consultation based on shared decision-making and the establishment of shared goals. Part of this process was the identification with patients of the services available to them. This is a potentially important factor in the patient experience of well co-ordinated services.

##### Primary Care Services

The patient pathway for diabetes commonly began with the GP who detected and diagnosed diabetes. Often the day to day care for the patient remained with the GP practice, who

conducted regular structured assessments of their condition. Other core services provided by practices in the case study area were: screening for complications; care planning with the patient; provision of advice for patients and carers by both telephone and email; provision of family planning and pre conception advice. A further core responsibility was the maintenance of an up-to-date diabetic register. These key services were paid for through GMS (as part of the General Medical Contract), PMS (services paid at a fixed annual rate as part of a Personal Medical Services contract) and QOF (requirements which earn points translating into greater income).

There were supporting services to which the GP could refer the patient upon diagnosis such as patient education programmes and cookery classes. If the monitoring of the patient's diabetes gave rise to concern about the management of the condition or suggested possible complications, the GP had the option to refer the patient onwards.

The case study commissioner was working to encourage GPs in the area to take on an extended role in relation to diabetes services, in line with the national shift towards a primary care led model of the management of Type II diabetes (Forbes et al., 2010). GPs had the opportunity to take on an extended role in the provision of services, and to extend their provision to Tier 2, and even Tier 3 services. These opportunities were provided by the QOF, by the introduction of GPs with special interests (GPSIs) in diabetes and intermediate care teams (Forbes et al., 2010). The case study commissioner had commissioned an additional GP local service (Locally Enhanced Service) for the initiation of insulin injections for diabetic patients within primary care, and had made available training for practice staff to gain accreditation to deliver this enhanced service. However it was reported that there was a limited number of GPs who had an interest in diabetes, and in the main in the case study area GPs provided Tier 1 services only.

Whilst it was possible that GPs could take on much more of the provision of diabetes services, and that this could be a potential site of competition for the provision of services with other organisations, interviewees, including GPs, did not think that GPs in the case study areas were interested in competing to provide more of the diabetes pathway locally.

#### Provider organisations

Tier 2, 3 and 4 services in the case study area were provided by a combination of NHS community health, secondary and independent sector organisations. There were examples

of different pathways within the case study area depending on where the patients were referred by the GP. At the start of the field work, the case study commissioner identified the main providers of services to their population as Providers A, B, C, D and F (see Table 5.1 below for a description of organisations). Providers E, G and H were identified during the field work period as organisations which provided elements of the diabetes pathways described by the organisations originally identified.

**Table 5.1: Description of organisations participating in the case study**

Provider	Type of organisation	Description
Provider A	NHS Trust. Acute and community services.	Provided hospital based routine elective and non-elective services (including A and E). Provided the majority of community services across 3 commissioning areas.
Provider B	NHS Trust. Acute services.	Large acute trust. Provided services from 5 hospital sites. Secondary and tertiary services.
Provider C	NHS Trust. Acute services.	Acute Trust which operated from a single hospital site.
Provider D	NHS Trust. Acute and community services.	Provided hospital based routine elective and non-elective services (including A and E) from 2 hospital sites. Provided a range of specialist services and some community based services in 2 commissioning areas
Provider E	Independent sector provider	Specialist provider of diabetic retinopathy screening services
Provider F	NHS Foundation Trust. Acute services.	Provided hospital based routine elective and non-elective services (including A and E) from 2 hospital sites
Provider G	NHS Trust. Community services.	A large community services provider.
Provider H	NHS Foundation Trust. Community and mental health services.	A large community and mental health services provider.

### 5.3 The Provider A pathway

The case study commissioner was the lead commissioner of Provider A, which was the main provider of community and secondary care diabetes services to the local population. This pathway is central to the fieldwork as it is the one for which there is most data available concerning organisational working and relationships from both the commissioner and provider point of view. Therefore it will be described fully here.

The Provider A pathway consisted of the acute and community diabetic services provided by Provider A, together with a small number of services provided by other providers. Provider A was an integrated care provider, providing both community and acute diabetes services. The community service spanned three commissioning areas. The services available to the case study population from Provider A at the start of the field work period are described in Table 5.2 below.

**Table 5.2: Diabetes services provided by Provider A**

Community services	Acute services
<p><b>Resources</b>            Community diabetic nurse specialists            Podiatrists            Dieticians            District Nurses            Community Matrons</p> <p><b>Services</b>            Patient education programme run by specialist nurses, dieticians and podiatrists            Diabetic podiatry services (accessed through general podiatry clinics)            Diabetes specific dietetics clinics</p>	<p><b>Resources</b>            Diabetes consultants and specialist registrars            Diabetic nurse specialists            Inpatient Diabetes Specialist Nurse            Podiatrists            Dieticians            Diabetes Specialist Midwife</p> <p><b>Services</b>            Diabetes clinics staffed by Diabetes consultants            Diabetes clinics staffed by diabetes specialist nurses            Specialist Podiatry Diabetic Foot Clinic (with multidisciplinary input)            Podiatrist foot clinics            Antenatal diabetes clinic</p>

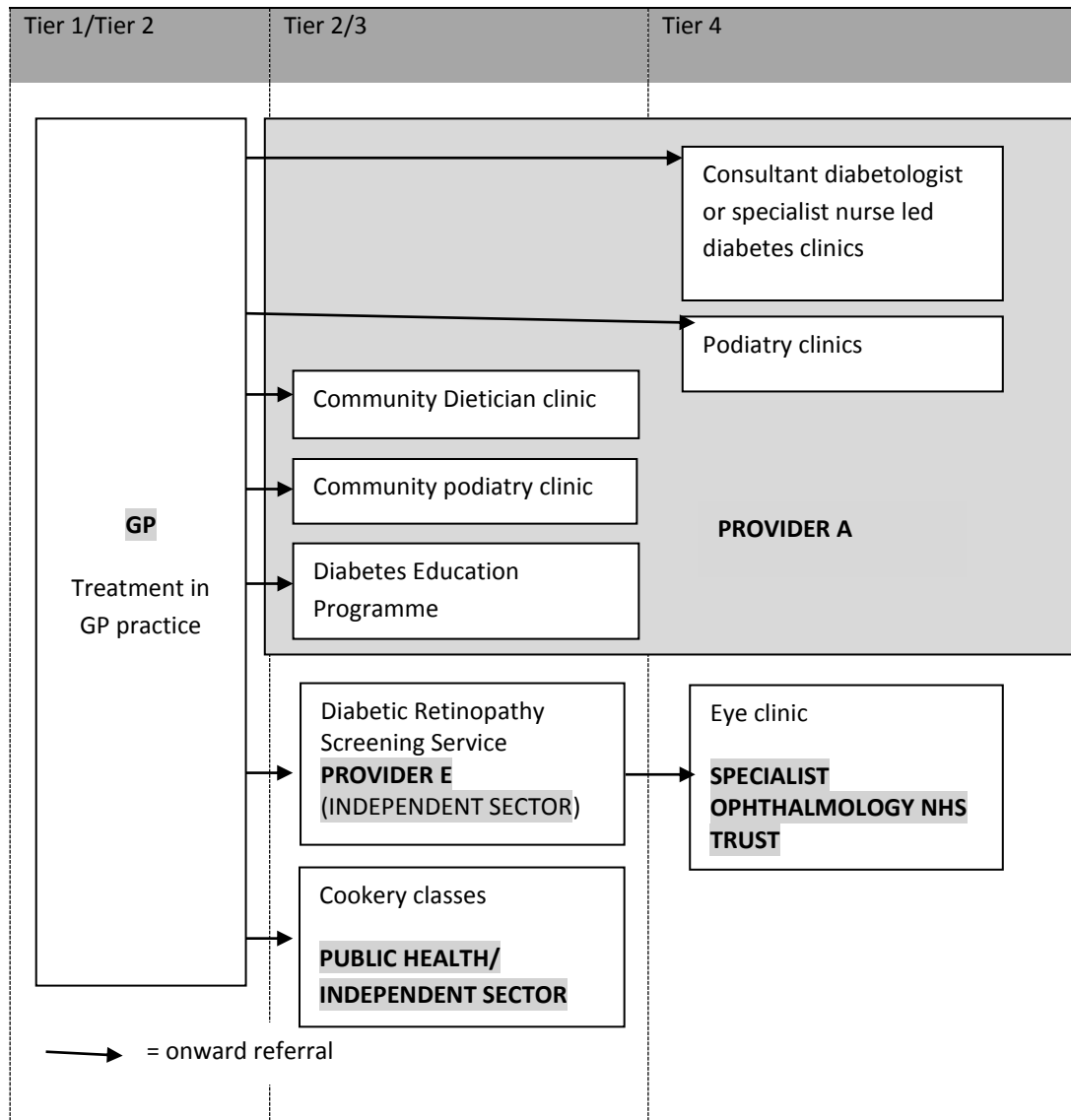
At the start of the fieldwork period the majority of diabetic care in the Provider A pathway was provided in secondary care. There was no Tier 3 service in existence. When a GP referred a patient with Type II diabetes onwards to Provider A they referred directly to the Diabetes consultants. The Diabetes consultants then decided whether to see the patient in an outpatient clinic or whether they should be seen by a diabetic specialist nurse in a hospital outpatient clinic. This was not in line with the division of care advocated in the best practice model in which only the most complicated cases would be seen in a hospital setting

The community aspects of the service provided by Provider A consisted of community dietetic and podiatric clinics, and a patient education programme

Whilst Provider A provided the majority of the services in the pathway, other organisations were also involved. At the time the pathway mapping took place cookery classes were provided by the case study commissioner’s public health department in partnership with an independent sector provider (although this provision altered from April 2013 when public

health functions were transferred to local councils). Patients were also included in a yearly screening programme for diabetic retinopathy, a service provided by an independent sector provider (Provider E). If this screening necessitated an onward referral for treatment for diabetic retinopathy, patients would be referred on to a specialist NHS Trust, who ran a clinic on Provider A's hospital site.

**Figure 5.2: Provider A diabetes pathway (as at June 2011)**



### ***Changes to Provider A's provision of services during the fieldwork***

A timeline of the changes affecting the provision of diabetes services in Provider A is at Table 5.3. During the fieldwork period the case study commissioner worked with Provider A to redesign the provision of diabetic services, with the creation of a community Tier 3 service to support primary care and an acute service to deal with patients who needed intensive inpatient activity. This was known locally as a 'step up, step down' model, whereby the community service would take patients from primary care on a short term basis, stabilise them, and discharge them back to primary care. It was also anticipated that the Tier 3 community service would educate the GPs and nurses working in primary care, and offer support such as quick assessments of unstable patients. By the end of the fieldwork period (October 2013) community clinics had been established in community settings, staffed by community specialist nurses. A diabetic nurse consultant had been appointed together with additional diabetes specialist nurses, and more dietetic and podiatric support. Patients had been discharged from the hospital setting to community setting.

In addition to the changes to the Provider A pathway during the fieldwork period, the provision of diabetes services in the case study area at the time of the field work were also subject to initiatives. The Year of Care initiative, which supported patients to self-manage where appropriate, was in place in some practices in the case study area at the start of the field work period.

An Integrated Care Pilot (ICP) was introduced to the case study area during the field work period. The initiative was a regional (pan commissioner) initiative in which the case study commissioner had agreed to participate. The aim of the ICP was to achieve improvements in the co-ordination of care. The ICP consisted of the establishment of multidisciplinary groups (with representatives from primary, secondary, community, social and mental health sectors) in service areas, including diabetes. GPs identified patients at risk of admission to secondary care for discussion in the regular meetings of the multidisciplinary groups. Therefore, the ICP did not change the organisations involved in the pathway or alter the way services were provided, but like the Year of Care initiatives, aimed to improve the co-ordination of services for patients.

**Table 5.3: Timeline of interviews and changes affecting the provision of diabetes services in the case study area**

Date	Event affecting diabetes services in Provider A pathway	Interviews
April 2011	Provider A becomes an Integrated Care Organisation	
May 2011		
June 2011	Interviewees report ongoing negotiations between commissioner and Provider A regarding establishment of new model of diabetes provision.  A third of case study GP practices involved in Year of Care.	Case Study PCT Director Case Study PCT Diabetes Manager
July 2011		Provider A General Manager Provider A Diabetes Consultant 1 Provider A Diabetes Consultant 2
August 2011		Provider A Director (Strategy)
September 2011		
October 2011		
November 2011		
December 2011	Changes to provision of diabetes pathway agreed	
January 2012	Diabetes community clinics commenced. Diabetes specialist nurses full time out in the community	
February 2012		
March 2012		
April 2012	Case study CCG starts work in shadow form	
May 2012		
June 2012		
July 2012		Case Study PCT diabetes Manager Provider A Director (Community Services)
August 2012	Integrated Care Pilot launched	
September 2012		Case Study PCT Project Manager
October 2012		
November 2012		
December 2012		Case study PCT GP and Clinical lead
January 2013		GP
February 2013		
March 2013		
April 2013	Case Study CCG goes live.	Provider A Director (Strategy)
May 2013		
June 2013		
July 2013		
August 2013		Vice Chair, Case Study CCG

### ***Other diabetes pathways in the case study area***

Whilst Provider A was the main provider of diabetes services to the case study population, referring GPs were of course able to refer to a variety of other providers. If a patient was referred to a provider other than Provider A, services across the four tiers of care were organised differently. Table 5.4 below gives an indication of the configuration of the diabetes pathways to which the providers interviewed for the study belonged. As will be explored in Chapters 6 and 7 the differing configuration of organisations within the diabetes pathway led to different incentives for competition and co-operation between organisations.

**Table 5.4: Additional diabetes pathways in the case study area**

<b>Pathway</b>	<b>Tier 1</b>	<b>Tier 2</b>	<b>Tier 3</b>	<b>Tier 4</b>
<b>Provider B/ Provider G</b>	GPs (Tier 1 and some Tier 2)	Provider G (NHS Community Trust) with consultant sessions and clinical leadership from consultants employed by Provider B		Provider B (Acute NHS Trust)
<b>Provider C</b>	GPs (Tier 1 and some Tier 2)	NHS Community Trust		Provider C (Acute NHS Trust)
<b>Provider D</b>	GPs	Intermediate team at NHS Community Trust	Intermediate team at NHS Community Trust with clinical leadership from consultants employed by Provider D	Provider D (Acute NHS Trust)
<b>Provider F/ Provider H</b>	GPs (Tier 1 and some Tier 2)	Provider H (Community NHS Foundation Trust) with consultant sessions and clinical leadership from consultants employed by Provider F		Provider F (NHS Foundation Trust)

### **5.4 The patients' views of the co-ordination of diabetes services**

The above section described how diabetes services in the case study area were organised across organisational boundaries. Whilst the main focus of this thesis is the organisational point of view regarding the impact of these incentives, a small element of the fieldwork concerned the experiences of patients in the case study area as they accessed services for people with diabetes. The purpose of this element of the research was to see how, in the environment organisations and professionals described, patients were experiencing the co-ordination of services. The aim of this analysis was not to attempt to establish a causal relationship between the patients' favourable or otherwise experiences of the co-ordination of services and the way organisations and professionals approach their relationships with each other when planning and providing care, but to gain a sense of the patient perspective



and the extent to which patients appeared to be alert to, and considered themselves affected by, the provision of care across a variety of health care organisations and professionals.

The patient experience of the co-ordination of services will be discussed here in two ways. Firstly, the patients' pathways through diabetes services will be described. Secondly, patients' experience of the co-ordination of services is considered in relation to the concept of continuity of care. Continuity of care is associated with patient centredness, and the acceptability of services to patients (Gulliford et al., 2006a). In a review of the literature concerning continuity of care, Freeman et al broadly define continuity of care as 'the experience of a co-ordinated and smooth progression of care from the patient's point of view' (Freeman et al., 2000, p7). Research has led to the development of a number of categories to describe aspects of continuity of care. As described in Chapter 4 (Research Methods chapter), the concept of 'team and cross boundary continuity' was one of four dimensions of continuity of care developed by Gulliford (2006b) as a result of in-depth interviews to explore the concept of continuity of care with adults with Type II diabetes. 'Team and cross boundary continuity' was described as 'the degree of consistency and co-ordination of care between different care settings and different individual clinicians' (Gulliford et al., 2006b, p549), and was the dimension most directly concerned with the co-ordination of care across organisational boundaries.

It was thought appropriate to consider the patient experience of services through the lens of continuity of care in order to gain an appreciation of how the issues highlighted by organisations featured in the patient experience of services. Indeed, one of the most interesting findings emerging from this element of the data is that patients are often not aware of, or interested in, the organisations that are providing their services. A further key finding is that patients did not report significant issues relating to the co-ordination of services across organisational boundaries.

As described in Chapter 4 (Methods chapter) eight interviews were conducted with adults with Type II diabetes. All patients were part of the provider A pathway because they were recruited from Provider A community and hospital clinics, or from the Diabetes Redesign Group for the Provider A service. The interviews took place towards the end of the fieldwork, after the changes to the Provider A pathway described in section 5.3 above had taken place, and after the Integrated Care Pilot had been launched.

## 5.5 Patient Pathways

All the patients interviewed were involved in a cycle of regular appointments, sometimes in primary, community or secondary care. However many of them also had one off episodes of treatment related to their diabetes. Some were seen by more than one secondary care provider, especially in relation to associated conditions. As expected from the organisational description of the Provider A diabetes pathway, many of the services the patients accessed were provided by Provider A. Other services regularly accessed by patients were the Retinopathy Screening Service (provided by an independent sector organisation) and appointments with staff within GP practices.

None of the patients interviewed was alert to the possibility that different organisations might be involved in the provision of their diabetes care. During descriptions of the patient pathway, patients did not identify the organisations which were responsible for providing services, they referred to services in terms of their physical location (for example the 'South Road clinic', 'North Hospital'). Two patients commented that they were not aware which organisations provided their care (A3 and A4), and had not particularly considered the issue before:

*'I wouldn't know, to be honest. No, I've never thought, really.'* (A4)

One patient went and found out who was the provider of a service during the interview, and then commented that it is all *'part of the NHS'* (A8).

## 5.6 Patient experiences of continuity of care

As described above, and in Chapter 4 (Methods chapter), the following analysis is based on patients' responses to a series of questions devised by Gulliford et al (2006a, 2006b) to measure diabetic patients' experience of 'team and cross boundary' continuity of care. The headings used for the analysis below are based on the five measures identified by Gulliford as relating to 'team and cross boundary continuity', which were used when interviewing patients about the co-ordination of services for this study. The final category is the amalgamation of two separate questions asked regarding firstly, professionals' knowledge of the individual's diabetes treatment and secondly, the sharing across professionals of agreed plans of treatment for diabetes.

### ***General co-ordination of care***

Interviewees were asked how well they felt their diabetes care was co-ordinated in general. Patient perception of continuity of care, and perceptions of what constituted 'satisfactory' co-ordination differed from patient to patient. The patients interviewed were generally positive about the co-ordination of services, although one patient (A1) said he was dissatisfied with the co-ordination of his diabetes care, basing this view on difficulties accessing podiatry treatment, and a lack of information about the services available.

Whilst the patients interviewed seemed satisfied with the way the services comprising their diabetes care were co-ordinated, the possibility was therefore also raised that patients may be unaware of shortcomings in the co-ordination of their services. One patient in particular, A1, expressed dissatisfaction about the continuity of his care. During the interview he raised many issues relating to the co-ordination of his care, including confusion between both professionals and patients about how to access podiatrist services and differing professional advice. This patient commented that he had taken on two roles as a patient participant on consultation groups (one in his GP practice and one with the CCG) and used these roles to raise questions about how diabetes care should be delivered.

In contrast, some patients, did not report any issues concerning continuity of care and were happy to take a back seat in relation to the co-ordination of care

*'Yeah, basically I didn't go to the Doctor at any stage and say, 'I want to be referred to a diabetic clinic'. But when he decided, he referred me. So I haven't – in answer to your question whether I had difficulties accessing these services, I've never sought them, if you see what I mean?...I'm really easy going.'* (A8)

All patients mentioned a central professional who had a key role in co-ordinating their care. The professional identified by patients as the central co-ordinator had responsibility for arranging the majority of referrals for the patient. The GP was an important person for some interviewees, particularly with reference to facilitating access to services and the co-ordination of care. Where care for diabetes had transferred to community and hospital settings due to the severity of the condition, the GP was less of a focal point. This role was also fulfilled by specialist nurses in primary, community and hospital settings. Less frequently patients were referred by hospital consultants. However for one interviewee (A2), the GP remained the focal point for the co-ordination of services even when the responsibility for treatment and monitoring of their diabetes had transferred from the GP to community care.

Patients reported a cycle of regular monitoring appointments which had occurred within the last year, in which appointments were pre-booked for them. The exceptions to this were podiatrist appointments, where some patients noted they could self-refer, and some that they needed to call to make their annual appointment.

Six patients referred to measures they had taken to ensure the smooth co-ordination of their own care. Some patients made sure that they kept their own records concerning their treatment. One patient (A2) kept a written log of all their appointments and filed all correspondence. Another (A6) asked professionals to write in his 'diabetic book' at every appointment, to keep a record of treatment as he saw so many doctors. One patient said she was sent copies of all hospital reports, which she valued in case she ever needed to access private treatment (A5).

A lack of concern with the organisation of services, did not necessarily indicate a general disinterest in the quality of the care that was received. For example, patient A3, who reported very few issues relating to continuity of care, had significant concerns related to other aspects of her care, namely access to her GP and the attitude of her consultant during appointments. Furthermore, whilst the focus of the patient interviews was on the 'team and cross boundary' aspects of continuity of care which related to the transfer of care between professionals, patients also identified other aspects of continuity of care as important to them. In particular, patients identified factors commonly associated with relational continuity. Relational continuity refers to the experience of interacting with, and developing a relationship with, a named professional whom the patient knows well (Gulliford et al., 2011). Patients valued seeing the same professionals at their appointments, particularly in regard to GP care, and some reported making an effort to see the same GP wherever possible.

### ***The provision of complementary advice and information by professionals***

Interviewees were asked whether the various professionals they saw gave them the same advice and information regarding their treatment for diabetes. Over half of the patients interviewed felt that they were given the same information and advice by all professionals. Three patients cited instances where differing advice had been given. One patient recalled three separate instances where he had been given differing diagnoses: firstly, by two GPs in the same practice, secondly by a GP and podiatrist, and thirdly by a GP and a Urology doctor.

This patient also recalled an instance where he had been referred incorrectly to a podiatry service:

*'When I had the foot problem and all this thing, I don't know where to start with treatment. But they referred me to the nurse and then she referred me to the Podiatrist to cut the nails, and the Podiatrist obviously was working to the rule, and can't do them...'* (A1)

The other example of differing advice was a difference of opinion between professionals (GP and hospital consultant) regarding diabetes medication (A4). Access to podiatry was raised by a further patient (A5) who had been advised incorrectly at the Diabetes Education Programme that they could self-refer to podiatry. However, difference in opinion between professionals was not always seen in a negative light. One patient (A2) was not concerned about the possibility of receiving differing advice:

*'I just thought well, you know, that's that person's point of view and that's that person's point of view. But they don't do that. It's very rare that happens now.'* (A2)

### ***Knowledge of medical history across professionals***

Interviewees were asked whether the professionals they saw knew their medical history.

The interviewees had not encountered any problems with the availability of medical notes. The majority of interviewees felt that the professionals they saw for their diabetes care were aware of their medical history as they had access to notes from previous appointments, either on paper or electronically.

Two patients thought that at some appointments, such as with the Podiatrist or Retinal Screening, the medical history was not known (A1 and A8). One of these patients (A1) was also not sure that staff checked the electronic records correctly all the time, or that the records were complete:

*'They try to look at the screen, but I don't know whether they've fully done that. I just sometimes remind them and one of the things I did discover, as a diabetic, and above 60, we had to have a flu jab every winter time. And I think it was last year, they're going through the records 'Did you have a flu jab last year?' I say 'Yes I did. What happened to your system?' I had to actually take my diary, find out the date then they corrected it'* (A1)

Patients were sometimes less clear about the sharing of notes across service boundaries. It appeared that the results of the Retinal Screening check were shared with both the patient and the GP, but patients were less sure about the sharing of notes from other appointments, such as between the Diabetic Nurse and the GP:

*'I'm not really sure whether – I've never really asked, so I couldn't be sure about that, whether the Diabetic Nurse sends what she does with me to my Doctor [GP], because I'm not sure...I must ask them that actually.'* (A7)

However, perhaps surprisingly, this did not appear to be an issue which had caused inconvenience to the patients interviewed, and did not appear to be an issue about which those interviewed felt strongly.

### ***Knowledge and sharing of patient treatment plans across professionals***

Interviewees were asked whether the professionals they saw in relation to their diabetes were aware of their diabetes treatment plan and whether there was an agreed plan of treatment shared across professionals. Various types of 'treatment plans' appeared to be in existence. One patient (A2) noted that she had a clear formal plan with her GP that was updated every six months and shared between organisations. She was the exception, as no other patients reported a formally written plan was in place. However, the patients interviewed were generally comfortable that they knew what was happening in the future:

*'Yeah, I'm quite happy actually. I know exactly what's happening and when it happens'* (A4)

One explanation given for this knowledge of future treatment despite the lack of a formal plan was that the patient was aware of the 'cycle' of monitoring appointments: *'yeah, I know basically, I would say because I know that [the GP] is going to do the tests regularly'* (A7).

The sharing of the treatment plan with other professionals was generally not an issue, as formal treatment plans were not in existence. Where discontinuities did occur these were not necessarily across organisational boundaries. One patient had experienced a lack of communication between hospital consultants, when referred internally within the hospital for a consultation:

*'And I get there and see the Specialist and I go in to see him, yeah, and he says, "Oh what are you here for? ". I said, "Well, it says, it's on the form," and he says, "Well, don't you know what you're here for?" I says, "Well, I can only say I'm here for what's*

*on the form.” And he says, “Oh, hold on a minute [patient name], I’ll just go and I’ll find what you’re here for ‘cause you don’t know and I don’t know neither.” I mean, what sort of thing is that, yeah?’ (A7)*

For one patient (A4) the duplication of care across the hospital and GP was a particular issue which negatively impacted on the co-ordination of her care. This patient thought that the hospital and GP *‘don’t communicate as much as the patient would like them to communicate in that sense’*. The patient noted that she underwent two lots of blood tests, for the GP and the hospital, and they were close together sometimes, and she wondered whether this could be better co-ordinated:

*“No, everyone actually does the same thing. They’ll just basically monitor the sugar level. It’s with the Nurse that she checks everything else, the height, weight, and the feet, which are the main area, and the GP will just be, like, general questions, medicine check reviews, yeah, and that’s about it.’ (A4)*

## **5.7 Conclusion**

There was a variety of diabetes pathways in operation in the case study area. These variations in the way services were organised suggest that there would be different relationships and incentives at play between organisations in the pathways. These will be explored in Chapters 6 and 7, which focus on the objectives and behaviour of commissioner and provider organisations when approaching their relationships with each other in the course of planning and providing care. The differences in the provision of services in the case study were not only between pathways, but also over time, particularly in relation to the changes which developed in the Provider A pathway during the course of the fieldwork. Of course, as suggested by the theoretical review in Chapter 2, it is not only the nature of services and the position of organisations that may affect inter-organisational relationships, and Chapters 6 and 7 will explore the other factors that may affect the behaviour of organisations and health care professionals when negotiating incentives for competition and co-operation to deliver co-ordinated services to patients, such as norms of behaviour, financial incentives and relationships with commissioners.

Patients did not report significant issues relating to the co-ordination of diabetes services across organisational boundaries, and indeed, highlighted other factors relating to the experience of continuity of care, such as seeing the same professional over time, which were of more importance to them. Interestingly, interviewees were generally unaware of, and

lacked interest in, the different organisations who were involved in the delivery of their diabetes care. This could, of course, be due to the irrelevance of this factor to the co-ordination of services, indicating that where patient care stretched across organisations this was not negatively impacting on the patient experience of continuity of care. This hypothesis is at odds with previous research that has suggested that patients may experience less continuity of care when they move between organisations (Gulliford et al., 2006a). It is also at odds with the organisational view of the co-ordination of services, where, as the analysis of the following chapters indicates, organisational boundaries were very important. It may be that patients were unaware of the organisations delivering their care because of the smooth delivery of services across organisational boundaries. Indeed where patients mentioned the diabetic retinopathy screening service, which was provided by an independent sector organisation, they praised the smooth running of the appointments system and the sharing of results with the GP and patient.

Previous research suggests that continuity of care is associated with the acceptability of services to patients (Gulliford et al, 2006a) and is a measure of quality from the patient perspective rather than a fixed concept. Certainly, the participants in this study showed different levels of concern relating to issues potentially affecting the co-ordination of services. Further evidence of the degree to which views about the co-ordination of services can differ substantially between patients is provided by a review of diabetes services by the local council, which was conducted during the fieldwork period. This review, which consisted of a focus group consisting of diabetes patient forum members, a visit to sites, and a meeting with commissioners and providers, found that some patients felt there was little co-ordination between services, and a high degree of proactivity was required in order to ensure all necessary checks and appointments took place. Whilst these differences between two studies may reflect differences in the services experienced by patients, they may also reflect the degree to which the perception of continuity of care can differ between individuals.

A further factor relevant to the co-ordination of services is the relative lack of organisational diversity in the Provider A patient pathway. For the majority of patients in this pathway, services were provided by the GP and Provider A. This may limit the potential impact of issues with co-ordination relating to organisational diversity within a pathway. Interestingly, however, patients interviewed had experienced discontinuities of care within organisational boundaries, such as differing professional advice, problems with communication regarding internal referrals, and problems accessing services. This suggests that integration of services



into a single organisation does not, of itself, remove obstacles to the co-ordination of services. This issue will be returned to from an organisational perspective when considering the integration of services between the providers of services in Chapter 7.

## CHAPTER 6

### The commissioner's interpretation and enactment of the policy and regulatory environment

#### 6.1 Introduction

As detailed in Chapter 3 (Institutional context), the policy and regulatory environment in the NHS at the time of the research consisted of a complex framework of national and European laws, NHS specific regulation, best practice guidance and professional codes of conduct. This chapter is concerned with the case study commissioning organisation's understanding of the policy and regulatory environment in place at the time of the research, including incentives for competition and co-operation, and its enactment of that framework when commissioning services.

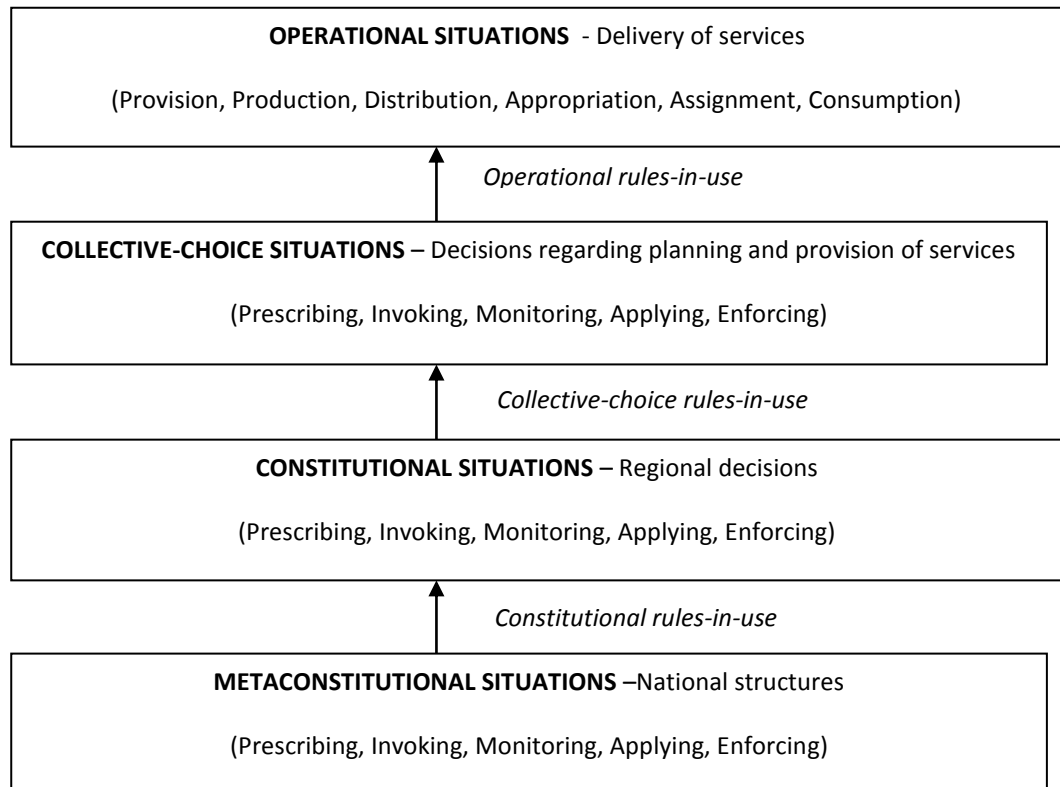
This chapter first examines the case study commissioning organisation's understanding of the way the policy and regulatory environment related to the local organisational context, with a specific focus on the understanding of the rules and guidance concerning competition and co-operation. The aim of this analysis is not to establish whether the staff interviewed understood the policy and regulatory environment 'correctly', but to establish how staff interpreted these rules in the light of their local context. The second section of this chapter examines how the case study commissioning organisation enacted the rules and guidance of the policy and regulatory environment when commissioning services for its population from provider organisations, specifically how the organisation approached its relationships with provider organisations, and the way competition and co-operation was incentivised.

A key finding of the chapter is that the commissioner had substantial freedom to deploy incentives for competition and co-operation as it wished locally, and its use of incentives was shaped by the local context. The chapter argues that the commissioner's primary concern lay with the management of financial risk, and that this led to the adoption of a predominantly hierarchical approach to the co-ordination of provider organisations, in which incentives for competition were used sparingly.

A key concept informing the analysis of this chapter is the notion that rules are socially situated, and that understanding and interpretation of rules may differ between parties. As described more fully in Chapter 2 (Theoretical Context), Ostrom's IAD framework (2005) suggests that rules are not fixed, that they can be influenced by local players and that the rules in operation during organisational interaction ('rules-in-use') can differ substantially

from the formal rules that are written down. A further concept from the IAD framework of use here is that of multiple levels of analysis (see Figure 6.1 below), which range from metaconstitutional situations involving national structures, to operational situations, with each level forming the ‘rules-in-form’ of the level below, which are then interpreted by players at the level, and enacted as ‘rules-in-use’.

**Figure 6.1: Levels of analysis of the case study (from Ostrom 2005, p59)**



Whilst Chapter 3 (Institutional context) is concerned with the ‘rules-in-form’ created at the metaconstitutional level, that is the written statements concerning incentives for co-operation and competition and the institutions and structures which had responsibility for the monitoring and enforcement of those rules, this chapter is concerned with exploring how the commissioning organisations who participated in the case study understood the rules and guidance of the policy and regulatory environment (the ‘metaconstitutional’ level) in relation to their local context and the action they took when they applied their understanding of the rules (‘the rules-in-use’) to the commissioning of services for their population (‘constitutional’ situations).

The analysis in this chapter is important in setting the scene for the examination in Chapter 7 of the way provider organisations understood the commissioning environment, and how

they managed incentives for competition and co-operation to deliver co-ordinated diabetes services to patients.

## 6.2 Background

### *Overview of case study commissioning organisation*

As described in the Chapter 3 (Institutional Context), the period during which the field work was conducted (June 2011 – October 2013) was a time of great change in the NHS. Not only did the status and nature of the policy and regulatory framework change during the field work period, but the organisations responsible for interpreting them at a local level changed too. The regulatory framework altered with the passing of HSCA 2012 in March 2012, coming into force on 1 April 2013, accompanied by a restructuring of the organisations responsible for the commissioning of NHS services, with the abolition of PCTs and Strategic Health Authorities, and the creation of CCGs. The data referred to in this chapter was gathered during this time of change. The data is drawn from interviews with the staff working in the case study commissioning organisation and from interviews with the participating provider organisations. The timing of the interviews with commissioning staff is detailed below (Table 6.1). Two interviews were conducted with PCT staff before the PCT was abolished, three were conducted with PCT staff whilst the CCG was running in shadow form alongside the PCT and one interview was conducted after the PCT was abolished and the CCG was authorised. A table detailing the timing of all case study interviews is in Chapter 4 (Methods).

**Table 6.1: Timeline of interviews with commissioning staff**

Date	Event affecting case study organisations	Interviewee
June 2011		PCT Director PCT senior manager (1 <sup>st</sup> interview)
April 2012	CCG begins working in shadow form	
July 2012		PCT senior manager (2 <sup>nd</sup> interview)
September 2012		PCT service manager
December 2012		PCT Clinical lead
April 2013	PCT abolished. CCG goes live Health and Social Care Act 2012 comes into force	
August 2013		CCG Vice Chair

In practice there was a gradual discharge of responsibilities between the commissioning organisations in the case study area. At the time the first commissioner interviews were conducted in 2011, the shadow GP commissioning consortium, or the ‘emerging CCG’ as they

were known locally, began a period of shadow running alongside the PCT. The shadow GP commissioning consortium was given 'full delegated power' from April 2012, when they were acting as a committee of the PCT, and assumed responsibility for commissioning services with medium and high complexity budgets. In the meantime the PCT clustered with other PCTs as a single Cluster Board, but continued to retain their statutory accountability for all duties, functions and responsibilities under NHS regulations and take decisions relating to individual PCTs where required by the relevant regulations.

In effect a complex situation was created where, whilst not officially operational, the shadow GP commissioning consortium appeared to be the decision-making body for much of the fieldwork period. The extent to which they were making decisions independently of the PCT throughout the fieldwork period is not clear. For example it is not immediately clear how closely their decisions were monitored, or indeed changed, by the PCT Cluster Board when they were deciding commissioning strategy and making procurement decisions. This lack of clarity presents a challenge to making an easy differentiation between the behaviour of the PCT and of the CCG in the analysis of commissioner behaviour. Therefore throughout most of the analysis reference is made simply to the 'commissioning organisation' unless there was a clear distinction which could be made between the behaviour of the PCT and CCG. That said, it is possible to make a distinction between the behaviour of the commissioning organisation before and after HSCA 2012 came into force in April 2013, and this is discussed in the analysis.

### ***Overview of the role of commissioning organisations***

As described in Chapter 1 (Introduction), commissioning in the NHS consists of deciding what type of services a population requires and how those services are to be provided to best suit the needs of the population in question. Commissioning involves a broad range of activities ranging from assessing health care needs and current service provision, to deciding how services should be delivered and procuring those services, and contract monitoring. Commissioning organisations in the NHS interpret the policy and regulatory environment in order to commission services for their local population. The policy and regulatory environment informs commissioning organisations of their duties regarding competition and co-operation during the process of procurement, in which the commissioning organisation decided how to engage with provider organisations in the planning and purchasing of services, the degree to which providers should be encouraged to compete and/or co-

operate, and the nature of the incentives encouraging that behaviour.

Commissioning organisations play a key role in shaping the local competitive environment through the process of procurement. They are able to choose whether to initiate a process of competitive tendering for services by inviting provider organisations to tender for services to win a contract (competition for the market). Alternatively they have the option of opening up services to ‘any willing provider’ a mechanism in which any provider who meets the minimum standard could compete for patients (competition in the market). It is possible for commissioners to decide to commission services without the use of competition, for example through the initiation of a single tender action for a service, where only a single possible provider could be identified. Alternatively, commissioners have the option of deciding that the service should remain with the original provider, but work to make changes through a ‘contract management’ approach.

### ***Overview of the policy and regulatory framework affecting commissioning***

As described in Chapter 3 (Institutional context) the relevant policy and regulatory framework consists of a combination of mandatory elements, overarching principles and best practice guidance to steer commissioning organisations in the deployment of incentives for competition and co-operation when commissioning services from provider organisations. At the start of the fieldwork period the majority of the rules affecting commissioning behaviour were NHS specific. The PRCC (Department of Health, 2010e), which was the main guidance concerning the way commissioners should behave in relation to competition and co-operation, was essentially internally governed rules. Whilst NHS procurement fell within the remit of procurement law (the Public Contracts Regulations 2006), the procurement of clinical services was largely subject only to the general requirements to treat providers equally and in a non-discriminatory way, and to act in a transparent way. Similarly, the NHS Procurement Guide, which was the main framework governing commissioners’ procurement activity, contained mainly principle-led overarching statements of expectations of behaviour (Department of Health, 2010f).

Whilst the guidance governing competitive procurement in the NHS prior to HSCA 2012 has been likened to a ‘voluntary code’ (Hudson, 2013), HSCA 2012 gave the rules a statutory footing. Although the Department of Health claimed HSCA 2012 merely repeated the earlier guidance of the PRCC and the NHS Guide to Procurement (Secretary of State for Health,

2013), HSCA 2012 is widely seen as favouring and protecting competition (Hudson, 2013). Most notably HSCA 2012 states that commissioners must not 'include any restrictions on competition' that are not necessary to attain benefits for patients (Procurement Patient Choice and Competition (No 2) Regulations, 2013, Reg 10 (2)), and that contracts may only be awarded to a single provider where that provider is the only body capable of providing the service (Reg 5 (1)).

### **6.3 The commissioner's interpretation of the policy and regulatory environment**

#### ***Interpretation of incentives for competition in the policy and regulatory environment***

When reflecting on the policy and regulatory environment, commissioning staff noted a lack of 'fit' between the requirements of policy and regulation when commissioning services on the one hand, and their assessment of the needs of the local organisational environment on the other. In particular these staff commented on a perceived disjointedness between the incentivisation of competition in the regulatory and policy environment and the way they felt competition could be enacted locally. Of course, as the policy guidance concerning competition (and particularly the rules in place for the majority of the fieldwork period before HSCA 2012 came into force) suggested, it was in the main for commissioners to decide how, or whether, to use competitive procurement processes. However it appeared that the commissioning staff interviewed in both the PCT and the CCG felt that their hands were tied by the local organisational context and, when it came to making decisions about the use of competitive procurement processes, they considered that the local institutional context made the deployment of incentives for competition on any significant scale unfeasible. Factors identified as inhibiting competition, and which will be discussed below, were the destabilisation of existing NHS providers, the pressure to support existing NHS providers to become Foundation Trusts, the lack of alternative providers, the continuity of services and the poor financial health of the region.

In part the case study commissioner's concerns focused on the impact of competitive procurement processes on the stability of Provider A. The case study commissioner was the main funder of services for Provider A, accounting for almost 90% of their total income. The PCT Director and senior manager (the PCT staff interviewed who were most directly involved with the commissioning of services) were particularly concerned that the use of competitive procurement processes for the commissioning of certain services could destabilise Provider

A. Whilst policy positioned competition as a route to innovation, service improvement and increased productivity (Department of Health, 2010b), the PCT staff interviewed were concerned that competition had the potential to be destructive locally. The basis for these fears was that 'decommissioning' (removing the contract for) any core service provided by Provider A risked the financial stability of the provider. The assumption appeared to be that, in a relatively small organisation like Provider A, the removal of a relatively large service and the subsequent loss of funding could, due to the cross subsidisation of services, risk the provision of other services provided by the hospital. This risk was seen as untenable for two reasons. Firstly, the organisational imperative to reach Foundation Trust status (all Trusts were expected by the Department of Health to become Foundation Trusts by April 2014) was seen by the PCT Director as inhibiting the use of competitive procurement processes which might otherwise be in the best interest of clinical service provision, as it was thought the decommissioning of a core service would jeopardise Provider A's attempt to merge with Provider D in order to reach Foundation Trust status:

*'I think at the moment that the danger is that the organisational discussions around the acute trust merger and the pathway for FT will cause people to try to get us to pull back once again [from tender] because an organisational imperative is going to start trumping a clinical imperative.'* (PCT Director)

Secondly, the avoidance of the use of competitive procurement was related to the perceived lack of alternative providers in the local area. This was a view strongly expressed by the CCG, which suggested that competitive procurement was difficult locally as the CCG was committed to commissioning services with their current providers:

*'Real competition can only exist if you have a level playing field, and if you have one community services provider, if there isn't another one in the wings, then you take a risk if you decommission from them.'* (CCG Vice Chair)

The interviewee suggested that the CCG had to commission services from their main providers to ensure the sustainability of those providers, but also that the CCG could not decommission services because there was no alternative provider of services 'waiting in the wings'. The CCG lead distinguished between the lack of 'real' competition in the area and the 'dictats' that 'the centre' required the CCG to implement such as opening up a selection of services to provision by Any Qualified Provider. Whilst the earlier interviews with the PCT



suggested there was a diversity of providers available, they still suggested that the need to keep Provider A on track by retaining its core services was a priority which would 'trump' any requirements in procurement law to go to competitive tender:

*'If you talk to Finance and you talk about, you know, procurement law and everything, there's this whole tension that if it's over a certain amount, which this would be, you have to go to procurement. But, there's this other tension that if you do that there's a chance that actually you're going to destabilise your local provider; what's going to happen to the local population then?'* (PCT Diabetes Manager)

In relation to the potential procurement of diabetes services being discussed here, there is a clear tension between the 'rules' of procurement, and the action which the commissioner feels is in the best interest of the provision of health services locally. It appeared that in some cases, including here the case of diabetes, the Board chose a non-competitive route, even though it was the belief of the managers involved that, due to the service redesign element and the cost of the service, the service should be put to competitive procurement. This particular example also raises an issue regarding the commissioner's understanding of the policy and regulatory framework and indeed the clarity of the rules, which will be discussed in Section 6.4.

There appeared to be a lack of confidence in the use of incentives for competition to the local environment, particularly in relation to the applicability of patient choice (competition in the market). There was agreement across PCT and CCG interviewees that whilst commissioners were required to ensure choice of provider was available to the local population, there was a lack of interest in such initiatives in the local population, and one interviewee went so far as to suggest that patients were 'very nervous' about competition in relation to health care, a fact which had limited the use of competition.

It appeared that the 'rules-in-use' by the local commissioner were that the need to ensure financial stability for the NHS providers was paramount, and that the use of market incentives was not the route to achieving this. Indeed, it appeared that, by the time the CCG was fully operational, hierarchical planning had become an important consideration in the development of commissioning strategy. The local context was dominated by the financial position of the health community. At the start of the fieldwork, Provider A had begun

negotiations about an acute sector merger with Provider D, which was intended to be the vehicle for both providers' attainment of Foundation Trust status. During the fieldwork period, which spanned three financial years (2011/12, 2012/13 and 2013/14), the financial position of the regional health economy as a whole worsened, and a consultation for an acute hospital reconfiguration programme commenced across a group of commissioning organisations, with the aim of making the necessary cost savings by reducing the number of acute service providers in the area by almost half, and the delivery of more services out of hospital. This agreement was key in steering CCG strategy regarding the type and nature of competitive procurement processes which were in place locally:

*'Absolutely, if in [wider region] all the CCG Chairs have decided that [organisational reconfiguration programme] is a good thing, then every CCG has to align their strategy to [organisational reconfiguration programme]. It's just understood. We've agreed that [organisational reconfiguration programme] is good, we've agreed that each CCG has an out of hospital strategy that means we're developing all services out of hospital that we can. So anything that can be provided out of hospital we try to provide out of hospital because it's better for the patients.'* (CCG Vice Chair)

The CCG strategy was shaped by an understanding that within the terms of the proposed reconfiguration Provider A might well lose all its acute and emergency services within 5-7 years. Indeed, one view, expressed by an interviewee at a different provider organisation, was that the site of real provider competition within the health economy was the centrally driven organisational change programme, and the jostling between organisations to become the major hospitals providing emergency services, and thereby avoid being downgraded.

### ***Interpretation of incentives for co-operation in the policy and regulatory framework***

As described in Chapter 3 (Institutional Context), the policy and regulatory framework also referred to the need for co-operation between NHS organisations. NHA 2006 gave all NHS bodies a statutory duty to co-operate (s72) and HSCA 2012 gave commissioners had a duty to promote integration (13 (n) and 14 (z)), where this would improve quality of services, reduce inequalities of access and reduce inequality of outcome. Interestingly, while the commissioning staff interviewed did not reference the policy and regulatory framework in relation to their responsibilities in this regard, they appeared to be embracing this element of their responsibilities. The PCT Manager interviewed saw the role of the PCT in terms of

service planning as one of facilitation, acting as a co-ordinator of clinicians across provider organisations involved in a pathway of care, and as a leader providing ‘an overarching strategic view’. The theories of co-operation between organisations in a market (outlined in Chapter 2), particularly theories of vertical co-operation such as flexible specialisation (Sabel, 1994) and industrial districts (Amin and Robins, 1992), suggest that provider organisations in a market would be motivated by their interdependencies to co-operate with each other. However in the case study area it appeared that co-operation between providers was not thought by commissioners to occur spontaneously as providers were not capable of organising themselves, due to the lack of a designated leader, and because provider organisations were distracted by other priorities. Instead the commissioner adopted a hierarchical approach in which providers’ interactions were co-ordinated from above. Both the PCT and CCG staff spoke of their role as co-ordinating interagency working, because ‘apart from us who will do that?’ (CCG Vice Chair). At times the commissioning organisation’s co-ordination role in this respect was itself hierarchically prescribed, as it responded to initiatives from the Strategic Health Authority, or, more latterly, NHS England, while at other times, as in the case of the organisation of the diabetes pathway that will be described later in this chapter, it was an approach that was chosen. The role of the commissioner as a co-ordinator of provider activities will be explored more fully in Chapter 7.

A further aspect relevant to the commissioner use of incentives for co-operation, was the dynamic between commissioners and the clinicians providing services. This foreshadows the divide, which will be explored further in section 6.6 below and Chapter 7, between the impact of incentives on managerial staff and on clinicians. It was apparent that, for both the PCT and CCG, there was a tension for the commissioner between the need to secure the co-operation of clinicians in relation to service developments and the retention of competition within the service pathway.

#### **6.4 The commissioner’s understanding of the policy and regulatory framework**

Neither the PCT nor CCG interviewees expressed concerns about their understanding of the policy and regulatory framework. When discussing the implications of these rules for commissioning, the main concern expressed by staff was the implication of the rules around procurement, specifically that they would be compelled to advertise invitations to tender in the Official Journal of the European Community when a contract exceeded a certain amount, and that they would be compelled to undertake competitive procurement processes for

contracts because they represented 'new' services. It was reported by the PCT that such issues were the subject of much debate at Board level. However, whilst interviewees felt that they understood the implications of the policy and the regulatory framework fully, at time there did appear to be confusion regarding the implications of the rules, for example the belief that a contract for a clinical service would have to go to tender as it exceeded a certain threshold, when this issue is, at the very least, unclear in the guidance.

Interestingly, although the rules governing competitive behaviour and guarding against anti-competitive behaviour became more stringent in the regime put in place by HSCA 2012, it appeared that the CCG was less concerned than the PCT staff interviewed about any potential discord between the rules concerning competitive behaviour and local commissioning practice. Whilst holding that regulation had a 'huge influence' and 'affect[ed] everything' the CCG interviewee did not profess himself to be particularly *au-fait* with the policy and regulatory framework and stated that all the CCG's commissioning decisions had to be checked with the 'lawyers'. This perhaps suggests that in the CCG there was a division in roles between those responsible for commissioning strategy and those responsible for understanding the 'rules'.

Whilst the staff in commissioning organisations did not appear particularly concerned about their understanding of the policy and regulatory framework, staff in provider organisations did express concern about commissioning organisations interpretation of the rules. Staff from NHS providers gave examples of a number of instances where they had concerns about the way commissioners conducted tender processes. Examples given included: the mismanagement of an award of a contract to a GP consortium (the contract was pulled by the commissioner as the result of a provider complaint); a problem with the administration of a tender process (the process was suspended by the commissioner following a provider challenge); the award of a contract without competition following the decommissioning of a service; a flawed process for awarding a contract. In addition to these concerns regarding procurement processes there were areas of confusion regarding the rules, for instance the extent to which a service model can be renegotiated and altered without going to tender. Interestingly, none of those concerns mentioned had been reported to the CCP or Monitor and, at least in part, the reason for this was the hierarchical relationship between commissioners and NHS providers. Where providers had not challenged procurement

processes they felt the matter was not worth pursuing in the light of the ongoing relationship and dependencies between the commissioner and provider:

*'And I suppose that comes to the second bit, which is about the co-operation bit, because there is always going to be this difficult line where you don't want to upset or damage your relationship with your Commissioners by declaring anti-competitiveness where that is not particularly helpful for the rest of your business. So, I think for me, there's something about how – you mentioned about the competition policy, how that's actually enacted is quite clumsy.'* (Provider C Director)

A further concern cited by staff in provider organisations was that commissioners in general, but particularly the less experienced GP commissioners in the newly formed CCGs, did not always fully understand the implications of their actions, particularly when they decided to commission services via a competitive tender:

*'And the pace of change, I think, because [GPs] largely employ people themselves and they make the decisions, and they go ahead and do it. Those levels of understanding about how organisations work and how they can respond to things, and the contract employment law and, you know, TUPE rights and all of those sorts of things are just not things I think, at the moment, are in their – are understood.'* (Provider A Director)

This reflects the view, repeated in other interviews, that GPs in CCGs would make different commissioning decisions to PCTs. In the main this was related to GPs' perceived lack of knowledge and skills regarding business processes rather than an inherently different attitude to the use of competition. For example, a concern articulated was that CCG commissioners did not fully appreciate the impact of a decision to move a service from an incumbent provider leaving 'stranded assets'.

## **6.5 Commissioning in action: the commissioner's use of incentives for competition and co-operation**

The foregoing section explored the way interviewees from the case study commissioning organisation interpreted the policy and regulatory framework, and showed that the commissioner's understanding of the rules regarding competition and co-operation was strongly influenced by the limitations of the local context. The remainder of this chapter

focuses on the behaviour of the case study commissioning organisation in practice, examining how, in the light of the policy and regulatory framework, the commissioning organisations utilised opportunities to encourage competition and co-operation between provider organisations in the planning and delivery of services. In particular the analysis draws on theories of the co-ordination of activity via hierarchies, markets and networks, and develops the argument that, whilst the commissioner had a 'tool box' of approaches of co-ordination available, the approach taken to the co-ordination of provider activity was a predominantly hierarchical one.

### ***The commissioning of a new diabetes service model***

The commissioning of a new service model for the provision of diabetes illustrates how the commissioning organisation approached its relationship with Provider A in the light of the policy and regulatory environment. When fieldwork commenced the commissioner, at that point the PCT, was engaged in an ongoing attempt to introduce a new service model for the provision of diabetes services in line with the best practice model outlined in Chapter 5, consisting of a community outpatient service, staffed by community nurses currently working in secondary care, facilitating the discharge of patients from the hospital to the community service. The PCT had been at an 'impasse' with Provider A (the main local provider of the service) for three years regarding '*what our model should be, between a community based, primary care based, self-care based model and a group of secondary care clinicians who wish to develop a diabetes centre of excellence*' (PCT Director).

The PCT Director interviewed was frustrated with the progress of discussions with the incumbent provider (Provider A), and as early as June 2011, had suggested that the use of competitive tender to achieve the preferred service model was an option. It was reported that the PCT had warned Provider A that they would instigate a competitive procurement if the provider did not co-operate in the establishment of the proposed service model. Despite the ongoing frustration with the protracted negotiations with Provider A, both the PCT and the shadow GP commissioning consortium chose not to put the service out to tender. Various difficulties with the use of competitive procurement for diabetes were cited: the upheaval for patients if the service provider should change; the lack of interest from other providers as diabetes was not seen as a 'money spinner'; and the timing of the decision in relation to the changeover from PCT to CCG. The shadow GP commissioning consortium's Board decided the service model was not a 'new service' and therefore bypassed the requirements

for competitive procurement. Instead the emerging CCG decided to follow a process of 'contract management' with Provider A to achieve the desired service model.

In practice the shadow GP commissioning consortium employed a variety of mechanisms to gain the co-operation of Provider A. Firstly, the commissioner undertook modelling of new appointment to follow up appointment ratios against national benchmarks to suggest what proportion of patients could be seen in community rather than acute care, and also modelled service costs. Secondly, this approach was supplemented by a raft of clinically led relationship building activities. A Diabetes Redesign Board consisting of representatives of the professionals involved in the provision of diabetes services was established, clinical workshops were held across primary, community and secondary care, and the commissioner's clinical lead for diabetes met individually with all the key stakeholders. Thirdly, future investment in Provider A's diabetes service was promised. Fourthly, the commissioner threatened to use competitive procurement to achieve the service model if Provider A did not co-operate.

An interesting aspect of the commissioning of the new diabetes service is the mix of approaches used by the commissioner to gain the co-operation of Provider A, which is suggestive of a mix of modes of co-ordination between that of hierarchies, markets and networks. As discussed in Chapter 2, whilst markets use the mechanisms of price, transactions and exit to co-ordinate activity, hierarchy, based in rules, command and authority, co-ordinates via 'a structure of consciously exercised authority and compulsion, in which people's status is by definition unequal' (Beetham, 1991, p136). Networks can be conceptualised as a third mode of governance between the market and hierarchy (Powell, 1991, Thompson, 2003). Co-ordination in networks is often characterised as based around trust and shared norms of behaviour. Powell (1991) suggests market transactions can be characterised by their use of haggling over price (in this case akin to haggling over new to follow-up ratios), and network transactions are relational in nature (here, the emphasis on relationship building with clinicians). Arguably, the 'contract management' process in this case contains elements of hierarchical modes of co-ordination as well, as the threat of competition is based on the dependency of Provider A on the commissioning organisation.

### ***Commissioner use of competitive procurement***

However, whilst there was indeed a mixture of co-ordination approaches in place, it is argued

here that the relationship between the commissioner and Provider A was a predominantly hierarchical one. The commissioning organisation in the case study area (both PCT and CCG) used competitive procurement processes sparingly in practice, and only in particular circumstances. A review of the tender advertisements on the Supply2Health website and the PCT and CCG Annual Reports for the financial years during which fieldwork took place indicates that the commissioner instigated competitive procurement for a small number of services each year during the fieldwork period. In the main these services were community services which were relatively small, standalone services or new services (as presumably none of these would destabilise the existing provider). During the fieldwork period there had been one tender affecting current acute service provision, for an urgent care centre on the site of Provider A's hospital. An interviewee from Provider A reported that the organisation had been given 'preferred provider' status on most of the tenders which directly affected their services. The interviewee explained that this meant the commissioner alerted Provider A to tender opportunities before they were put out to tender, to allow the provider to decide whether to put in a bid or not, without the contract going to the open market. Although it is difficult to judge a change over time in the number and nature of the services being competitively procured by the case study commissioner, partly due to the long lead in times for competitive procurements, a Director in Provider A thought that there had been an increase in competitive procurements for community services after the establishment of CCGs in April 2013, and that CCGs in general felt increased pressure to go to competitive procurement due to *'the feeling that with the changes in the system they have or should be tendering stuff out'* (Director, Provider A). It was clear however that the cost of the tender process was a disincentive to its use. The resources needed to run tenders, especially tenders for small services was 'crazy', and was seen as a potential waste of money: *'And why should you waste that money when it can be used for frontline services?'* (CCG Vice Chair)

The relationship between Provider A and the case study commissioner could, from some perspectives, be described as a binary one in which the commissioner depended on Provider A for the provision of most of the services for their population, and Provider A depended on the commissioner for the majority of their income. The dilemma for the commissioning organisation was how to achieve change without destabilisation, and how to secure ongoing co-operation from Provider A through this process. Whilst the use of market mechanisms was always a possibility and indeed they were used in certain circumstances, the commissioning organisation approached their relationship with Provider A as a hierarchical



one. The clearest example of this is the use of planning with other commissioning organisations (the adoption of the acute services reconfiguration plan) rather than competitive mechanisms to decide the arrangement of local services. As Powell terms it, within the hierarchy *'the visible hand of management supplants the invisible hand of the market in co-ordinating supply and demand'* (Powell, 1991).

Unsurprisingly, it appears that this hybrid of co-ordination mechanisms between planning (hierarchy) and the market contained its own tensions. Commissioner behaviour in combining both competition and planning approaches had the effect of both encouraging and preventing the achievement of provider merger:

*'So, you know, the Intermediate Care Service that [Provider B] have won in [place] with us supporting them, they've terminated that contract now for non..., you know, I don't know the exact reasons. So actually what they're starting to do is pull out some of the dominoes, and you're in this Catch 22 of actually, the system says, 'oh, we want the merger', but actually, parts of that system are doing things that are actually completely counterintuitive to the merger happening, so by decommissioning, by not agreeing contracts with us that actually enabled a full business case. And this is the loop that we've been going round for three years.'*  
(Provider A Director)

### ***Use of contracts in case study***

Commissioner/provider contracts in the case study were an important mechanism by which the tension between competition (the market) and planning (the hierarchy) was played out. The purpose of the contract is *'a voluntary agreement through which parties make legally binding commitments about their future behaviour'* (Bennett and Ferlie, 1996, p50). Contracts are market mechanisms that offer an alternative form of governance to hierarchy. Contracts are seen to offer an opportunity for parties to tailor incentives to suit themselves:

*'Whatever the rules of the game, the lens of contract is also usefully brought to bear on the play of the game. This latter is what I refer to as private ordering, which entails efforts by the immediate parties to a transaction to align incentives and craft governance structures that are better attuned to their exchange needs.'* (Williamson, 2002, p172)

The negotiation of contract terms between parties is an important element of the co-competition framework, as it is seen to represent a key opportunity for players to influence the rules of the game or indeed to generate the rules themselves (Brandenburger and Nalebuff, 1996, p159).

As described in Chapter 3 (Institutional context), contracts and price setting were important mechanisms for commissioners to influence provider behaviour. The NHS contract specifies how pricing should be set and how financial risk should be allocated. In relation to contracts for acute services, commissioners should reimburse providers using the PbR tariff, which is a key element in the competitive environment for the NHS services, as it encourages providers to work to attract activity (and therefore compete) as they are paid per procedure undertaken. There is also the opportunity to agree aspects of payment locally, including local tariffs where national tariff does not exist, and the flexibility to 'bundle' tariffs together to encourage providers to co-operate to provide co-ordinated care within a pathway.

The data suggest that commissioner/provider contracts in the case study were not being used as intended by policy, and were in fact being used as 'instruments of the hierarchy' (Petsoulas et al., 2011) rather than a site of negotiation. During the fieldwork period the case study commissioner, along with many other commissioners in the region, adopted the use of block contracts (a fixed price for the treatment of a population of patients) rather than the use of the national tariff (payment for activity). This is interesting from the perspective of the incentivisation of provider competition in the market because a provider which is paid regardless of activity undertaken has no incentive to compete with others to attract more patients. During the research period all providers interviewed for the study, with the exception of the Foundation Trust (Provider F) and the independent sector provider (Provider E), had been moved from a Payment by Results contract onto a block contract. Whilst the Foundation Trust (Provider F) was not subject to a block contract, they were subject to a PbR contract with an end of year settlement, which in effect may have been capped in a similar way to a block contract. There are a number of points to be made in this respect.

Firstly, this shows the tension between the use of incentives for competition between providers and the need to achieve financial stability. An important factor in this behaviour was the overall financial deficit, which at the end of each financial year would sit either with

the provider as a result of unpaid activity, or with the commissioning organisation. The block contract was a mechanism for the case study commissioner to manage its financial exposure. It was reported that tension had worsened since the policy and regulatory changes associated with the HCSA 2012 as there was now no third party to broker the relationship (previously the Strategic Health Authority), and it was harder to move money between CCGs to overcome deficits. Evidence from other studies suggests that the Trust Development Authority may fulfil this role post HSCA 2012 (Petsoulas et al., 2010).

Secondly, the acceptance by providers of this departure from the rules regarding the use of the national tariff is indicative of the hierarchical relationship between commissioners and NHS providers. There remained an interesting question concerning the reason for provider compliance with commissioner demands in respect of block contracts. On the one hand providers felt that whilst everyone was on a block contract in the region, the factor deadening competition was the lack of money itself:

*'I think there's a recognition from Trusts, you know, across the country that just bringing in more income is no longer an option. So even if, you know, you can just keep treating patients, and I suppose that was always the problem about PbR, is it worked in a system that had money in it, but now it doesn't have money in it.'*  
(Director (Strategy), Provider F)

The suggestion was that it was not the block contract *per se* that was impeding provider competition for patients, but that providers had made a commitment not to, essentially, 'overgraze' the resources available in the local health economy, even when this might have been in their direct economic interests had the national tariff been in force. Indeed this view was supported by the single NHS Trust under a PbR contract in 2012/13 (Provider F) who reported that their contract did not incentivise them to act competitively as *'you only exercise those freedoms on the basis of the environmental factors you face'* (Director). This suggests that behaviour was being governed by norms, and a shared understanding and responsibility beyond the contract mechanism. It could be argued that the commissioner/Provider A relationship was at times 'relational' rather than hierarchical. Relational contracting refers to the continuance of activity without recourse to a contract (Macneil, 1978), and stems from studies which observed business relationships where disputes were not conducted or resolved through legal or contractual mechanisms, but with

recourse to norms of behaviour, and sector specific customs (Macaulay, 1963, Beale and Dugdale, 1975). Relational contracting is like 'relationships over time' (Allen, 2002), which are based on 'informal agreements and unwritten codes of conduct' (Baker et al., 2002).

Interviewees from Provider A referred to some aspects of trust which aided their dealings with the commissioner. Some of Provider A's staff, particularly those in the community services who previously were employed by the PCT, had longstanding relationships with the staff in the commissioning organisation. Both the case study commissioner and Provider A had a shared understanding of how competition would be used locally, and Provider A trusted the commissioner to act a certain way. Provider A interviewees reported that the PCT would only use tendering as a last resort '*when change has not occurred or relationships are not good*' (Consultant). However, these elements which might have been considered relational, are also inherently hierarchical:

*'[In a hierarchy] relationships matter and previous interactions shape current ones, but the patterns and context of intra-organisational exchange are most strongly shaped by one's position within the formal hierarchical structure of authority'* (Powell, 1991, p270).

Perhaps, more pragmatically, it could be argued that providers simply had no choice regarding the terms of the contract due to the dependencies between the commissioner and provider. Indeed, the relationship between commissioners and NHS organisations was variously described by NHS providers as 'win/lose' and 'parent/child'. It was noted that the cost of arbitration and/or legal enforcement of the contract was prohibitive within the NHS, and that there was little point going to arbitration with commissioning organisations because commissioning organisations 'would always win' as they were required to end the financial year without a deficit (Director, Provider C).

Quite apart from the organisational behaviour observed in the case study, the NHS Contract itself has been noted to contain aspects of hierarchy (Hughes et al., 1996, Petsoulas et al., 2011). It is a centrally, rather than locally, drafted document which contains within it the requirement to meet central performance targets and is, from this perspective, a tool to enable performance management and address the priorities of the hierarchy. It has been suggested the NHS contract can be viewed as an 'administered contract' (Goldberg, 1976,

Hughes et al., 1996). Administered contracts, in common with relational contracting, are characterised by ongoing relationships and action rather than discrete transactions but, in contrast to relational contracts, are 'nested' in a 'collective contract', which constitutes:

*'...a complex shifting pattern of contractual jurisdictions which, taken together, establish the rights and obligations of the respective parties and the roles of the agents'* (Goldberg, 1976, p429)

Rather than providing an opportunity for both parties to influence the rules of the game, as envisaged in the co-opetition approach to relationships, the administered contract regulates behaviour by means of administrative processes and bureaucratic rules. Hardy et al (1998) suggest that these situations, in which co-operation is between parties with differing power reserves, can be characterised as 'capitulation', in which the subordinate party capitulates early to cut losses or accepts that it has no room for manoeuvre. The problem with capitulation, it is suggested, is that the quality of the trust relationship, particularly in relation to goodwill trust, is diluted. The issue of trust and the effect that it has on the quality of interactions will be discussed in more detail in relation to provider behaviour in Chapter 7.

It is important to note at this point that, whilst the majority of the commissioning organisation's contracts were with Provider A, the commissioner also had contracts with other organisations, including those, such as the diabetic retinopathy screening service, with independent sector providers. The use and status of the contract in relation to these organisations was potentially very different to that with NHS providers, not least because independent sector providers were unlikely to hold a large number of contracts from a single commissioner, so issues of dependency or control would not arise.

## **6.6 Relationships between individuals**

Whilst organisations can be analysed as composite actors, they are, of course, made up of individuals who may have differing motivations, and may be motivated by both intrinsic and extrinsic rewards (Mannion et al., 2007). These differing motivations can lead to different reactions to incentives for competition and co-operation. A common distinction is made in the NHS between managerial and medical cultures in this respect (Davies et al., 2000). Managers' utility is commonly associated with efficiencies and clinicians' with effectiveness. Professional norms and values can also impact on co-operative or competitive behaviour.

These differences, particularly the differences in motivations between managers and clinicians, were reflected in the way staff in the commissioning organisation approached interactions with individuals engaged in providing services, and the deployment of incentives for competition and co-operation. This section describes the way that the managerial commissioner/provider relationships were hierarchical in nature, whilst clinical commissioner/provider relationships centred on the development of co-operation based on network relationships. Whilst many theories associated with economic sociology, such as the study of network relationships (Ouchi, 1980, e.g. Uzzi, 1997, Becattini, 1992) or the literature relating to trust (e.g. Gambetta, 1988) suggest that social ties can be beneficial to economic relations, the interactions between commissioning staff and provider clinicians are particularly interesting to this analysis as they suggest that commissioners' need to incentivise clinicians to co-operate can block the operation of organisational competition.

### ***Relationships between managers***

Those involved in contract negotiation at both the commissioner organisation and Provider A suggested that personal relationships were considered a 'drag' on business relationships. There was a history of interpersonal relationships between old PCT provider arm (now part of Provider A) and commissioning team, where some staff had previously worked in the same organisation, and indeed some were still co-located in the commissioning organisation's offices. However in order to be effective commissioners and providers (albeit in a largely hierarchical environment, in which there were only weak competitive incentives) it appeared that these relationships were being dropped. It was reported by both commissioner and provider that the worsening financial situation had left no room for goodwill gestures or give and take in negotiations, and that all personal relationships were being put to one side. It was reported by both the CCG and Provider A towards the end of the field work period that interaction between the two organisations, specifically in relation to contractual issues was becoming increasingly transactional:

*'If we try to reduce a community contract to a certain level we want, then they'll come back with ten things and say, well these ten things that we were doing we cannot do at that price.'* (Vice Chair CCG)

Both commissioner and provider managers appeared to feel that it was necessary to 'harden' their relationships and become more 'contractual' in order to manage the worsening

financial position.

### ***Relationships between clinicians***

In contrast, the relationship between the commissioning organisation and clinicians, particularly in relation to the CCG, appeared akin to network modes of governance, with an emphasis on relationship building and reciprocity. The CCG was keen to develop a network based relationship with the clinical staff who were involved in service planning and provision. It appeared that the CCG was keen both to nurture relationships between itself and clinicians (for example gaining the support of GPs for the work of the CCG) but also to encourage clinicians to build relationships with each other. The process of contract management to revise the diabetes service (detailed in section 6.5 above) had much more emphasis on the development of clinician to clinician interpersonal relationships, face to face conversations and close relationships than, for instance, any description of interactions between managerial staff within the organisations. The CCG clinical lead for diabetes not only met face to face with all stakeholders, but also led the Diabetes Redesign Board which facilitated relationships between clinicians who worked in the same organisation. Interestingly, in their management of the diabetes service redesign the CCG appeared to view the clinicians in Provider A as part of their clinical team. The CCG clinical lead was reported to have seen all the work plans for the staff of the new diabetes service, and also met monthly with the diabetes nurse consultant *'without her management, without any [Provider A] management interfering with my and her clinical working'* (CCG Vice Chair). This is a dynamic unique to CCGs due to the emphasis on the GP leadership in CCGs.

However securing the co-operation of clinicians interfered to some extent with the operation of competition. This dynamic was first raised by the PCT Director who alluded in interview to difficulties the PCT had experienced in balancing the need to gain clinical engagement in the development and provision of services with the need to ensure that providers were treated equally. For example, in engaging a group of clinicians to provide quality assurance for a new diabetic retinopathy service, the PCT had inadvertently compromised patient choice of provider, as they felt powerless to stop those clinicians steering referrals to themselves:

*'And the tension between where the buy-in sits between needing to get the clinical engagement and what that means in terms of the organisation, and how it is that some of those pathways run, and it is where is collaboration really collusion? Often*

*for the kind of detriment of patients' (PCT Director)*

A similar tension between the commissioning organisation's desire to use competitive procurement processes and the need to retain clinical co-operation appeared to have the potential to affect CCG procurement decisions. The CCG interviewee gave an example of the reversal of a decision to invite tenders for the provision of anticoagulation services after the decommissioning of the secondary care service, which was halted due to a 'huge amount of uproar' from GPs who felt the pilot service in primary care should continue on a permanent basis:

*'And we said, hang on, as a CCG we're not here to protect the provision of services in primary care, we're here to ensure a fair and equitable service for the population of [case study area]. So you see how the dynamic went? We're trying to enable a true competitive level playing field, but primary care feedback was that we're destabilising primary care and not doing what's best for the patient.'* (CCG Vice Chair)

It appears that, in the absence of further contextual information, the arguments regarding destabilisation and patient interest are not particularly convincing in this case, not least because the service had only recently been piloted in primary care so its removal was unlikely to destabilise the provision of primary care services. It seems more reasonable to assume that the CCG bowed to pressure from GPs regarding the service because GP support was important to the success of CCGs. These examples illustrate the tension the commissioning organisations, and particularly the GP leaders of the CCGs, experienced between the need and desire to instigate competition, and the type of network relations needed to incentivise the co-operation of clinicians, a tension which potentially resulted in anti-competitive practices.

This is indicative particularly of the risk of conflicts of interest occurring in CCGs, where GPs are both the commissioners and providers of services. There is the possibility that competition was dulled by the need for commissioners to gain clinical engagement (co-operation) in order to provide high quality and safe services. A more detailed examination of the clinical networks which exist between clinicians in provider organisations is given in Chapter 7.



## **6.7 The behaviour of other commissioning organisations**

Whilst this case study focuses on a single commissioning area, and the commissioning organisations (PCT and the subsequent CCG) which were responsible for commissioning services for the population during the period of the fieldwork, a variety of provider organisations who provided services to the population were interviewed. The data in this chapter has focused in the main on the relationship between the commissioning organisation and Provider A, as the provider for whom the commissioner was the 'lead commissioner'. However, the other provider organisations interviewed for the case study also commented on the behaviour of their lead commissioning organisations. This data, whilst not directly relevant to the case study, provides an interesting comparison of the behaviour of different commissioning organisations. Provider accounts suggest that different commissioning organisations have contrasting attitudes to competition, even where the organisations appeared to share similar local environmental contexts in regard, for example, to the local financial situation. One CCG in particular which neighboured the case study CCG was reported to be very keen on the future use of competitive procurement for key hospital services. In this example, the interviewee at the provider organisation suggested that this aggressive competitive strategy was related to an acrimonious historical relationship between the GPs and the provider. This indicates the extent to which behaviour is the result of a complex combination of variety of factors in the local environment.

## **6.8 Conclusion**

The analysis of the case study commissioner's interpretation and enactment of the policy environment shows the complex way the commissioner interpreted the rules governing the deployment of incentives for organisational competition and how to ensure co-operation. Whilst various policy and regulatory documents focused on the operation of competition in the NHS, and the way in which commissioners should behave, it appeared that in practice commissioning organisations have substantial freedom in creating the 'rules-in-use'. The local context was an important influence on the commissioner's deployment of incentives for competition and co-operation. Various factors relating to the local context were found to be pertinent in shaping the commissioner's use of competitive incentives in the case study: the stability of the main local provider, the availability of appropriate alternative providers, the financial stability of the local health economy and the wider health economy, the nature of previous interaction with providers. The commissioner's ability to use competitive

procurement processes was at times inhibited by, or in tension with, other policy requirements such as the necessity for Trusts to become Foundation Trusts, and it was also influenced by agreements of strategy across commissioning organisations. Interestingly, whilst there was a change in the regulatory structure during the field work period, it appeared that the worsening financial position of the local health economy was an important factor in changing the competitive environment. The case study commissioner had concerns, such as the achievement of financial stability and the management of financial risk, which it was not considered feasible to address via market mechanisms, and the case study commissioner at different times used elements of hierarchy, network and market co-ordination to achieve their ends. The hand of planning (hierarchy) was very discernible in the way the case study commissioner approached their relationships with providers.

While this research was predicated on the notion that it would be the relationship between providers that was susceptible to tension between incentives for competition and co-operation, the relationship between the case study commissioner and the main provider (Provider A) appeared at risk. This was particularly, and increasingly, focused on the relationship between the leaders of the CCG and the managers of Provider A, which was reported to be acrimonious, transactional and lacking in trust. In contrast there was an effort to build relationships between the commissioners and clinicians. This division of competitive managerial relationships at a contractual level and collaborative clinical relationships closer to service delivery could be seen as a way in which commissioning organisations are dealing with the tensions between competition and co-operation. This dynamic will be explored more fully in Chapter 7.

## CHAPTER 7

### **Relationships between provider organisations involved in the planning and provision of services**

#### **7.1 Introduction**

This chapter is concerned with the way the organisations and individuals which provided diabetes services in the case study area responded to incentives for competition and co-operation. The examination of the commissioning organisation's interpretation of the rules in the previous chapter helped to identify the 'rules-in-use' in the commissioning of services in the case study area. This chapter examines how organisations and professionals responsible for the delivery of services in this environment reacted to and interpreted these rules as they interacted with each other in the planning and provision of services for the local population.

As outlined in Chapter 2 (Theoretical context chapter), in addition to encouraging analysis of the rules of the game, game theoretical approaches such as co-opetition (Brandenburger and Nalebuff, 1996) and Ostrom's IAD (Ostrom, 2005) framework also focus on the 'players' in the game, and the positions (roles) they occupy. Much of the analysis of this chapter rests on a differentiation between the 'players' involved in the planning and provision of services in the case study area and the positions they occupy which lead to differing motivations affecting their behaviour and their interaction with others. One group of 'players' consists of organisations as composite actors, which occupy different positions and motivations due, for example, to their ownership structure, the portfolio of services they provide, and the resources they possess. 'Players' are also the individuals both within and outside of organisations who themselves are involved in the planning and provision of services. These individuals may be subject to differing motivations, based for example on their professional background, or a desire for career progression.

To analyse the behaviour of players as they deal with incentives for co-operation and competition the chapter draws on the theoretical literature concerning inter-organisational behaviour, examining the observed behaviour in light of both economic models of behaviour and approaches based in economic sociology. Of particular importance to the analysis is the notion of trust between parties who need to combine competitive and co-operative behaviours.

Theories of co-opetition suggest one of the ways organisations combine competition and co-operation is to divide these activities for instance between individuals, or alternatively between different activities. Bengtsson and Kock (2000) suggest for example that organisations co-operate at a strategic level to create a bigger pie, and compete close to service delivery to divide the pie up. Barretta (2008) meanwhile in a study of hospitals in Italy observed that competitive roles were the remit of clinicians whilst managers led co-operative activities. This chapter examines how these incentives were handled in the case study area. This chapter discusses organisation-wide strategies regarding competition and co-operation and examines the impact of competition and co-operation on the provision of diabetes services within the case study area.

The chapter argues that, at organisational level, whilst incentives for competition and co-operation were combined successfully in relation to activities such as joint tender bids, in other areas, such as the development of longer term strategic partnerships, issues of trust limited the ability of organisations to co-operate. In relation to the planning and provision of diabetes services the chapter argues that whilst incentives for competition did not impede the delivery of diabetes services, there were issues of trust in relation to the planning of services which appeared to affect the quality of interactions. An important further argument made by the chapter is that, conversely, an absence of competitive incentives does not preclude the existence of issues relating to co-operation and integration.

## **7.2 Structure of the chapter**

The analysis in this chapter is based on data from interviews with staff in provider organisations who were involved in the planning and provision of diabetes services, and also with staff who had a remit across pan-organisational strategy. The data draws on interviews with Directors of Strategy, senior managers in NHS provider organisations, consultants, GPs and a nurse. The provider organisations interviewed consisted of an integrated community/acute NHS Trust (Provider A), three acute NHS Trusts (Provider B, Provider C and Provider D), an acute Foundation Trust (Provider F), a community NHS Trust (Provider G), a community NHS Foundation Trust (Provider H) and an independent sector provider of screening services (Provider E).

This chapter firstly looks at provider organisations' understanding of the policy and regulatory environment in which they were operating, particularly their understanding of incentives for competition and co-operation in that environment. In this section interviewees

who discussed organisational strategy have been treated as speaking for the organisation as a composite player. The second half of this chapter examines the behaviour of the clinicians and managers involved in the planning and provision of diabetes services, and looks at the way in which co-operation and competition affected the integration of services.

### **7.3 Competition and co-operation – the organisational perspective**

Chapter 6 explored the way the case study commissioner interpreted and enacted the policy environment when incentivising provider behaviour, and the ‘rules-in-use’ adopted by the case study commissioner and applied to the local health community. This section concentrates on the way provider organisations (as composite actors) interacted with each other in this environment, and focuses on the descriptions given of general organisational strategy. The view of those involved in the provision of diabetes services is discussed in section 7.5 below.

A notable aspect of the way staff in NHS provider organisations spoke about inter-organisational relationships was the suggestion that organisational behaviour was tempered by a normative, value based approach to the operation of competition and co-operation. In their analysis of the ‘syntax’ of institutions, Crawford and Ostrom distinguish between rules (‘shared commitments based on rules created and enforced by a community’), norms (‘shared obligations based on normative judgements’) and strategies (‘shared advice based on prudence’) (Crawford and Ostrom, 1995, p583). In game theory a norm is understood to relate to a situation in which behaviours are shared among a majority of individuals (Helbing and Johansson 2010). ‘Norms, values and standards of conduct’ are thought to be an important source of trust which enables co-operation (Nooteboom, 2002, p86).

Interviewees suggested the competitive impulse was tempered by a strong co-operative norms. Some expressed confidence in NHS ‘gentlemanly behaviour’ (Manager, Provider G), and felt that competition between NHS providers had, to date, been conducted ‘in the right spirit’ (Director (Strategy), Provider F). Other interviewees held that competition between NHS organisations was not considered ‘appropriate’ at times when there was so little money in the system (General Manager, Provider B). It was suggested that organisations would not use their knowledge of competitors in a destructive way (Manager, Provider G), and that competing NHS organisations would co-operate for the good of the patient as ‘we are all part of the NHS’ (Manager (Contracts), Provider G). In speaking about organisational interaction as couched in norms of co-operation, interviewees suggested that NHS organisations would

avoid the most destructive, lose/lose competitive strategies when approaching potentially competitive situations, and would seek to act in the good of the 'NHS' rather than out of individual self-interest.

The co-operative norm of provider behaviour articulated can be seen therefore as a value based norm rooted in an idea of the 'NHS family' and associated with the promotion of fairness and wider social duty to patients. Alternatively, the co-operative norm can be interpreted as a pragmatic (rather than value based) strategy, which appeared to be steered by the 'shadow of the future' (Parkhe, 1993), that is organisations co-operated with each other because their fates were closely intertwined. This was reflective of the hierarchical nature of the commissioner/provider relationship, and the nature of the local health community in which the providers planned and provided services. Staff interviewed in NHS provider organisations were mindful of the dependencies between provider organisations within a local health community. In contrast with the prioritisation of an individual organisation's self-interest which competition policy was based around, NHS organisations to a degree identified as part of 'a bigger whole' (Provider A), as one Director of Strategy explained *'we work in geographies in the NHS and we work in sectors or in regions, so there's always going to be a need to make sure that we look after that region I guess'* (Provider C). In the case study area, there were interdependencies between smaller and larger secondary care providers to enable the day to day provision of clinical services. For example clinical staff at Provider D helped Provider A manage their surgical rota. There were also shared consultant appointments between providers, for example 10% of the consultant posts at Provider C were shared appointments with Provider B. Further links existed between secondary and tertiary provision of services, where referrals for specialist services within the region went to the area's tertiary provider. So for example, a Director at Provider C explained the organisation would not pursue a strategy to steer tertiary referrals out of area, for financial gain, because it would destabilise their network. This pragmatic co-operation was based on the fear of reprisals, organisations had to carry on dealing with each other, and their interdependencies influenced their action.

Notably there were fewer interdependencies between provider organisations at a strategic or organisational level. Interviewees cited NHS organisations' membership of clinical networks concerned with the organisation of, for instance, stroke services, across a wide geographical area, and also organisations' membership of Academic Health Science Networks Centres (network based enterprises made up of NHS organisations, universities,

businesses, patients and the public to improve health and generate economic growth for a region).

From a game theoretic perspective, an interesting aspect of norms is that their impact on behaviour is variable, and articulation of a strong co-operative norm by organisations does not mean that this would translate into the dominance of co-operative strategies in practice. The co-operative norm is acknowledged to be contingent and context dependent. Adherence to norms of behaviour can bring benefits, but alternatively may also be subject to costs. Ostrom views norms as strongly dependent 'both on the strength of the norm and the context of the situation' (Ostrom, 2005, p123). The co-operative norm is thought to be strengthened or weakened by repeated interactions (Axelrod, 2000), reputation (Raub and Weesie, 1990), clusters of co-operative individuals (Imhof et al., 2005), sanctioning (Heckathorn, 1990) and economic interventions (Parkhe, 1993). Interviewees suggested that the co-operative norm was contingent on a number of further factors. There was a view from some acute providers that competition was not yet fierce, and it may be that these co-operative norms were representative of the current context, in which competition within the market had been dampened within a largely hierarchical system. Indeed, there was reported to be a distinct lessening of competitive behaviour as the financial health of the local and wider health economy deteriorated during the field work period. Behaviour was of course affected by the move to block contracts and the removal of financial incentives for competition in the market. Some providers also noted there were possible future situations in which their co-operative strategies and relationships might alter, for instance if a tender was awarded to an acute competitor to provide services on another provider's site (Director Provider F).

A further dimension of the contingency of the co-operative norm is organisations' perspectives of the other players. Game theory suggests that players are more likely to co-operate when they think the other player will co-operate (Raub and Weesie 1990). We have seen that there was a belief that 'NHS' players would act in the same way due to shared values, but it was not clear that the same would apply to independent sector players. A common perception of interviewees in NHS organisations was that the private sector entailed a different set of values, and indeed a different set of incentives, to the NHS:

*If I was suddenly find myself working for Virgin Health, guess what? I'd be using every single resource I had because I would be working not for the NHS. (Manager Provider G)*

As one Director succinctly put it *'People like NHS people. They don't like, you know, commercial providers'*. This raised the possibility that NHS providers would be less willing to co-operate with private providers.

#### **7.4 Organisational behaviour in the light of incentives for competition and co-operation**

The norms articulated by the provider organisations suggest that NHS organisations are inclined towards co-operation rather than competition. However, it is important to examine how these high level organisational interrelationships functioned in practice, and what factors affected organisations' behaviour. Whilst competition between provider organisations was limited in the case study area, an exception was competition 'for the market', that is competition between organisations to bid for work via competitive tender. These invitations to tender are interesting because, firstly, they represent points at which organisations decide their strategy regarding competition against other provider organisations, but also because secondly, these tenders represented an opportunity for co-operation between organisations.

##### ***Decision-making in organisations***

Before examining what kind of decisions organisations in the case study were making regarding their behaviour towards other organisations, it is helpful briefly to consider the impact of the way in which organisations make decisions. Whilst this is not the area of primary interest here, it is important to recognise that the decisions to co-operate and compete which form organisational strategies in relation to inter-organisational behaviour are not always sophisticated. Firstly, and importantly, the approach to decision-making described by organisations differed. For some organisations the decision-making process regarding bids was not particularly refined. Processes ranged from those described as 'relatively unsophisticated' (Provider F) and lacking in a clear criteria, to examples of a brief cost benefit analysis (Provider C), and to the operation of a scoring process (Provider D) based on factors such as mobilisation costs and financial viability. Providers had a general view that sometimes it was obvious when the organisation should submit a bid, for example if the service being tendered was part of their current portfolio. It was noted that the support of the clinicians from the service involved was fundamental, and their reputation and willingness to contribute fully to the service planning was also very important. Secondly, unlike the conventional conception of a 'game' in which players have complete knowledge



and act in a rational manner, there were many factors which could not be known, for example because the financial information was not available (Provider F) or the cost of knowing was too great. Organisational strategy appeared to be influenced by an interpretation of the 'wider game', most significantly a 'best guess' about how the organisation might be affected by the proposed future reconfiguration of acute trusts in the area, and the kind of service portfolio which would therefore be most favourable in the future, a process which unavoidably involved an element of guess work. As Cyert and March (1963) point out decision-making within organisations is complex, not only is it affected by 'subjective utility' among the different individuals in an organisation which leads to lack of internal goal consistency, but also there may be biases in the computations.

### ***Resource based view of organisational inter-relationships***

Interestingly, whilst economic approaches to organisational interrelationships in the NHS often focus on an analysis in the light of transaction costs theory (Roberts, 1993, Goddard and Mannion, 1998, Allen, 2002, Marini and Street, 2007), the rationale driving organisational decisions for case study provider organisations regarding tenders appeared to be more aligned to the value creation associated with resource based views of decision-making rather than cost minimisation approach associated with transaction costs, an approach which could perhaps be summarised as driven in '*pursuit of gains rather than in flight from losses*' (6 et al., 2006, p23). Although the cost of bids was a significant issue for organisations, particularly the administrative resources required to put bids together, it was not the deciding factor in whether to bid or not. Organisations took decisions in the light of their own resources, and those of others. Often these resources were skill and knowledge based, particularly clinical expertise and reputation. Organisations' strategy was to grow and achieve stability and, in particular, Acute Trusts and Community Trusts wanted to achieve vertical integration. In the resource based view vertical integration, horizontal expansion and diversification are ways of achieving control and power in exchange relationships and of decreasing dependence on other organisations. In other words action is taken to achieve stability rather than for reasons of profitability or efficiency (Pfeffer and Salancik, 2003). The Resource Based View is conventionally used to analyse behaviour in markets, but here appears to have resonance with organisations competing for position within a hierarchy. This approach was seen as having both the benefit of reducing dependence on the other organisations, but also placing providers in a stronger position to deal with commissioners:

*‘...it’s not just being big for the sake of being big. You know, I think we thought there’s financial benefits, and there’s quality benefits, but there’s also reputation and clout benefits, you know. If you’re a big player with a reputation on the national scene, it’s harder for Commissioners to ride roughshod over what your views are. I think the sense has always been that the NHS revolves around the Acute agenda.’* (Director (Strategy) Provider H)

To achieve this expansion, it was common practice for organisations to co-operate with each other to put together a joint bid for a tender. Common reasons for joint bids between organisations were to ensure access to assets, resources and competencies. Assets cited by providers as drivers for partnership bids included, the reputation and skills of particular clinicians, the bid writing expertise of the private sector, the management expertise of third sector organisations, and association with the NHS brand names and networks.

Providers also second guessed the kind of partnerships which would be attractive to commissioners. An Acute Trust (Provider F) reported partnering with a community provider (Provider H) for more defensive reasons on the basis that together they would be a better prospect than the private sector. Provider A gave the example of partnering with a GP led organisation to make the bid more favourable to commissioners who ‘want Urgent Care Centres to be Primary Care led’.

As Combs and Ketchen (1999) note, organisations in need of specific resources have to use inter organisational co-operation even when this might not be prudent from other perspectives such as an organisational economics point of view. Tender invitations from commissioners often were issued with a relatively short window of opportunity for organisations to respond, and in these type of circumstances organisations may not have the opportunity to invest in their own resources (ibid).

### ***Management of co-operation and competition between bid partners***

Whilst NHS organisations’ explanations of the rules governing organisational interactions referred to the importance of norms of loyalty to NHS organisations and avoidance of aggressive competition, the process of selecting partners for tenders did not appear to follow these norms, instead appearing to have more in common with market like relationships based around temporary relationships with interchangeable partners. Bid partners tended not to be chosen on the basis of previous inter-organisational relationships or history, but on

resources. These relationships were temporary and disposable. Partners and competitors were reported to change with each specification, and it was also reported that there was no expectation of ongoing relationships. Indeed it was suggested that partners could be dropped without rancour:

*I just think because there's more at stake now, and, to be honest, you haven't got a lot of time to kind of – you know how the NHS used to be sort of – it was all a bit indulgent and stuff. If you fanny around on this sort of stuff, you'll just lose out, so, you know, I certainly – where was it? It was in Cardiology. We realised that actually [private sector organisation] were actually causing us problems, so I dropped them, and I rang them on a Friday, because I had to, because we were putting the bid in the following, you know, almost – can't remember which stage of the process we were, and they were kind of – you know, they were alright about it.'* (Director (Strategy) Provider D)

This was interesting as an example of co-operation between competitors which was presented as unproblematic. For this Director, escape from personal relationships and loyalties was a freedom to be embraced. Indeed, whilst trust is thought to bring advantages to organisational performance, a surfeit of trust can tie organisations in to suboptimal performance (Kern, 2000). Theories of trust would lead us to expect that the inherent instability of these tender bid partnerships would lead to issues associated with a lack of trust, for example unwillingness of partners to share confidential information with each other (Sako, 1998) or a reduction in transaction efficiency (Sydow, 1998). In general, however, managers claimed that the inherent instability of these relationships did not interfere with co-operation, or the bid process.

There are various possible explanations for this phenomenon. Firstly, organisations did not have the luxury of choice, and the issue of trusting partners had to be overcome due to the lack of alternative partners. Some providers interviewed were less sanguine about the risk of betrayals from bid partners, but were still of the view that partnerships had to be pursued even in low trust relationships. In reality providers had a very limited pool of potential partners to work with. Organisations with the appropriate resources for each bid were limited, for instance due to scarcity of expertise or the cost of fixed assets, and the organisations spoken to were generally clear that they would only bid for tenders within a certain geographical area.

Secondly, co-operation in relation to the service being tendered appeared to be managed in part by contract. Unlike more complex ongoing relationships between organisations, these partnership arrangements were relatively concise and definable, and the legal agreements between partners provided assurance of the performance within the partnership. This suggests that there may be a reliance on calculative trust in these relationships. Calculative trust stems from 'the strategic interaction of self-interested economic agents', and persists as long as it remains in the self-interest of the party to do so, during which time the possibility of defection is restrained by sanction (Deakin et al., 1997). Calculative trust is therefore a rational model of trust, and indeed whether it is accurate to deem such a rationally based model as trust is debatable (Williamson, 1993). A similarly impersonal model is that of institutional-based trust (Zucker, 1986), in which parties rely on structures which guarantee trust where there is exchange across group boundaries without close social links.

Thirdly, and importantly, in the case of tenders the senior managers leading the tenders, and who were responsible for initiating and breaking organisational partnerships were not same people as those who would be involved in the provision of services. Tenders appeared to be commonly put together at Director level in organisations, rather than by those directly involved in the day to day running of the services concerned. The Senior Managers interviewed for the research in general reported weak social links with each other. It is likely that issues of trust and co-operation would be much more pertinent and testing for those who needed to form an ongoing relationship in the delivery of partnership services. It is also possible that, whilst Senior Managers were seen to be generally happy with the depersonalised transactions involved in writing tender bids, these preferences were not shared by health care professionals, who have been traditionally envisaged to have more socialised relationships (Bourn and Ezzamel, 1986). The description of one Director gave an indication of the different approaches of managers and clinicians to the temporary co-operative partnership involved in putting together a bid:

*'So you kind of – and initially, you know, "Oh, they're all bastards, we couldn't possibly work with them," so, Cardiology, it's like trying to get people's ex-wives to go. [Acute Trust] hate us and we hate them. But actually, we competed for [location], but in [location] we've gone into partnership, and one of the satisfying things about my job is actually getting those people in the room and it's just hysterical, because they really don't like each other. I tried to do it once by teleconference because we couldn't all get down there and you know teleconferences*

*work well when people get on alright. When they hate each other, it was a disaster. You couldn't walk out, and you could hear this sort of sharp intake of breath [laughter]. I didn't know where it was coming from. It was just – it was horrible.'*  
(Director, Provider D)

The way health care professionals approach issues of co-operation and competition will be dealt with more fully in Section 7.5 below.

Examples of attempts to create longer term co-operative relationships between organisations, suggest that co-operation with a competitor was much harder to sustain outside the well-defined arena of tender bids. In situations where trust was required to initiate and sustain a longer term partnership, so for instance making a commitment to work together in the future, outside the clear framework of a bid for a specific piece of work, it appeared that organisations found it much harder to reach agreement. In the course of the case study field work examples of organisations considering strategic partnerships were discussed. An interesting illustration of the difficulty of securing co-operation between competitors is the relationship between Provider H, a community trust, and Provider F, an Acute Foundation Trust. The two organisations were direct competitors in relation to the raft of 'intermediate' services, such as diabetes, which could be provided by either acute or community organisations. Provider F's ideal position was to acquire Provider H to become an integrated acute/community organisation, however, recognising that this was not an achievable objective in the short to medium term, Provider F decided to treat Provider H as a collaborator rather than a competitor. The driver for the partnership working between the two providers was that the community trust (Provider H) had a very strong reputation, was likely to continue to win bids, and the contract for services would not be up for another two years. Whilst both organisations agreed that they should work together, they both reported that securing partnership working in practice was a difficult process. The two organisations had been engaged in Board to Board discussions to explore and agree joint working, including the development of a memorandum of understanding. Provider H reported that the acute Foundation Trust had issues with trust due to the community trust's reputation (*'so the people see [Provider H] as being an ambitious and acquisitive organisation, so they were completely paranoid'*). It was reported there were difficulties reaching agreement about any projects which could be used as vehicles for joint working.

This illustrates the difficulty achieving long term strategic level co-operation between potential competitors. Particular characteristics in this case appeared to exacerbate the difficulty of establishing partnership working between the two organisations: the perceived reputation of the community trust, the lack of a history of previous interaction. Sydow (1998), discussing the establishment of inter-organisational trust, suggests that trust is also specific in nature, and it may be that in this instance the lack of a specific need to co-operate may also be hindering the partnership:

*'In the face of the willingness to take such risk and to accept vulnerability, **interorganizational trust**, therefore, is the confidence of an organization in the reliability of other organizations, regarding a given set of outcomes or events. This latter proviso takes into account that one does not usually trust a person, an organization or another system in every respect (global trust) but only with respect to certain kinds of behaviour (specific trust).'*' (Sydow, 1998, p35)

It may be therefore, that in this instance, the lack of a specific driver (reward or risk) for partnership working means that there is no necessity to take the risk of placing trust in a competitor. The establishment of trust is often seen as an incremental process (Lane, 1998). Nootebaum for example (2002) sees the source of much trust as 'process based trust' which grows from interactions in specific relations, but this model is unhelpful when trying to establish how trust can be generated in order to begin interaction. This may be a problem that is inherent with high level, strategic organisational interaction, and that trust is easier to establish closer to service delivery, where interaction is more oriented to a specific task, such as the delivery of a co-ordinated service for diabetic patients. This dynamic is examined in relation to the delivery of diabetes services in the next section.

## **7.5 The behaviour of provider organisations in the planning and provision of diabetes services**

One of the areas of interest in the study of how organisations combine co-operation and competition ('co-opetition') is how competitive and co-operative activities are separated within organisations. Studies suggest that the competitive and co-operative activities may be managed by different people (Becattini, 1992) or may take place in different areas of the organisation or be divided by proximity to the customer (Mariani, 2007). These studies suggest that we might expect to find differences between the strategic organisational level

interaction and the operational service level in the way that incentives for co-operation and competition are handled. It is likely that those delivering services are subject to different incentives and objectives to those who are engaged in planning organisational strategy, and may approach co-operation and competition in different ways.

This section firstly examines the relevance of clan relationships observed between consultants and the impact of this on interpretation of the rules and operation of incentives for competition and co-operation. It argues that clinicians appeared to be more embedded in social relationships, and were not motivated by organisational level incentives for competition. However the data also indicated that clinicians do adopt competitive roles in certain circumstances. Secondly the section examines the impact of incentives for competition and co-operation on provision of diabetes services between organisations, and argues that organisational integration is not a panacea for well co-ordinated services. When co-operation was required where there was strong incentives for competition it appeared that the co-ordination of services was not affected, but issues relating to lack of trust threatened the quality of interactions in relation to the planning of services.

### ***Clinicians' incentives***

Consultants were acknowledged by organisations to be important players in relation to competition. The support of consultants was considered to be fundamental to tendering for a service, and consultants were important assets and resources for organisations both for presenting strong bids and for attracting tender partners.

Interviews with consultants suggested that they were not motivated by the incentives for competition in the policy and regulatory framework, which were aimed at organisational level. The root of this dissonance was that NHS competition was incentivised as, as one consultant termed it, a 'competition of industries' rather than a 'competition of individuals'. Regardless what happened to the organisation, for instance if it failed and was taken over, the consultants themselves would not be adversely affected:

*'I think, you know, we understand there is a difference between the huffing and puffing that institutions and Chief Execs have to say for the sake of this, that and the other, and the reality being that we know there aren't enough Consultant Diabetologists in [geographical area] to provide the care we would like to. There isn't really any, in reality, likelihood that anybody's going to lose their job. There may be people that maybe have to work in a slightly different way than they do at the*

*moment, but ultimately the effect on the Consultants is not going to be affected very much by competition' (Diabetes Consultant, Provider F)*

Consultants tended not to be motivated or concerned by incentives such as tariff payments for their services. The interests of consultants were not aligned with those of the organisation and they may therefore have approached relationships differently. Although it may be that consultants are not motivated to compete through the policy and regulatory framework, they may of course compete for other reasons, not to do with competition policy or organisational competition. For example, consultants may be motivated to compete to improve the quality of their service, or may be motivated to defend their professional remit or identity (Drenth et al., 1998), and indeed it was clear that development and leadership of the service was an important motivator for the consultants interviewed.

Consultants were presented as more embedded in social relationships, which influenced their behaviour. Clans can be defined as occupational groups who have 'organic solidity', stemming from a unity of objectives due to interdependence (Ouchi, 1980). Clan relationships in the NHS are commonly associated with the relationships between clinicians (Bourn and Ezzamel, 1986), and it is thought that the autonomy required of professional work encourages clan relationships (Mintzberg, 1991). Indeed consultants, to varying degrees, articulated shared values and a shared code of behaviour. Some felt that loyalty to other members of their profession shielded them from competition due to a 'gentlemanly code' of behaviour. These were characterised as high trust relationships which exceeded any bonds which individuals might feel to their employing organisation. For instance it was claimed that consultants would warn each other of an aggressive competitive strategy. In part some saw this as due to strong social links and personal relationships between consultants relating to historical relationships dating back from training. The Diabetes consultants were essentially a small community who knew each other and met at regional and national events. However it was not clear that these strong links were shared by all consultants, and it is possible that personal relationships can hinder as well as strengthen co-operative relationships, if, for example, consultants did not get on with each other. Indeed there was evidence that within the case study area strong links existed between some consultants but not others.

In contrast with the importance of consultants as leaders of clinical co-operation and important assets in relation to organisational competition, other clinicians appeared to have less of a role to play. In particular, GPs in the case study area were not considered particularly



alert to competition and the market in relation to diabetes. Whilst in other clinical areas (for instance urgent care) GPs had adopted the role of competitor, mobilising to compete for tenders, this was not the case in relation to diabetes, where they had no desire to expand their role. One suggestion was that this was because the GPs did not yet have sufficient skills in the area to take this role on. Similarly, the nurse interviewed for the study did not consider herself to have a role in relation to competition. The role of clinicians in relation to competition is discussed further in section 7.7.

### ***Co-ordination of services***

Within the case study area there was a variety of models of service provision for diabetes pathways, which contained differing incentives for competition and co-operation. This section will look at two broad models which were used in diabetes services in the case study area. First, where the patient pathway for diabetes services was integrated within the boundaries of a single organisation, and second where competing organisations were required to co-operate in the provision of the diabetes patient pathway.

#### Co-operation and competition within organisational boundaries

The pathway for patients referred to the main provider for the case study commissioner, Provider A, took place almost entirely within Provider A as it was an integrated community and secondary care organisation. The community, intermediate and secondary care service were provided from within a single organisation. The pathway can therefore be characterised as a pathway almost entirely lacking in organisational diversity, and therefore not subject to organisational competition. The exception within the Provider A pathway is the provision of diabetic retinopathy services which was provided by an independent sector provider, Provider E. This element of the pathway will be dealt with below. Whilst the analysis of this pathway does not, therefore, offer much learning about the way competition and co-operation might be combined by those organisations involved in the provision of services, what is of interest in relation to the Provider A pathway is that it offers an example of the integration of services within a single organisation, untroubled by organisational competition. The default position is often that it is competition which prevents the integration of services (e.g. Ham and Smith, 2010), however the evidence here suggests the position is more nuanced than this.

At the time the interviews with Provider A commenced, the organisation had been an integrated community and acute services Trust for 3 months. The belief of the Provider A management was that the integrated organisation would make the services run more efficiently, and that the organisation would be able to make use of the flexibilities in tariff available for community services (unlike in acute trusts). The diabetic consultants expected that it would be easier to arrange support for diabetes services from the wider team (for example the provision of podiatry support in diabetes outpatient clinics). However it is notable that, whilst unsurprisingly at this early stage after the merger (three months at the time of the first Provider A interviews), there were as yet no benefits for the diabetes service, it was not reported that there had been issues regarding working across organisational boundaries before the merger. Interviewees reported there had been close working across organisational boundaries between the community and secondary diabetic staff prior to the merger, to the extent that the diabetes specialist nurses who were employed by the community (PCT provider arm) were based in the hospital and had, to the annoyance of the commissioner organisation, ended up working directly for the acute service in hospital clinics. Where services were described as less well integrated, this was not related to organisational boundaries. An interviewee from the case study commissioner described the diabetes service as 'siloed' even where teams had previously been managed within the same organisation prior to the acute/community merger. For example the podiatrists and dieticians, who had always been managed within a single organisation, would refer to each other if clinically necessary but would not communicate beyond that.

When Provider A was revisited two years later at the end of the fieldwork period, it was suggested that limited gains in relation to clinical services had been made from organisational integration. While progress had been made bedding in the new arrangements, *'sorting the management structures out, clearing a lot of the dead wood out and rationalising back office functions'* (Director (Strategy) Provider A) the clinical service change agenda was only recently being addressed.

Integration by means of a single organisational structure was not a panacea for achieving close working in the provision of services. Boundaries can exist quite apart from organisational boundaries. The data here confirms the findings of other studies that informal forms of co-operation and collaboration may be just as important to achieving integration as organisational merger (King et al., 2001, Burns and Pauly, 2002, Ramsay and Fulop, 2008).

Furthermore, even if the integration of a pathway within a single organisation was the answer to achieving the co-ordination of services, 'full' organisational integration of a pathway was not possible within the NHS system at the time due to the separate provision of GP services. Indeed one interviewee (a GP) made the argument that the integration of acute and community into a single organisation under Provider A had separated community services from general practice, and it was proving very difficult to engage community services in the GP agenda. As Leutz points out some connections will always be left on the outside and may cause 'differentiation and fragmentation' (1999).

The evidence suggests that the provision of services within a single organisation does not necessarily address factors which impinge on the integration of services within a patient pathway. Even before the potential benefits of organisational integration for services can be realised, the mechanics of the integration process (aligning the back office functions) must be completed, which can be a lengthy and costly process. The evidence also suggests that the co-ordination of the efforts of staff providing services, and the relationships between them, may be influenced by issues quite apart from organisational boundaries, and therefore will not necessarily be addressed by moving staff so they are managed within a single organisational boundary.

#### Co-operation and competition in organisationally diverse pathways

Elsewhere within the case study area there were examples of the co-ordination of diabetes pathway between competing organisations. In these pathways secondary care, intermediate services and community diabetes services were provided by separate organisations. Details of the diabetes pathways relevant to the case study area, and the organisations within them, can be found in Chapter 5 (Figure 5.4).

The health care professionals involved in the provision of services in these organisationally diverse pathways cited issues relating to the co-ordination of services across organisational boundaries. However it was not clear that these difficulties were related to competition between organisations. The organisational integration of diabetes services remained an attractive way of organising diabetes services to consultants, who were at times frustrated by their lack of control over the elements of the pathway outside their organisational boundary. One illustration given in interview was the alleged poor human resource management of podiatry staff by their employing organisation which was thought to be leading to staff resignations. A second involved the alleged prevention of close working

between diabetes consultants and community nurses, as the nurses' employing organisation was reportedly worried that the consultants would 'poach' the nurses if they were allowed to meet. Interestingly the acute based diabetes specialist nurse interviewed for the study did not report any problems with communication between hospital based and community based nurses, apart from those related to a lack of time in their working day to communicate. The issues raised by consultants do not appear to be directly caused by competition between organisations, but are instead issues of inter-professional working. As Mur-Veeman, Eijkelberg et al. (2001) note in relation to the implementation of shared care in the Netherlands, to achieve integration issues of power and culture as well as issues of structure need to be considered in relation to inter-professional working and networks.

In Provider A's pathway the provision of diabetic retinopathy was from a for profit provider. This provider had competed with Provider A for the contract, but there was no ongoing competition between the two organisations. There were two issues highlighted in relation to the operation of the pathway. Firstly, the Provider A consultants reported problems with the interaction of the NHS and private provider computer systems, and secondly the screening service provider reported that it was not always easy to obtain the information they needed from the GP practices regarding patients to be screened. It may be that these problems, particularly the lack of co-operation from the GPs, reflect the 'outsider' status of the private provider. Indeed, the senior manager interviewed at the screening company was very concerned about the perception of them from within the NHS, particularly the perception of the NHS staff transferred to them as *'some kind of evil independent company who's going to sack them as soon as they can'*. It is also important to note that the co-ordination of the screening pathway across a diversity of organisations was in fact the responsibility of the case study commissioner rather than the organisations in the pathway themselves. It may be therefore that the screening company was shielded from potential problems in the co-ordination of the pathway. The role of the commissioner as a co-ordinator of services is discussed in section 7.6 below.

The clearest example of tension between competition and co-operation within diabetes planning and provision in the case study area was the interaction between Provider G, a community NHS Trust, which provided an intermediate service for diabetes in which the consultant sessions were subcontracted from Provider B, an acute NHS Trust. This is of particular interest to this analysis as Provider B was Provider G's direct competitor in relation to the provision of intermediate services across a range of specialities. From Provider G's

point of view the combination of the competitive and co-operative relationships between the two organisations raised issues. Some of these related to the management and accountability lines for the subcontracted consultants, which were an important issue for the provision of the service, but were not directly related to the competition between the two organisations. However the ongoing competition between the two organisations did raise issues of trust for the manager of Provider G's diabetes service, namely whether they could trust the consultants with the confidential service information necessary for them to take part in service development. The community manager outlined concerns regarding where the consultant's loyalty lay:

*'They're on board, but if we're talking about competition and integration there is always this conundrum that it's whether or not they believe that they actually work for us or not and that is a very powerful thing...Belonging is so important and it's not just about the terms of employment, it's about their perception of their responsibilities and who trumps who in these responsibilities.'* (Manager, Provider G)

The intermediate service required the input of the consultants in order to develop it, giving access to sensitive finances to people 'who are potentially my competitors' (Manager, Provider G). Some of the theoretical literature regarding trust distinguishes between different levels of trust. One such theory is Sako's hierarchy of trust (1998) which provides a useful framework for considering the concerns of the manager of the intermediate diabetes service. As described more fully in Chapter 2, Sako identifies three levels of trust, contractual trust, competence trust and goodwill trust. These levels of trust operate in a hierarchy, one needing to exist before the other can be established. In this instance there were not issues of contractual trust, which concerns the belief that the party will carry out an agreement, or indeed to competence trust, that the party will act in the way they say they will. What appeared to be in question was the demonstration of commitment and fair behaviour which constitutes good will trust, in this instance the question of whether the consultant would refrain from taking unfair advantage of sensitive information shared with them.

Goodwill trust enhances the effectiveness of transactions, and can lead to the exploitation of opportunities for mutual benefit. If in this situation Provider G was willing to share financial information with the subcontracted consultants and the consultants were willing to, for example, share learning from their own service, both parties could benefit. It represents the opportunity for competing parties to achieve mutual benefits from co-operation of the kind envisaged by the co-opetition framework. The fundamental question

is how this type of goodwill trust might be achieved. Sako hypothesises possible ways it might arise from a long previous trading relationship, or from the expectation of future interaction. She also suggests an approach based on gift exchanges. For example in this instance Provider G could invest in the consultants' knowledge and skills, to show that Provider G knows enough to enhance the consultants' skills, and acts as a goodwill gesture.

Interestingly this kind of trust building approach appeared to be a common factor in the interaction between Provider G and their main commissioner. The Senior Manager identified a number of 'favours' they had undertaken in order to keep the commissioner 'sweet', including providing an appointment booking service at low cost. It is noteworthy that this 'gift' relationship existed within a framework of a longstanding provider/commissioner relationship, which had its roots in the fact that the provider and commissioner were originally part of the same organisation before the divestment of the commissioner provider arm.

The case study flagged potential difficulties relating to the provision of diabetes services within an organisationally diverse pathway. However, as was the case with the problems of co-ordination and relationships within the organisationally integrated pathway, these issues were not necessarily related to organisational boundaries or to competition between organisations. Notably though, where organisations who were in direct competition with each other needed to co-operate to provide services, there were issues relating to trust which, whilst not affecting the co-ordination of services, may impact on other wider benefits potentially available to co-operators such as shared learning.

## **7.6 Commissioner led co-ordination and networks**

A striking aspect of the diabetes pathways in the case study area was the prominence of the case study commissioner as the co-ordinator of services. The theoretical literature regarding supply chain relationships between the producers of products and services focuses on the gains to be made from close co-operation between the producers involved in supply chains. Theories associated with supply chain management such as Sabel's notion of flexible specialisation (1994) suggest that there is benefit to close co-operative activity between supply chain organisations, and that the development of close working relationships in long term supplier/provider relations can bring benefits without formal integration such as through the exchange of tacit knowledge. However in the case study it appeared to be the

commissioner rather than the providers who took the lead in ensuring co-ordination within the supply chain.

The prominence of the commissioner in the co-ordination of the supply chain for services can partly be explained as a result of the nature of the contracting process in relation to NHS services. Conventionally, the NHS commissioner would commission the organisational elements of the service separately. Interviewees recognised that the nature of NHS contracting created issues relating to the ownership of, and responsibility for, supply chains. However, in relation to the provision of diabetes services in the case study area at the time of the fieldwork, the activity of organisations involved in the provision of diabetes services tended to be co-ordinated centrally rather than by the providers themselves.

In relation to the Provider A diabetes pathway, the case study commissioning organisation took responsibility for facilitating meetings between the staff involved in the provision of diabetes in order to encourage the building of relationships. Furthermore, the commissioner took responsibility for the co-ordination and performance management of the diabetic retinopathy screening service pathway. In addition they led activities focused on integrating the diabetes service. The commissioning organisation convened the planning body for the diabetes service, organised training events for the GPs, and met with all the staff involved in the Provider A pathway. There was no formal diabetes network in existence at the time of the fieldwork. The only regular multi professional and multi organisational meeting appeared to be the commissioning organisation convened planning body for the diabetes service. Provider A clinicians did report leading multi- disciplinary meetings on a roughly annual basis to discuss issues of service quality.

### ***The Integrated Care Pilot***

An important example of the commissioner role in relation to the co-ordination of services, and the possible effect it had on the way organisations related to each other is the Integrated Care Pilot (ICP), which the case study commissioner launched together with partner (shadow) CCGs in August 2012. The ICP was aimed at accessing improvements in the co-ordination of care to improve the quality of care and achieve efficiencies. The ICP was based on the establishment of multi-disciplinary groups, across organisational and professional boundaries, most commonly GPs, social care staff, hospital consultants and occupational therapists. The multi-disciplinary groups were based around service areas, including

diabetes. Participating GPs identified patients who were at risk of admission to secondary care, and took a detailed case history for discussion in the monthly multi-disciplinary meeting. The pilot aimed to decrease emergency admissions and nursing home admissions, to reduce the cost of these groups and significantly to improve patient experience through increasing trust, co-ordination and collaboration amongst health care professionals. Chapter 5 (Figure 5.3) gives a timeline showing the relationship of the ICP to the other developments in diabetes services in the case study area.

The ICP is interesting as a model of network governance in which providers had a degree of autonomy. Provider organisations signed a Memorandum of Understanding, setting out financial arrangements. In addition to the participation of health professionals in Multi-Disciplinary Groups to discuss the care of patients, they were also able to participate in local Integrated Management Groups and Integrated Management Boards. These bodies allowed providers a degree of freedom to run the network as they saw fit, to set the rules of financial, performance and evaluation frameworks and to administer limited funding. The ICP also offered opportunity for providers to retain financial savings resulting from the work of the pilot.

However, the provider network was also firmly situated with the hierarchical control of the commissioning organisation. It was centrally funded by the commissioning bodies. The Integrated Management Group was held to account by the commissioning organisation. When it was established in 2012 it was proposed that financial savings in the first year would be retained by commissioners as it was funded centrally. It was also proposed that, in subsequent years, 50% of any savings would be divided between providers and 50% would be retained by the commissioners as additional savings.

This is an example of integration without the alteration of organisational boundaries and shows the important role of a third party (in this case both NHS London and the commissioning organisation) in achieving this. Whilst providers were given a degree of freedom to act, to find their own solutions to problems and to reap the rewards of their successes, the initiative was situated within the control of the commissioner who performance managed it and also took a share of any profits. It is not possible here to comment on the success of the ICP in the case study area. It appears that the pilot was popular and helped build networks which aided the quality of care. Interviewees suggested it was particularly useful in terms of building relationships between professionals,



particularly between GPs and consultants. Similarly a review of the first year of the pilot carried out by the commissioning organisation in November 2012 found that the vast majority of professionals involved in the pilot felt that productive relationships were built across organisational boundaries.

The hybrid nature of the ICP illustrates the tensions of combining a hierarchical structure with network governance. It is a situation which has resonance with the model Ostrom envisages in which individuals can self organise to solve collective problems, and can establish and enforce rules concerning the appropriation of common pool resources. However the example also indicates the difficulty of creating the kind of collective choice situations which Ostrom outlines in a system such as the NHS. Whilst Ostrom envisages that third party governance can have a role to play in the resolution of common resource problems, it is questionable whether the strong hierarchical framework which exists even in relation to 'network' initiatives such as the ICP can bring the anticipated benefits of self governance. The central funding which enables the ICP, also weakens the incentive structure for provider co-operation as half of the savings are taken centrally. Furthermore, whilst providers had a degree of freedom within the pilot to decide how the pilot would be run, this activity was necessarily situated firmly within the other central planning activities of the hierarchy.

The role of the commissioner in co-ordinating the activities of provider organisations was a very important factor in the sustenance of links between providers. One of the 'coping' strategies for combining co-operative and competitive behaviours which has been identified by a previous study is for a third party regulatory body to instigate co-operation (Mariani 2007). However it may also be argued that the role of the commissioner as co-ordinator inhibits provider willingness to adopt these roles themselves. Game theoretic studies suggest that intrinsic motivation is decreased when individuals perceive that their actions are controlled by external intervention (Deci and Ryan, 1985).

## **7.7 Competition at service level**

The data analysed so far in this chapter suggest that competition and co-operation are at least partly managed in organisations by means of a division of activities across professional groups and activities. Senior managers in organisations embraced competition, whilst clinical teams focused on co-operative activities closer to services. However it is not correct to say

there was no competition at service level, and to assume a divide between competition led by managers at an organisational level and co-operation led by consultants and commissioners at a service level. The collegial ties between consultants do not prevent competition between them. It may be that consultants are fundamental to both co-operation and competition. Whilst consultants were not motivated by policy or organisational incentives for competition they were motivated by the desire to develop their services. In the case study one consultant was using relationships built with GPs through the ICP to steer additional referrals into his services. The friendship between a diabetic consultant and GP with a management role in a commissioning organisation also led to a plan to divert referrals:

*'If [Provider A] is going to downsize and go, which is, sort of, you know, potential,[area] is closer to us and the [area] GPs would much rather deal with me than with [Provider D], or at least that's what they tell me, and [CCG GP] is their Lead, so we're going to meet up and try and help facilitate that.'* (Consultant Provider F)

This is an example of network co-ordination, making plans together in advance to co-ordinate their activities. It is a reminder that competition is not necessarily controlled or incentivised by policy nor is it exclusively a top down activity. In this case the competition was led by the consultant, who had let the Trust management know of his intent, and was supported by them.

## **7.8 Conclusion**

This chapter has focused on the behaviour of players, both organisations and individuals, as they navigated incentives for competition and co-operation to agree organisational strategy and plan and deliver diabetes care to patients. The data suggest that NHS providers were subject to a strong co-operative norm, but that this was context dependent and could be subject to change based on the strength of competitive incentives in the environment, dependencies between the players concerned and belief in the 'nature' of other players.

Competitive and co-operative behaviours differed between managers and clinicians, and on proximity from service delivery. Competitive activity was largely confined to the sphere of competitive tenders. Interestingly here, co-operation between competitors was relatively spontaneous with managers embracing 'market' like behaviour with interchangeable partners. Outside of this sphere, co-operative relationships were predominant. Consultants

were both co-operators and competitors. They used social ties gained through co-operative activities to improve their competitive position.

Problems which may have arisen relating to the need for competing organisations to co-operate, including the potential problems of co-operation between NHS and private providers, were largely smoothed by the co-ordinator role adopted by the case study commissioner which appeared fundamental in achieving co-operation across organisations and professionals to deliver co-ordinated services.

Where competition and co-operation were in tension with each other, what appeared to be at risk was not the delivery of services but the deeper trust which related to the quality of the relationship between parties. This may affect aspects relating to improvements to services. A similar dynamic relates to the commissioner role as co-ordinator which can be seen as limiting the ability of providers to find their own innovative solutions to problems. This is a possible shortcoming of the hierarchical approach taken to co-ordination which may inhibit benefits which arise from spontaneous co-operation.

Importantly whilst it did not seem that incentives for competition and co-operation were impacting on the delivery of services, it was clear that other, non-organisational issues, such as inter professional relationships, had the potential to disrupt the delivery of services.

## **Chapter 8**

### **Discussion**

#### **8.1 Introduction**

The aim of this thesis was to explore the co-ordination of public services in the light of incentives for both competition and co-operation, through an analysis of the way organisations in the English NHS negotiate incentives for competition and co-operation to plan and provide co-ordinated care to patients. This discussion chapter summarises and discusses the findings of the research in the light of the research aims and objectives, and in relation to both NHS policy and public service policy generally, the theoretical framework and other empirical studies. The chapter also discusses the strengths and limitations of the research methodology. Finally the chapter explores the contribution that the thesis has made theoretically and empirically, discusses how the findings can be useful for policy makers, and makes suggestions for future research in this area.

#### **8.2 Summary of thesis aims and objectives**

The question of how to achieve the co-ordination of public services is a vexatious one. Traditionally in the UK, public service planning and provision has been achieved by a predominantly hierarchical model. One of the reasons for this is the characteristics of public services which mean that co-ordination via market mechanisms is problematic and subject to 'market failure', such as problems of asymmetry of information, high regulatory barriers, the need to provide specialist services and, additionally, the need (in the UK at least) to ensure that health care is delivered fairly across the population. In recent times in the UK there has been interest in using competitive incentives to gain the perceived advantages of competition in the market for public services. For example, the provision of primary and secondary state education is subject both to parental choice and diversity of provision, social care has similarly been opened up to competition through the use of direct payments and the commissioning of residential and domiciliary care for older people, and local government makes use of competitive tendering for the provision of multiple services (Gash and Roos, 2012). In relation to health services in the UK, competitive incentives were first introduced in the early 1990's and, since 2002, competition in the English NHS has been stimulated on the supply side through an increase in the diversity of providers of care, the introduction of patient choice and a payment system which rewards providers for activity. However it is clear that, due to the differences between public services and private goods, market incentives

may not function in the same way in relation to public services. In relation to the planning and provision of NHS services a particular concern had been that incentives for competition would disrupt incentives for co-operation and, by doing so, negatively affect the provision of services across organisations.

The objective of this thesis was to explore how the conflicting demands of competition and co-operation affected the behaviour of organisations in health care systems by asking: firstly, in relation to the national policy and regulatory framework, how the need for competition was being balanced against other needs by regulatory bodies and how the rules are being interpreted at a regulatory level; secondly, in relation to inter organisational behaviour, how the policy and regulatory framework is understood and implemented at a local level; and thirdly how incentives for competition and co-operation are impacting on the planning and provision of diabetes services.

These objectives were addressed through a review of the related theoretical literature and empirical studies (Chapter 2), an analysis of the contemporaneous institutional context (Chapter 3), and case study research of the planning and provision of diabetes services in a local commissioning area of the English NHS (Chapters 5, 6 and 7).

The case study research addressed the following questions:

- 1) How do organisations planning and providing NHS services understand the policy and regulatory environment, including incentives for competition and co-operation, and how does this understanding affect their objectives?
- 2) What are the objectives of professionals, particularly managers and clinicians, involved in the planning and provision of NHS services in the current environment, and how do these objectives affect their behaviour?
- 3) In the current environment, how do those organisations and professionals approach their relationships with each other in relation to the planning and delivery of care for diabetic patients?
- 4) What is the patient experience of the co-ordination of services in this environment?

### **8.3 Contribution of the thesis**

Whilst the impact of combining incentives for competition and co-operation is the subject of debate, there has been little research addressing this issue. This thesis has made a unique contribution to research which considers the interplay of incentives for competition and co-operation in the English NHS in three respects.

Firstly, the study is unique in its approach to examining the impact of incentives for co-operation and competition on organisational behaviour. Whilst other studies examine organisations' behaviour in the light of the use of incentives for competition in the English NHS (Bennett and Ferlie, 1996, Flynn et al., 1996, Allen, 2002, Bartlett et al., 2011, Porter et al., 2013, Frosini et al., 2012, Allen et al., 2014a), they have either not looked at organisational behaviour in relation to a tracer condition (Bartlett et al., 2011, Frosini et al., 2012, Allen et al., 2014a), or have focused on a specific condition or conditions but have focused on commissioner/provider relationships rather than provider/provider relationships (Bennett and Ferlie, 1996, Flynn et al., 1996, Allen, 2002, Porter et al., 2013). Powell et al (2011) did focus on tracer conditions and the interactions between provider organisations, but the research was concerned with the impact of complex policy initiatives in general and not incentives for competition and co-operation in the policy environment specifically, nor the co-ordination of services. By examining the impact of the combination of incentives for co-operation and competition on organisational behaviour in relation to both commissioner/provider and provider/provider behaviour in the light of the co-ordination of a tracer condition, the research has taken a unique perspective.

Secondly, in relation to the contemporaneous institutional context, the thesis examined the decisions which have been made by regulatory bodies regarding the operation of competition in the NHS. Most of the academic work in relation to this has been policy commentary which sought to predict the impact of HSCA 2012 (e.g. Davies, 2013, Stirton, 2014). In particular, the thesis contains an analysis of the regulatory decisions made by the CCP between 2009 and April 2013, and the decisions made by Monitor, the OFT and the Competition Commissioner from April 2013 to October 2013. This is the only publicly available analysis of these decisions to date, and therefore constitutes a unique contribution to knowledge about the type of decisions being made and the way regulatory bodies are in practice balancing the protection of competition against other concerns.

Thirdly, the thesis has made a unique contribution from a theoretical perspective. It considered the game theoretical approaches of co-opetition and Ostrom's IAD framework in the light of behaviour in the case study area to help understand and compare theories of behaviour. The concept of co-opetition has been discussed in relation to organisational behaviour in the NHS (e.g. Crump, 2008, Player, 2008, Gilbert et al., 2014), but has not previously been applied to empirical research in the English NHS, although it has been used in relation to the planning and provision of health services in Italy (Barretta, 2008, Mascia et

al., 2012) and Taiwan (Peng and Bourne, 2009). Furthermore, Ostrom's IAD framework, whilst used extensively in other areas such as irrigation systems (Benjamin et al., 1994) and forest governance (Gibson et al., 2000), has not been applied previously in this way to the interaction of organisations in the NHS, although the concept has been discussed in relation to the operation of market incentives in the NHS (Taylor-Gooby, 2008). Pollitt et al (1988) used the elements of the 'action situation' identified by Ostrom, in relation to accounts from NHS senior managers and clinicians of attempts to encourage doctors in the NHS to become resource managers. However in that case the IAD framework was not applied in relation to inter-organisational behaviour or in relation to competitive incentives. Therefore the analysis of organisational behaviour in competitive situations in the light of IAD framework in this thesis represents a development of its use in relation to the NHS, and the first time Ostrom's ideas about the management of incentives for competition and co-operation have been applied to an empirical study of organisational behaviour in the NHS.

#### **8.4 Summary of findings**

The thesis has argued that the impact of incentives for competition and co-operation on organisations' and professionals' behaviour as they planned and provided services was profoundly influenced by the predominance of hierarchical modes of co-ordination. The hierarchy blunted both incentives for co-operation and competition for providers of services. Local context was very important in shaping the deployment of incentives for competition and co-operation. Where organisations and professionals were exposed to both incentives for co-operation and competition, the delivery of services did not appear to be unduly affected, but issues of trust inhibited the sharing of sensitive information between parties, and reduced the quality of interactions.

This section now outlines in more detail the findings of the thesis as they relate to the objectives of the research.

The first objective of the research was to explore how, in relation to the national policy and regulatory framework, the need for competition was being balanced against other needs by regulatory bodies, and how the rules were being interpreted at a regulatory level.

The review of the institutional context in place at the time of the fieldwork found that the rules affecting competition and co-operation in the planning and provision of NHS services were complex, spanning both legal regulation and best practice guidance. This was further complicated by the changing legal framework during the research period when HSCA 2012

came into force from April 2013. The non-NHS specific legal framework pertaining to competition and procurement in the English NHS reflected a clear need to protect the operation of competition, but its application in practice to the NHS was untested at the time of the fieldwork. The NHS specific rules delegated much of the decisions concerning the actual use of incentives to a local level, there was a clear intention that local commissioners should decide how to deploy incentives to achieve the overall aims of the legislative framework in their locality, including the integration of services and the achievement of value for money, as well as the promotion of competition.

Where matters were referred beyond local level, it was found that, in the period before HSCA 2012, the promotion of competition was secondary to other concerns for the NHS specific regulator (CCP), particularly in relation to mergers. Where mergers were found to be inconsistent with the rules regarding competition, either benefits were identified which were thought to outweigh the loss of competition (such as the achievement of better services, costs savings, quality and safety benefits in the interest of patients and the optimisation of estate), including the maintenance of co-operative local relationships or, where these benefits did not outweigh the loss of competition, remedies to address this loss were agreed. The research identified a change in emphasis after HSCA 2012 (albeit based on a single decision pertaining to the fieldwork period) where increased exposure to national law and external bodies placed more emphasis on the promotion of competition and the principle that competition is the most effective route to achieving quality in services.

The second objective of the research was to explore how the policy and regulatory framework was understood and implemented at a local level. The case study fieldwork found a significant difference between the 'rules-in-form' described in relation to the institutional context, and the 'rules-in-use' by the case study commissioner. The commissioner in the case study had significant freedom to use incentives for competition and co-operation as it wished in the local area, but in practice the use of incentives was limited by local factors, most notably the financial position of the local health economy, the local configuration of organisations, and the perceived risk of destabilising the existing provider of services. The changing financial position in the local health economy appeared to have more influence on commissioner behaviour than the rules regarding the use of incentives for competition and co-operation in the policy and regulatory framework, and the changing policy and regulatory context during the fieldwork period. Indeed, the research found that the case study commissioner at times acted in clear disregard of the rules regarding competition, resulting



in NHS providers feeling unable to raise concerns regarding commissioner adherence to the rules due to the fear of souring relationships.

Whilst the commissioner had a tool box of approaches it could use in its dealings with providers, including the use of incentives for competition, and indeed the encouragement of more network based relationships, the method of co-ordination predominantly employed by the commissioner was the hierarchy. For example, contracts, which in theory represent a key opportunity for negotiation between parties, were in the case study better understood as instruments of the hierarchy and providers co-operated with the commissioners due to dependencies within a hierarchy. The reliance on hierarchical relationships between the commissioner and NHS providers to achieve co-ordination raises questions about the difference between the 'rules-in-use' for providers within the NHS family (i.e. NHS Trusts and NHS Foundation Trusts) and those outside the NHS family (i.e. independent sector providers).

The third objective of the research was to explore the impact of incentives for competition and co-operation on the planning and provision of diabetes services. The research found the impact of incentives for competition and co-operation differed in relation to the configurations of organisations and service portfolios in the area (most notably the split of services between acute and community providers), the role individuals occupied, and the type of activity being undertaken. In particular the research found a notable difference between the impact of organisational level incentives for competition (such as patient choice and tariff payments) on managers and consultants. Consultants were not susceptible to these organisational level incentives for competition, however they were incentivised to compete for other reasons, most notably to secure the control and leadership of clinical pathways.

In relation to the delivery of diabetes services the research found that co-operation relating to the delivery of services was not disrupted by incentives for competition. However the research did identify other barriers to co-ordination, not relating to competition, but relating to working across organisational and professional boundaries. This finding was reinforced by patient reports of discontinuities of care within organisational boundaries. The benefits of organisational merger, especially in relation to changes to clinical services took time to realise, and the integration of services suffered from professional silos, which operated independently of organisational boundaries. It is noteworthy that the case study commissioner was prominent as the co-ordinator of services in the diabetes pathway. This

approach was successful in achieving co-ordination in the light of incentives for competition and co-operation, but also incurred the possibility of inhibiting the willingness of participants to co-operate spontaneously.

Whilst incentives for competition and co-operation were generally blunted in the case study area, the research found that particular activities within the planning and providing of services were trigger points which contained strengthened incentives for both competition and co-operation. Competition and co-operation appeared to be combined unproblematically in relation to competitive tenders, where co-operation was often required to produce joint bids between organisations who also competed in relation to other bids. However, in other settings, competition appeared to impede the formation of trust which was necessary for activities which required longer term co-operation, for example, in relation to the planning of diabetes services, sharing of sensitive information necessary to improve services with clinicians employed by competing organisations. The research found that, in such cases, what was negatively impacted was not the co-ordination of services, but the quality of interaction between parties, which may affect for example, improvements to services.

## **8.5 Strengths and limitations of the methodology used**

This section considers the strengths and limitations of the research methods used. The research questions were addressed by a single case study design which focused on a commissioning organisation and the providers involved in the provision of services for that commissioner. As described in Chapter 4 (Methods), the single case study design was chosen in light of the resources available, and after a consideration of the balance to be achieved in the research between breadth and depth of data gathered.

In general the case study design proved to be a strength of the research. It allowed an in-depth examination of the operation of incentives in a single area, which included assessment of both the planning and provision of services. Access was gained to all the organisations approached, so a good spectrum of relationships and behaviour was encountered. The spread of interviewees, ranging from those with a strategic overview of an organisation's activities to those concerned with the provision of a specific service, allowed a focus on a specific service, but also gave me the flexibility to identify and gather data concerning interesting examples of the interplay of competition and co-operation across the spectrum of organisational activities. A further strength of the research is the extended time frame of

the fieldwork. The fieldwork was carried out in two blocks of interviews, with a gap of nearly a year between the two groups of interviews. This spacing gave the fieldwork a temporal dimension and facilitated the comparison of the behaviour of organisations in the light of the changing institutional context before and after HSCA 2012. This time frame also allowed the tracking of the developments in diabetes planning and provision in the case study area over a longer period of time than originally anticipated.

The main criticism commonly made of a single case study design is the lack of generalisability, specifically concerns that one cannot generalise from findings concerning a single example. It could be argued that generalisability of this sort is not a limitation for this research, as it seeks to make analytic generalisation based on the relation of the findings to theory, rather than seeking to make generalisations across the population. However, that said, the limitations of the single case study were addressed in the following ways in the research.

Firstly, this research is situated within a cohort of studies which are also concerned with organisational behaviour regarding competition in the quasi-market in the English NHS (Bennett and Ferlie, 1996, Flynn et al., 1996, Allen, 2002, Greener and Mannion, 2009, Dixon et al., 2010, Bartlett et al., 2011, Powell et al., 2011, Allen et al., 2012a, Frosini et al., 2012, Porter et al., 2013, Hughes et al., 2013, Sheaff et al., 2015), and this precedent allows a consideration of the extent to which the findings of this study agree or disagree with the findings of other studies. Indeed as illustrated by the review of empirical studies in Chapter 2 and the summary and discussion of findings in this chapter, the findings of this research in some respects are comparable with the findings of these other studies. However, this research focuses on a different aspect of relationships not covered by previous research, specifically the impact of incentives on commissioner and provider relationships in the light of the co-ordination of a tracer condition, and therefore takes a unique perspective.

Secondly, the case study contained within it a number of interorganisational relationships, including descriptions provided of the behaviour of other commissioning organisations by the providers interviewed. This data allowed an element of comparison of provider and commissioner behaviour within the case study area with that of organisations outside the case study area. Interviewees in provider organisations themselves compared the behaviour of the case study commissioner with other local commissioners in order to gain a sense of the spectrum of behaviours, and the data gathered from both commissioner and provider organisations allowed an understanding, which proved important to the analysis of the

findings, of the way local commissioning organisations were working together to make decisions about commissioning strategy.

A further potential limitation of the single case study design is the replicability of the research. The description of the methods used in Chapter 4 attempts to describe the case study in sufficient depth to allow the research to be repeated. However, as with many studies of organisational behaviour in relation to a specific policy context, the study reflects a particular policy environment at a particular time. The fieldwork was conducted in a 'handover' period between two commissioning organisations, and two regulatory frameworks. Whilst this may be considered a limitation, this type of issue is a frequent one for many studies regarding NHS policy in which policy rules and the configuration of organisations are often in flux. A further factor to be taken into account when considering the replicability of the research is the finding that the local context in which organisations operate is very significant in terms of influencing organisational behaviour when they approach their relationships with each other. Therefore, it is not reasonable to expect that a repetition of the research would find a similar mix of competitive and co-operative behaviours. However what might be encountered is similar tensions experienced by organisations when trying to balance incentives for co-operation and competition.

There are limitations to the research relating to the recruitment of interviewees. Although I successfully recruited all the organisations approached for participation in the study, recruitment within organisations proved challenging, and I was unable to recruit successfully across the spectrum of interviewees. As described in Chapter 4, I had a greater degree of success with the managers I approached than the clinicians. For example I did not interview consultants in all provider organisations, and interviewed only two GPs and a single nurse. In the case of nurses, they were not pursued as the data from the interviews indicated that they did not work at the right level to be affected by competition. The GP interviewed who did not also work within the commissioning organisation also appeared to be unaffected by competition. However ideally the fieldwork would have encompassed interviews with more consultants, nurses and GPs, and indeed representatives of the other professional groups involved such as chiropodists and dieticians. It is possible that findings therefore do not fully represent the experiences of those delivering the services. Certainly, there was variation in the views of the consultants interviewed which suggests that understanding of the impact of incentives for co-operation and competition on the work of this group would have deepened if further interviews had been secured. However the lack of interest of some of the clinicians

approached for interview could be interpreted as suggesting that the interplay of incentives for co-operation and competition was not detrimental to their work. The lack of saturation in relation to the interviews with the professionals delivering services suggests this may be an area which would benefit from further research.

The use of diabetes as a tracer condition should also be critically appraised. It was chosen, as described in Chapter 4, because I anticipated that it was a condition which necessitated treatment across a variety of settings, and therefore, probably, a number of organisations. Organisations would be required to co-operate to co-ordinate diabetes services, and to compete both for and in the market. During fieldwork it became clear that this was not necessarily the case, and that competitive incentives were not prevalent in relation to diabetes. The design of the research though, in which I spoke to interviewees with a strategic overview of the planning of services across the remit of the organisation, in addition to those solely involved in diabetes services, allowed me to address the extent to which diabetes was atypical.

In summary the strengths of the research are: firstly, the case study design which allowed an in depth examination of behaviour across different organisations and professionals, and across an extended time frame; secondly, the situation of the research within a cohort of studies which allows a consideration of the extent to which the findings of this study agree or disagree with the findings of other studies (further discussion of this aspect can be found in section 8.6 below); thirdly the inclusion of interviewees with a remit across organisation-wide activity, in addition to those focused on the planning and provision of diabetes services, allowed me to assess the extent to which diabetes is a typical case through the inclusion of examples from other services.

## **8.6 Discussion of findings**

This section discusses the implications of the research findings for knowledge and understanding of both theory and policy. There are three areas of discussion which will be dealt with here. The first is a discussion of the hierarchy, markets and networks modes and the co-ordination of activity in public services. The second area of discussion is the behaviour of organisations and professionals in the case study area. The third is an exploration of the implications of the research for the use of game theoretic approaches to the analysis of behaviour in the NHS and other public sector services.

### ***Modes of public sector co-ordination and the persistence of hierarchy***

An important finding of this research was the predominance of the hierarchical mode of co-ordination in the case study area, and the way this influenced the use of incentives for competition and co-operation.

The NHS operates in an environment which has mixed modes of co-ordination. Whilst it is traditionally thought of as a hierarchy, it contains both market incentives and elements of network co-ordination, some of which exist as a result of policy initiatives, and some of which have arisen for other reasons, such as the professional networks which exist between clinicians. The suggestion that co-ordination is achieved through a mixture of modes is not particularly unusual or controversial, either generally (e.g. Bradach and Eccles 1991), or in relation to the NHS (Exworthy et al., 1999).

The dominance of hierarchical modes of co-ordination in the case study area when the local commissioner has a tool box of approaches available is notable. The persistence of hierarchy is particularly noteworthy in light of a prominent view of the contemporary state role in relation to public service, encapsulated by the theories of New Public Governance (NPG) (Osborne, 2006) and network governance (Rhodes, 2007), that the state has been 'hollowed out' and fulfils a more strategic, less operational role. Despite the theoretical prominence of the NPG perspective, empirical studies suggest that the persistence of hierarchy in relation to the delivery of public services is not uncommon. Hill and Lynn's (2005) meta-analysis of research pertaining to issues of public sector governance found a predominance of hierarchical explanations of public service delivery and policy. In relation to co-ordination in the NHS, a number of studies of the quasi-market showed that the rhetoric of the internal market did not mirror the reality, where hierarchy remained in place (Hughes Tuohy, 1999, Schofield, 2001, Allen, 2002, Allen et al., 2015), in an environment consisting of 'top down policy path, risk averse officers, formal guidelines [and] public accountability' (Schofield, 2001, p84).

There is a number of reasons for the enduring appeal of hierarchy in the NHS in the face of initiatives to replace it with both the quasi-market, and network relationships, which shall be briefly explored here in the light of the findings from the case study. Firstly, the shortcomings of the alternative co-ordination mechanisms of the market and networks, secondly, the possibility that hierarchy may be a hangover of a changing system, and thirdly

that hierarchy endures because it provides advantages missing from other modes of co-ordination.

One explanation for the persistence of hierarchy within the NHS rests on the shortfalls of the alternative modes of co-ordination. The difficulties of a market environment in relation to the co-ordination of NHS services have been well documented from both theoretical (e.g. Williamson, 1996, Jackson, 2001, Dixit, 2002, Taylor-Gooby, 2008, Allen, 2013) and empirical perspectives (e.g. Flynn et al., 1996, Bennett and Ferlie, 1996, Porter et al., 2013, Allen et al., 2015). The quasi market is a market created within a hierarchical structure, and there are substantial differences between the way incentives for competition function in the NHS, and the way competition functions in a free market. Given these differences, as Jackson (2001) points out, it is wrong to assume that the market can provide solutions to the difficulties of public service co-ordination:

*'Given that many activities, which were organised through the public sector, were located there because of the failure of markets to allocate them effectively and given our understanding of what markets cannot do, then it is a bit strange to believe that the problems of bureaucracy could be solved by taking these services out of the traditional bureaucracy and confronting them with greater amounts of competition and managerial control.'* (p 13)

The most notable difference in the case study explored in this thesis is the degree of control which the commissioner was able to exert over how the market functions. Unlike a free market in which competition is unimpeded, competition in the case study area was switched on and off at will by the commissioner, by removing the tariff payments for providers, and the sparing use of competitive tender processes. An explanation for this behaviour might be that the financial risk implicit in the market (in that it incentivises providers to undertake as many episodes of care as possible) was untenable in a cash limited local health community, leading therefore to the effective rejection of the market, and a retreat into the certainties of cash limited budgets administered through hierarchy. The imposition of block contracts has also been noted in surveys of commissioner behaviour in relation to pricing and contracts (PriceWaterhouseCoopers, 2012, Allen et al., 2014b), and empirical studies (Petsoulas et al., 2011, Sheaff et al., 2015). Research from both the reforms of the 1990's (Bennett and Ferlie, 1996), and from the use of market incentives since (Powell et al., 2011, Allen et al., 2015) found that purchasers were reluctant to destabilise existing providers by rerouting funding.

In addition to the financial risk of rerouting funding, there are also issues of the transaction costs associated with competition, such as the cost of competitive procurement processes.

The establishment of networks in the NHS is also thought to carry associated difficulties. Networks are thought to be an alternative co-ordination mechanism to that of the market, although they are often used in conjunction with markets, as illustrated by network-related links between organisations, such as joint ventures. Evidence indicates that networks in the NHS may be difficult to establish as organisations are firmly separated from each other by performance management structures, and inflexible payment structures (Currie et al., 2011). To establish networks within a hierarchical environment requires 'simultaneous changes to structure, organisational capability and process' (Ferlie et al., 2011, p308), for example effective cross organisational working requires joined up Information Technology systems, willingness and ability on behalf of network members to share information, and costly personnel resources to enable effective leadership and facilitation. Where more relational approaches were made in the case study (for example, the commissioners efforts to discuss the diabetes service model face to face with all clinicians involved, or to set up the ICP), these discussions were time consuming and resource intensive, which may explain why a hierarchical approach was taken overall.

A further potential explanation of the persistence of hierarchy in the case study area relates to the process of change from one mode of co-ordination to another. There was evidence in the case study that some interactions, particularly those between providers and commissioners, occurred within a frame of long standing, trusting relationships which threatened to interfere with or alter 'business' relationships. It is suggested that co-ordination to a degree follows the path of 'habitual ties' (Hughes Tuohy, 1999) or an older organisational culture (Allen, 2002). The studies which, like this one, suggest that the NHS quasi-market has not had the impact it should have had, may simply be reflecting the fact that cultural and system change takes time. There is a growing interest in exploring institutional 'hybridity' in the public sector (Denis et al., 2015, Waring, 2015) particularly the question of whether competing logics of co-ordination can co-exist or are inherently unstable. The theory of institutional pillars (Scott, 2008) suggests that institutions' stability rests on three pillars which act as 'the elastic fibers that guide behaviour and resist change' (ibid, p57) : the 'regulative' pillar consisting of rules and sanctions, the 'normative' pillar based on shared norms, and the 'cultural cognitive' pillar consisting of taken for granted assumptions and shared understandings. When cultural or regulative change occurs which



misaligns one of these pillars, such as the introduction and development of market mechanisms in the NHS changing the 'regulative' pillar, then the result is conflict and imbalance. From this theoretical perspective, there is a scepticism that hybridity can be maintained indefinitely, and a belief that over time one logic will come to dominate. The findings of this thesis suggest that currently in the NHS the logic of hierarchy has prominence, however it remains open to question whether this logic will continue to dominate in light of the ongoing changes to the 'regulative' pillar.

The endurance of hierarchy also reflects that, whilst changes have occurred to introduce markets and networks in aspects of the NHS, elements of hierarchy have always remained the foundation of the NHS. As illustrated by the complexities of the institutional context discussed in Chapter 3, the planning and provision of NHS services is nested within a hierarchy. The reforms of HSCA 2012 represented an attempt to free commissioners and providers from 'top down' control from ministerial interference through the establishment of intermediary bodies (NHS England and Monitor) which were themselves arms length bodies rather than in a hierarchical relationship. However, even in the NHS post HSCA 2012, organisations are still subject to the NHS Mandate, which is in effect, a contract stating the Secretary of State's expectations for the NHS, including the outcomes it is expected to achieve (Klein, 2013).

Perhaps the most persuasive argument concerning the endurance of hierarchy in the NHS, rests on the premise that hierarchy persists because it is retained and returned to by commissioners on the basis of its merits. Many advantages have been claimed for hierarchy, such as its efficiency (Weber, 1968), its effectiveness at dealing with complex tasks (Jacques, 1991), and its expression of cultural values (Olsen, 2006). An advantage of hierarchy which sets it apart from other modes of co-ordination is its potential to satisfy the need for accountability in public services (Allen, 2013). Jacques (1991) suggests hierarchy is the most effective way to combine the management of multiple complex tasks across diverse groups with a system of accountability. As a publicly funded service, the NHS is required to serve the public interest. To do so, it is argued, the system of co-ordination is required to provide certainty and clarity, and a clear line of accountability and leadership:

*A fortiori, hierarchy is arguably essential to (the essence of) liberal democratic governance, in which the sovereign people and their representatives will, in one way or another, sooner or later, insist on accountability on the part of those who act in their name using resources appropriated from them. It is better that such*

*accountability be institutionalised in rule-governed hierarchies than in loose, unaccountable, possible unstable arrangements of an indeterminate localism (Lynn, 2011, p231)*

From this perspective, it is the inflexible, rule bound nature of hierarchy, which makes it a form well suited to serving a democratic purpose, due to its predictability and transparency. The importance of accountability was articulated directly at some points in the case study, most notably in the case study commissioner and providers' concerns about the use of market mechanisms in light of the perceived public unease with competition in the NHS, and the use of taxpayers' money to fund the transaction costs associated with competitive bids. Whilst the suggestion that hierarchy was employed as a means to achieve accountability was not articulated directly, the need for transparency and public accessibility led to the use of a centrally run organisational reconfiguration process to agree the arrangement of services in the area.

The importance of the hierarchy in the co-ordination of organisational behaviour raises questions about the behaviour and role of independent sector providers in the planning and provision of services, who are situated outside the hierarchy of the NHS and who, as illustrated by the independent sector provider interviewed for the study, operate in markets outside the local area and provide services both within and outside the NHS. It is difficult to see how these providers can be controlled by commissioners in the same way as NHS organisations. The control of independent sector providers was a marginal issue within the case study area as independent sector involvement in the provision of diabetes services was minimal. However NHS policies since 2002 have been focused on increasing the provision of NHS services by the independent sector (Allen and Jones, 2011). One report indicates that 70% of contracts awarded from April to December 2013 were awarded to non-NHS providers (NHS Support Federation, 2013), however the volume of work this refers to is unclear (Krachler and Greer, 2015). Recent reports suggest that the spend on the NHS private sector in 2014/15 was £6.9 billion, a rise of 7% (£400 million) from 2013/14 (Department of Health, 2015). If the provision of NHS services by the independent sector were significantly to increase, it is likely that the enactment of incentives for competition and co-operation would be affected. The analysis in Chapter 3 of the procurement and conduct complaints made to and investigated by the CCP shows that all were made by independent sector providers, suggesting that these providers are willing to challenge the status quo. However it is not at all clear that the independent sector will indeed become responsible for the provision of

more NHS services, owing to ongoing barriers and disincentives to entry, such as the difficulty of securing profits (Krachler and Greer, 2015) and the high profile failure of the privately run Hinchingsbroke Hospital.

### ***Behaviour in the light of incentives for competition and co-operation***

Whilst the environment in which organisations and health professionals were planning and providing services at the time of the research was largely hierarchical in nature, there were still incentives for competition in existence, and providers did have to navigate incentives for both competition and co-operation. A key question addressed by this thesis was how providers and professionals understood their environment, and how they approached their relationships with each other.

The examination of the relevant theoretical context in Chapter 2 identified a number of theories which described the basis on which organisations may make decisions about how to approach inter-organisational relationships. These were theories based in economics, economic sociology and organisational strategy. In the course of the analysis it was clear that all of these theories have traction. In particular, the resource based approach which is concerned with decision-making in the light of organisational resources seemed to provide a good fit with organisational strategy, suggesting that organisations were motivated to use their tangible (staff, facilities) and intangible (knowledge, brand name, networks) resources to improve their position in the hierarchy. Indeed, transaction cost analysis was not a particularly helpful model when looking at the way organisations were strategizing. There are two reasons for this. Firstly, there were insufficient incentives in place. In the case study area, NHS provider organisations were on block contracts, and consequently they had little financial incentive to develop services. Secondly, and importantly, is the issue of the ownership of property rights. In essence, NHS provider organisations were not incentivised to make decisions on the basis of efficiency because surpluses could not be retained. Of course, this argument does not apply to the NHS Foundation Trusts in the study. Theories based in economic sociology which focus on the impact relationships have on decisions to compete or co-operate varied in their relevance to decision-making. Interestingly, the management relationships, particularly those between provider and commissioner managers, could be characterised as undersocialised, with participants keen to assume 'business like' relationships. Less surprisingly, given the common perception of the predominance of clans in relation to clinical relationship, interactions between clinicians appeared to be clearly embedded in networks of interpersonal relationships.

### ***Local context***

The local context proved important in steering commissioner decisions regarding the use of incentives for competition and co-operation. The importance of local context has been noted in other studies of a similar nature (Flynn et al., 1996, Powell et al., 2011, Frosini et al., 2012, Allen et al., 2012a, Hughes et al., 2013, Porter et al., 2013, Sheaff et al., 2015). The importance of these local factors suggests that the deployment of, and reaction to, incentives may be different depending on the local context. Whilst other studies found that relationships within the local health community were important influencers of behaviour (Flynn et al., 1996, Frosini et al., 2012, Allen et al., 2012a, Hughes et al., 2013), relationships did not appear to figure significantly in the case study commissioner's use of incentives for competition and co-operation (although previous interactions were reported by providers to influence the decisions being made by other local commissioners). However unsurprisingly in light of the social embeddedness of all markets, relationships did appear to be more important influencers of behaviour in consideration of provider/provider relationships, particularly as described by clinicians (this is discussed further below). However, elements of the local institutional context were found to be important influencers of the commissioner deployment of incentives namely: the existing configuration of organisations in the area, their service portfolios, interdependencies and financial position; the availability of alternative providers; the financial stability of the local health economy and the wider region; and the strategy of other commissioners.

### ***The co-ordination of services***

The data suggested that the co-ordination of diabetes services at the point of delivery of services to patients was not inhibited by competition. This finding is supported by the interviews with diabetic patients, which suggested that the patient pathway was not adversely affected by organisational boundaries. Where there was a need for organisations to co-operate and compete in the same area (for instance in the provision of diabetes 'intermediate' services) there appeared to be issues of trust between the parties which did not affect the co-ordination of services or the patient pathway, but did have implications for the quality of planning services. This finding echoes the work of Sako (1998) who suggests the existence of 'goodwill' trust which relates to the confidence a party has to the commitment of the other party to continuing the co-operative relationship, and which relates to the quality of exchange between parties, especially the development of new ideas. Findings in relation to the detrimental impact of competitive behaviour on the planning of

services should be treated with caution however as, due to the lack of strong incentives for competition in much of the activities in the case study area, examples of this behaviour were scarce.

### ***Clinicians and incentives***

The role of clinicians was particularly interesting in relation to competition and co-operation. Consultants were fundamental to competition, most notably in terms of giving their support to the leadership of tenders for services, and were also key co-operators at service level. Consultants articulated a clear divergence of interests from those of the organisations to which they belonged. They were not particularly motivated by the organisation-level incentives for competition, such as the PbR tariff or the fear of organisational failure. Indeed it appeared that they considered themselves somewhat insulated from their employing organisation's trajectory. This was partly due to faith in the protection of the strong collegial relationships with their professional network, as illustrated by the view that consultant colleagues in other organisations would forewarn them of any predatory competitive strategies, and partly due to the belief that, as the most 'expert' clinical profession, their services would always be required regardless of the organisational configuration of services. The consultants interviewed appeared to have strong identification with their professional 'clan' and weak identification with employing organisation, a dynamic which has been noted by others (Ferlie et al., 2010, Hoque et al., 2004).

However, the extent to which the insulation of consultants from competition was an actuality is unclear. It is clear that consultants, to a degree, are not as accordant with their employing organisation as other staff groups. It has been suggested that professional groups within organisations can be understood as an 'organisationally encapsulated quasi-organisation' (Ackroyd, 1996). They are in some respects self-governing: in relation to consultants, standards tended to be set by the professional colleges, performance management and clinical governance tended to be conducted amongst peers. Although it is argued that there has been a significant management intrusion in this regard in recent years (Exworthy and Halford, 1999). This position of relative independence is also a position of power: consultants have a clear area of professional expertise, they are a finite resource due to the high professional entry controls, they embody a specialist knowledge which cannot be replicated, and they also exert significant control over the flow of patients into and out of organisations. For example, a key struggle experienced by commissioners in the case study when establishing the community based diabetic service was persuading consultants to discharge

diabetic patients from their care, and reduce the number of follow up appointments made. Consultants are generally viewed as the top of the professional hierarchy (Currie et al., 2011), and it is difficult for anyone below consultants in the professional hierarchy (for example GPs) to successfully challenge a consultants' specialist expert clinical judgment regarding a patients' needs.

Whilst the view that consultants occupy a position which insulates them from organisational competition and associated organisational change is understandable, it is not clear that clinicians were as buffered from organisational competition as they appeared. A distinction can be made between the organisational level financial incentives (PbR) which did not appear to hold great sway with consultants, and the more intrinsic motivations based on job satisfaction, service development and clinical leadership. Where there was an intersection between organisational level competition and more intrinsic motivations, competition mattered greatly to consultants. For example if a competitive tender for a community service led to separate organisational homes for community and secondary arms of a single services, consultants were concerned that their leadership of the service had been jeopardised. To a degree then, consultants were drawn into organisational competition in order to protect the elements of service which were important to them. However, what is also clear is that consultants were engaged in a different competitive game from others within organisations, one that was not conducted in response to policy incentives for competition. This behaviour has implications for the game theory analysis, particularly whether consultants should be considered as composite actors with the organisations they are based in.

### **Game theory**

A key question considered in this thesis was how organisations and professionals dealt with incentives for competition and co-operation. Game theoretic approaches, and in particular the concepts of co-opetition (Brandenburger and Nalebuff, 1996) and Ostrom's IAD framework (Ostrom, 2005) were used as frameworks to analyse the elements of interactions, and to compare theories of organisational behaviour. As described in Chapter 2, these frameworks are tools of analysis, but they are also concerned with how actors can react to incentives for competition and co-operation in a mutually beneficial way.

Both theories have made important contributions to the thesis.

Firstly, both theories give credence to the insight that incentives for competition and co-operation can co-exist and can be combined in a positive way.

Secondly the frameworks are useful tools for describing the constituent elements of interactions in the market (co-opetition) and in networks (IAD framework). Co-opetition relates to behaviour in business situations, relationships are between organisations rather than individuals, players are customers, suppliers, competitors or complementors, and rules of behaviour relate to terms contained in contracts. Ostrom's IAD framework meanwhile focuses on communities who share common pool resource problems. The attributes of communities and the identification of the players (who may be individuals or composite actors) are important factors affecting interaction, and rules of behaviour are those agreed by the community. Therefore the degree of fit between these models and the institutional context and behaviour in the case study area is a helpful identifier of the kind of institutional environment in place.

Thirdly, in the analysis of the research data it became clear that the IAD framework provided a good fit with elements of interaction in the case study, in particular the recognition that rules of behaviour are socially situated. This was a particularly useful framework for recognising the complexities of rule making and rule enactment in the NHS, where rules are transmitted within the hierarchy from one level to another, and where each level has responsibility for making the rules 'work'. Importantly, the IAD framework also acknowledges the role that third party governance can play in attempting to ensure co-operation between competitors. As the IAD framework has proved more useful in relation to studying organisational behaviour in the case study, its applicability in relation to the NHS and its possible development will be considered further below.

However there were limitations to the applicability of both approaches to behaviour in the NHS. A key concept influencing the applicability of the two frameworks is the notion that players can influence the rules of the game. Co-opetition focused on the opportunities players had to create win/win situations through the negotiation of contracts. However in the case study area contracts were found to be primarily instruments of the hierarchy, and providers had little or no prospect of negotiation of the terms of the contract. To a lesser extent similar limitations applied to IAD framework, which envisaged that communities agreed rules between themselves. In short, both frameworks envisaged a context in which players had much more scope to influence their environment than was the case in the case study area. Whilst this does limit the direct applicability of these frameworks to the behaviour observed in the case study, the value of the frameworks lies partly in what their incompatibility tells us about the case study area. The incompatibility also suggests that the

advantages/benefits which can be garnered from situations where competition and co-operation combine will not be gained in the case study in the way envisaged in these models.

It may be that co-opetition in particular is more suited for the analysis of areas of the public sector where a more marketised system is in place, and where subsequently incentives for competition are much stronger such as the social care sector, where 89% of state funded home care services were provided by the private sector in 2012 (Fotaki et al., 2013).

### **The use of the work of Ostrom to analyse co-ordination in the NHS**

As explained previously, the work of Ostrom is concerned with common pool resources, and understanding how communities can be encouraged to co-operate to self-manage resources for the benefit of all community members. Her position is that self governance is a favourable alternative to state and market, which both, she argues, operate for the benefit of parties other than the communities themselves. This section explores the applicability of Ostrom's general theory about the management of common pool resources to the NHS and, in particular, how her theory can be developed to consider in more depth the role of the state in facilitating communities' self-governance of common pool resources.

Ostrom's IAD framework, designed to aid the analysis of institutions, is complex. It contains a large number of components which can be investigated to gain an understanding of interactions and their relation to institutional context, consisting of the exogenous factors that affect the structure of the action arena, and, within the action arena itself, the variables making up the action arena: the rules used by participants, the attributes of the biophysical world influencing action and the structure of the more general community in which the arena exists (Ostrom, 2005). The area of Ostrom's work which has proved interesting in relation to this thesis concerns the applicability of Ostrom's general theory about the management of common pool resources to the NHS, and in particular the role of the state in facilitating communities' governance of common pool resources. The general view of the state in Ostrom's work, although it does not appear to be discussed directly a great deal, is that it is a coercive force, which does not act in the stakeholders' best interests and instead works to provide outcomes of benefit to the state itself rather than the resource users. This may be because many of the case studies Ostrom draws on relate to the managements of small, naturally occurring common pool resources occurring in remote, isolated communities.

Ostrom's extensive analysis of many case studies of long-enduring institutions for governing sustainable resources resulted in the development of 'design principles' for successful self-



organised systems. There appears little scope for the role of the state in Ostrom's diagnosis of the 'design principles' for successful self management of common pool resources. Those who monitor the use of resources should be 'at least' partially accountable to resources users, or should indeed be the users themselves, sanctions should be administered by other users or by officials accountable to users, and the rights of users to devise their own institutions should not be challenged by external governmental authorities (Ostrom, 2005, p259). This view is countered by Mansbridge's (2014) reading of Ostrom's reflections on state involvement, which suggests that Ostrom acknowledges that higher levels of state action are often necessary to solve complex common resource problems. However the role allocated to the state is of the enforcer rather than the enabler of interaction, for example to threaten to impose a solution if local parties cannot agree, or to monitor compliance and implement sanctions.

The absence of a role for external authority is unsurprising given the original focus of Ostrom's work on small communities managing natural common pool resources in which external authorities were a distant force:

*'To explain commitment in many of the cases of sustainable, community-governed CPR External enforcement is largely irrelevant. External enforcers may not travel to remote villages other than in extremely unusual circumstances. The CPR [common pool resource] appropriators create their own internal enforcement to 1) deter those who are tempted to break the rules and thereby 2) assure quasi-voluntary compliers that others also obey.'* (Ostrom, 1994, p7)

The issue of state involvement becomes more pressing in relation to governance of common pool resources which exist in a complex, large scale institutional environment such as the NHS. If it is believed that the involvement of the state to any degree prevents the successful establishment of co-operation between the users of common resource pools, then the application of the model to the NHS is problematic. This issue has been explored by Anthony and Campbell (2011) who argue that the role of the state should re-evaluated to create a more 'nuanced' view of its input in relation to common pool resources. They note that the state remains in the 'theoretical shadows' (ibid.) in Ostrom's work, and suggest that Ostrom has misread the role of the state. Whilst Ostrom's design principles suggest that to achieve successful community management of resources, monitoring and the administration of sanctions should occur close to the resource users, it is unlikely that even small common pool resources are unaffected by wider institutional frameworks. The state is present, for

example, in the management of local fisheries who may be subject to international fishing laws (Berkes, 2001). It has been suggested that case study evidence in fact suggests that the state involvement in the management of common pool resources can be a positive force:

*'The commons literature includes many examples of how certain forms of state involvement may strengthen or rejuvenate local-level institutions. These include state reconfiguration of local institutions; development of enabling legislation; cultural revitalization; capacity building; and local institution building' (Berkes, 2001, p298)*

The central issue at stake when considering the common pool resource framework in relation to the NHS, is the role of the state, and specifically whether different types of state involvement in aspects of community management of common pool resources can be beneficial rather than coercive. This is an important issue because, due to the enduring nature of NHS hierarchy, the influence of the state is unavoidable within the present structure of the NHS. Not only is the NHS encased in a complex wider institutional framework, but, the state also has an important role of ensuring accountability to the wider public. The case study explored in this thesis illustrated that commissioners took a clear role in facilitating the interactions between providers, for instance conferring legitimacy on the creation of inter-organisational forums through the Integrated Care Pilots and providing the resources necessary to establish the pilot.

These seemingly beneficial state interventions to encourage community co-operation in the management of common pool resources suggest that there would be value in revisiting and developing our understanding of the role hierarchy can play in supporting the management of common pool resources. It appears particularly important to analyse the role of hierarchy in the encouragement of the self management of common pool resources in the light of the theoretical explanations of the enduring role of hierarchy in the provision of public services.

## **8.7 Policy implications and further research**

This final section of the discussion chapter focuses on the implications of the research for NHS policy, and outlines where further research would be beneficial.

### ***Policy implications for the NHS***

The reticence of commissioners to use the incentives for competition and co-operation available to them, and their preference for co-ordination through hierarchy, naturally raises

questions about the appropriateness of the use of competition policy in the NHS. However the analysis here indicates that the use of competitive incentives is a valuable tool available to commissioners if the local context supports its use, for example if the local financial position is sound, and the dependencies between existing organisations allows it. Furthermore it appears that where providers were exposed to incentives for competition and also needed to co-operate, the co-ordination of services was not unduly affected.

As has been noted elsewhere in this thesis (Chapter 2 section 2.4), systems can have within them a mix of hierarchy, market and network modes of co-ordination. It appears in the case study area the system in place was predominantly hierarchical, with elements of market and network co-ordination, where incentives for both competition and co-operation between provider organisations were weak. If the theoretical views are to be accepted that firstly, central co-ordination can drive out co-operation, and secondly that close co-operative relationships can increase the quality of the outcome of interactions between organisations, then renewed attempts should be made to encourage the hierarchy of the NHS to lead the development of network relationships. Indeed, concepts like New Public Governance (NPG) (Osborne, 2006) and network governance (Rhodes, 2007) highlight the potential gains which can be made in the provision of public services by encouraging the development of network approaches within hierarchical systems.

Commissioning practice in the NHS is starting to address this issue in part, with the introduction of more innovative approaches to care pathway commissioning (NHS Commissioning Board, 2013b) such as of prime contractor models, in which the prime contractor sub-contracts specific roles and responsibilities (and allocates risk associated with their performance) to other providers (NHS England, 2014b). However, a key challenge will be how to secure the support of clinicians in this agenda, as this research suggests that they are unmotivated by organisational level incentives. The NHS England policy document, The Five Year Forward View, suggests that 'vanguard areas' be put in place to promote collaboration between acute providers (NHS England, 2014a). These models may include greater use of clinical networks across nearby sites, joint ventures between NHS organisations, or the delivery of specialist single services across a number of different providers. However, any working of this nature between provider organisations will need to comply with the rules around collusive activity between competitors.

As is clear from the decisions which were made in relation to the specific cases considered by the CCP during the majority of the fieldwork period, the need to promote and protect

competition in the NHS was balanced against other concerns when regulatory decisions were made. However, later in the fieldwork period, the policy and regulatory framework changed when HSCA 2012 came into force, bringing the possibility that decisions regarding the regulation of competition will be more exposed to the inflexibilities of the law in the future. There is a clear tension between the enshrinement of the protection of competition in the NHS in law, and the proposals for radical new care delivery options which have been presented in the recent NHS England policy document, *The Five Year Forward View* (NHS England, 2014a). Key to the document are the proposals for new integrated organisations: Multi Speciality Community Providers which will be merged organisations of GPs with nurses, community specialists, hospital specialists, mental health and social care, and Primary and Acute Care Systems which will consist of GPs and hospital services. There are clear issues for these arrangements in terms of competition rules, for example the impact on patient choice of provider at the point of GP referral, and at other points within pathways if the organisations are monopoly providers for their population, and possible conflict of interest for GPs, who would be both commissioners and providers of services. Mergers to achieve these integrated organisations would also need to be considered in terms of the protection of competition, if the organisations currently provide similar services within portfolios. It is very difficult to see how these reforms are compatible with the current rules about the use of competition in the NHS. *The Five Year Forward View* suggests that rules regarding competition should be suspended to implement these local arrangements, however whether this is possible without repealing HSCA 2012 is unclear.

### ***Further research***

The foregoing analysis suggests a number of issues which would benefit from further empirical investigation.

As noted above, the proposals in the NHS England policy document *The Five Year Forward View* for the creation of new integrated organisations, Multi Speciality Community Providers and Primary and Acute Care Systems, raise clear issues in terms of competition rules, which it is envisaged will be resolved by the suspension of the rules of competition as necessary to achieve these configurations locally. As highlighted in the review of the policy and regulatory framework in Chapter 3 of this thesis, the framework in place following the implementation of HSCA 2012 suggests that, now the protection of competition in the NHS is more exposed to the rule of law, it is much more difficult to suspend or tailor the operation of competition in order to address the specific needs of local NHS communities. In light of these proposals

there is a need to investigate how the reconfiguration of services proposed in The Five Year Forward View is to be operationalised in relation to the use of incentives for competition and the enactment of the policy and regulatory framework.

Whilst the co-opetition and IAD frameworks were found to be useful frameworks to aid the consideration of organisational and professional behaviour, they were not found to be a good fit with the operation of incentives for competition and co-operation in the NHS due to the predominance of hierarchy as the main mode of co-ordination. However the frameworks may well have resonance for the interactions between organisations and professionals in other public services. For example, social care, which contains more marketised services than the NHS (Fotaki et al., 2013), may represent a good fit with the co-opetition framework.

The thesis has analysed the role of hierarchy in relation to the co-ordination and encouragement of organisations' self management of shared resources in the light of Ostrom's theory about the management of common pool resources. This has led to a re-evaluation of the way the role of the state in the management of common pool resources is conceptualised, as discussed in section 8.6. It is suggested that, as hierarchy appears to be such an enduring mode of governance in the NHS, further research is conducted into the role of the state in the management of common pool resources in the NHS, in order to refine and develop Ostrom's theory. One avenue would be to identify more spontaneously occurring network based organisations in the NHS to examine the role hierarchy takes in relation to their establishment and ongoing governance.

In addition to examining the impact of incentives for competition and co-operation on the behaviour of organisations in the case study area, the thesis also described and interpreted the decisions which were made by national regulatory bodies during the fieldwork period regarding the operation of competition. The findings of the analysis in this thesis suggest that there may be a change in the nature of the decisions that are being made, which could have significant impact on the deployment of incentives for competition and co-operation in the future. The review of decisions in Chapter 3 suggests that the changes to the policy and regulatory framework in the period following the implementation of HSCA 2012 may be changing the nature of the decisions which are being made regarding the regulation of competition, particularly the degree to which other concerns in relation to the NHS (such as the views and wishes of local stakeholders and the financial health of the organisations (Cooperation & Competition Panel for NHS-funded services, 2012d)) take precedence over the preservation of competition. Whilst some analysis has been conducted of decisions taken

by regulatory bodies regarding the regulation of incentives for competition following HSCA 2012 beyond the end of the field work period (Sanderson et al., Forthcoming), there is a need to conduct further analysis as more decisions are made.

## APPENDIX 1 – INFORMATION SHEETS

Information sheet for NHS staff

**London School of Hygiene & Tropical  
Medicine**  
(University of London)  
Department of Public Health and Policy  
Department of Health Services Research and Policy  
Tavistock Place, London, WC1H 9SH



Tel: (Direct) +44 (0)207 827 2458  
E-mail: Marie.Sanderson@lshtm.ac.uk

Date 13 March 2011 Version 1

### THE CHALLENGE OF PROVIDING CO-ORDINATED DIABETES CARE IN AN INCREASINGLY DIVERSE NHS

#### Study information sheet

Your organisation has kindly agreed to take part in this research study which examines the challenge of providing co-ordinated diabetes care in an increasingly diverse NHS. You are one of a group of professionals and managers being asked to take part in the research. Before you decide whether or not you wish to take part please read the following and contact me if you would like to discuss it further.

- **What is the purpose of the study?**

The aim of the study is to investigate the impact of incentives for competition and co-operation on the behaviour of organisations when they are planning and providing diabetes services. The research will investigate the way organisations in a Primary Care Trust area behave in relation to the planning and provision of diabetes care, and the effect this has on the co-ordination of diabetic services, including patients' experience of continuity of care.

- **Why have I been chosen?**

We are seeking a variety of views from managers and professionals who represent key members of staff involved in the planning and provision of diabetes services.

- **Do I have to take part?**

No. It is completely up to you. Should you agree to help us, you are free to withdraw from the study at any time, without having to give a reason. If you do decide to take part, please keep this information sheet.

- **What will the study involve?**

The study will involve one interview. The interview will be conducted by an experienced researcher. The interview will take place at your organisation. The interview will last no more than one hour and will be tape recorded so that we do not miss anything important.

- **What are the possible benefits of taking part?**

Staff views will hopefully be used to understand how organisations are responding to incentives for competition and co-operation and to identify ways in which organisations can successfully combine co-operative and competitive behaviour. The research will also explore patients' views of continuity of care in the light of the findings about organisational behaviour.

- **Will my taking part in this study be kept confidential?**

The information that you provide is strictly anonymous and confidential. The information will be stored using study numbers, and your name will not be used. No information about any

*Page 1 of 2*

*Information sheet for staff*

single individual, or named organisation will be available to any other person. No indication of any participant's identity will be given in any reports of the study. Ten years after the research completed and reported, all the transcripts and audio-tapes will be destroyed.

- **What will happen to the results of the study?**

The results of the study will be used in my thesis which will be submitted for the award of a PhD from the London School of Hygiene and Tropical Medicine. Results will be disseminated to the organisations involved. The results will also be written up for publication in professional journals.

- **Who is organising and funding the research?**

The study has been funded by a National Institute for Health Research Doctoral Research Fellowship award, which is funded by the government.

- **Who has reviewed the study?**

NHS Research Ethics Committee (London – Central) and NHS Trust Local Research Ethics Committees.

Thank you for reading this form.

Please do not hesitate to contact me if you require any further information ([Marie.Sanderson@lshtm.ac.uk](mailto:Marie.Sanderson@lshtm.ac.uk), 020 7927 2458).

Alternatively, independent advice about taking part in research and about this specific research project can be sought from Stephen Peckham, Reader, London School of Hygiene and Tropical Medicine ([Stephen.Peckham@lshtm.ac.uk](mailto:Stephen.Peckham@lshtm.ac.uk), 020 7927 2023).

**Marie Sanderson**  
**PhD Student**  
**London School of Hygiene and Tropical Medicine**

*Information sheet for staff*



**London School of Hygiene & Tropical  
Medicine**  
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Date 17 March 2011 Version 1

**THE CHALLENGE OF PROVIDING CO-ORDINATED DIABETES CARE  
IN AN INCREASINGLY DIVERSE NHS**

**Study information sheet**

This research is part of my PhD which examines the challenge of providing co-ordinated diabetes care in an increasingly diverse NHS.

• **What is the purpose of the study?**

The aim of the study is to investigate the impact of incentives for competition and co-operation on the behaviour of organisations when they are planning and providing diabetes services. The research will investigate the way organisations in two Primary Care Trust areas behave in relation to the planning and provision of diabetes care, and the effect this has on the co-ordination of diabetic services, including patients' experience of continuity of care.

• **Why has this meeting been chosen?**

I am seeking to observe meetings where the planning and/or provision of local diabetes care are discussed.

• **Do I have to take part?**

No. Meeting participants will be asked for permission for the meeting to be observed.

• **What will the study involve?**

The study will involve observation of a meeting where the planning and/or provision of local diabetes care are discussed. The observer will not take part in the meeting, and will take notes.

• **What are the possible benefits of taking part?**

Staff views will hopefully be used to understand how organisations are responding to incentives for competition and co-operation and to identify ways in which organisations can successfully combine co-operative and competitive behaviour. The research will also explore patients' views of continuity of care in the light of the findings about organisational behaviour.

• **Will my taking part in this study be kept confidential?**

The information that you provide is strictly anonymous and confidential. The information will be stored using study numbers, and names will not be used. No information about any single individual, or named organisation will be available to any other person. No indication of any participant's identity will be given in any reports of the study. Ten years after the research completed and reported, all the transcripts and audio-tapes will be destroyed.

- **What will happen to the results of the study?**

The results of the study will be used in my thesis which will be submitted for the award of a PhD from the London School of Hygiene and Tropical Medicine. Results will be disseminated to the organisations involved. The results will also be written up for publication in professional journals.

- **Who is organising and funding the research?**

The study has been funded by a National Institute for Health Research Doctoral Research Fellowship award, which is funded by the government.

- **Who has reviewed the study?**

NHS Research Ethics Committee (London – Central) and NHS Trust Local Research Ethics Committees.

Thank you for reading this form.

Please do not hesitate to contact me if you require any further information ([Marie.Sanderson@lshtm.ac.uk](mailto:Marie.Sanderson@lshtm.ac.uk), 020 7927 2458).

Alternatively, independent advice about taking part in research and about this specific research project can be sought from Stephen Peckham, Reader, London School of Hygiene and Tropical Medicine ([Stephen.Peckham@lshtm.ac.uk](mailto:Stephen.Peckham@lshtm.ac.uk), 020 7927 2023).

**Marie Sanderson**  
**PhD Student**  
**London School of Hygiene and Tropical Medicine**

*Information sheet for meeting participants*

**London School of Hygiene & Tropical  
Medicine**  
(University of London)  
Department of Public Health and Policy  
Department of Health Services Research and Policy  
Tavistock Place, London, WC1H 9SH



Tel: (Direct) +44 (0)207 827 2458  
E-mail: [Marie.Sanderson@lshtm.ac.uk](mailto:Marie.Sanderson@lshtm.ac.uk)

Date 11 March 2011 Version 1

## THE CHALLENGE OF PROVIDING CO-ORDINATED DIABETES CARE IN AN INCREASINGLY DIVERSE NHS

### Study information sheet

You are one of a group of professionals and managers being asked to take part in the research which examines the challenge of providing co-ordinated diabetes care in an increasingly diverse NHS. Before you decide whether or not you wish to take part please read the following and contact me if you would like to discuss it further.

- **What is the purpose of the study?**

The aim of the study is to investigate the impact of incentives for competition and co-operation on the behaviour of organisations when they are planning and providing diabetes services. The research will investigate the way organisations in the Primary Care Trust area behave in relation to the planning and provision of diabetes care, and the effect this has on the co-ordination of diabetic services, including patients' experience of continuity of care.

- **Why have I been chosen?**

We are seeking a variety of views from managers and professionals who represent key members of staff involved in the planning and provision of diabetes services.

- **Do I have to take part?**

No. It is completely up to you. Should you agree to help us, you are free to withdraw from the study at any time, without having to give a reason. If you do decide to take part, please keep this information sheet.

- **What will the study involve?**

The study will involve one interview. The interview will be conducted by an experienced researcher. The interview will take place at your organisation. The interview will last no more than one hour and will be tape recorded so that we do not miss anything important.

- **What are the possible benefits of taking part?**

The views of those professionals involved in the planning and provision of diabetes services will hopefully be used to understand how organisations, teams and individuals are responding to incentives for competition and co-operation and to identify ways in which co-operative and competitive behaviour can be successfully combined. The research will also explore patients' views of continuity of care in the light of the findings about organisational behaviour.

- **Will my taking part in this study be kept confidential?**

The information that you provide is strictly anonymous and confidential. The information will be stored using study numbers, and your name will not be used. No information about any

*Page 1 of 2*  
*Information sheet for GPs*

Information sheet for GPs
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single individual, or named organisation will be available to any other person. No indication of any participant's identity will be given in any reports of the study. Ten years after the research completed and reported, all the transcripts and audio-tapes will be destroyed.

- **What will happen to the results of the study?**

The results of the study will be used in my thesis which will be submitted for the award of a PhD from the London School of Hygiene and Tropical Medicine. Results will be disseminated to the organisations involved. The results will also be written up for publication in professional journals.

- **Who is organising and funding the research?**

The study has been funded by a National Institute for Health Research Doctoral Research Fellowship award, which is funded by the government.

- **Who has reviewed the study?**

NHS Research Ethics Committee (London – Central) and NHS Trust Local Research Ethics Committees.

Thank you for reading this form.

Please do not hesitate to contact me if you require any further information ([Marie.Sanderson@lshtm.ac.uk](mailto:Marie.Sanderson@lshtm.ac.uk), 020 7927 2458).

Alternatively, independent advice about taking part in research and about this specific research project can be sought from Stephen Peckham, Reader, London School of Hygiene and Tropical Medicine ([Stephen.Peckham@lshtm.ac.uk](mailto:Stephen.Peckham@lshtm.ac.uk), 020 7927 2023).

**Marie Sanderson**  
PhD Student  
London School of Hygiene and Tropical Medicine

*Information sheet for GPs*

**London School of Hygiene & Tropical  
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(University of London)  
Public Health and Policy  
Department of Health Services Research and Policy  
Tavistock Place, London, WC1H 9SH



Tel: (Direct) +44 (0)207 927 2458  
E-mail: Marie.Sanderson@lshtm.ac.uk

Date: 17 March 2011

Version 1

## THE CHALLENGE OF PROVIDING CO-ORDINATED DIABETES CARE IN AN INCREASINGLY DIVERSE NHS

### Study information sheet for patients

I am undertaking a research study as part of my PhD to investigate how incentives for competition and co-operation affect the behaviour of health care organisations in the English NHS when they are planning and providing diabetes services. As part of this study I would like to find out about the co-ordination of diabetic services from the point of view of diabetic patients. You are one of a group of patients who have been who are being asked to take part in the research. Before you decide whether or not you wish to take part please read the following and contact me if you would like to discuss it further.

- **What is the purpose of the study?**

The aim of the study is to investigate the impact of incentives for competition and co-operation on the behaviour of organisations when they are planning and providing diabetes services. The research will investigate the way organisations in two Primary Care Trust areas behave in relation to the planning and provision of diabetes care, and the effect this has on the co-ordination of diabetic services, including patients' experience of continuity of care.

- **Why have I been chosen?**

We are seeking a variety of views from patients about their experiences of the co-ordination of diabetic care. You have been chosen because you have attended a diabetes clinic at your GP practice recently.

- **Do I have to take part?**

No. It is completely up to you. Should you agree to help us, you are free to withdraw from the study at any time, without having to give a reason. If you do decide to take part, please keep this information sheet.

- **What will the study involve?**

There are two ways in which patients can be involved in the study.

Firstly, I am conducting two focus groups with patients. The focus group will involve talking with a group of five other patients about your experiences of the co-ordination of diabetic services between different organisations and over time. Everyone will be given the opportunity to speak and I will be present to guide the discussion. The group will take place at a location which provides privacy from the staff involved in the provision of diabetic care. The group will

last no more than one and a half hours and will be tape recorded so that I do not miss anything important.

The second way to be involved in the study is through a one to one discussion with me about the care you have received for your diabetes, and how well co-ordinated you found the care to be. I will be asking about the different types of care you have received for your diabetes within a defined period. The discussion would take place in your home where possible.

- **Will my expenses be paid?**

I will reimburse your travel expenses to attend the focus group, up to £5.

- **What are the possible benefits of taking part?**

Patients' and carers' views will hopefully be used to improve how organisations work together to deliver care to diabetes patients.

- **Will my taking part in this study be kept confidential?**

The information that you provide is strictly anonymous and confidential. The information will be stored using study numbers, and your name will not be used. No information about any single individual, or named organisation will be available to any other person. No indication of any participant's identity will be given in any reports of the study with. Ten years after the research is completed and reported, all the transcripts and audio-tapes will be destroyed.

- **What will happen to the results of the study?**

The results of the study will be used in my thesis which will be submitted for the award of a PhD from the London School of Hygiene and Tropical Medicine. Results will be disseminated to the organisations involved. The results will also be written up for publication in professional journals.

- **Who is organising and funding the research?**

The study has been funded by a National Institute for Health Research Doctoral Research Fellowship award, which is funded by the government.

- **Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people, called a research ethics committee, to protect your rights, well being and dignity. This study had been reviewed and given a favourable opinion by *[NHS XXXX Multi-centre Research Ethics Committee and NHS Trust Local Research Ethics Committees]*

Thank you for reading this information. Please do not hesitate to contact me if you would like any further information.

**Marie Sanderson**  
**PhD Student**  
**London School of Hygiene and Tropical Medicine**



**APPENDIX 2 – CONSENT FORMS**

Staff and GP consent form

London School of Hygiene & Tropical Medicine  
 (University of London)  
 Department of Public Health and Policy  
 Department of Health Services Research and Policy  
 Tavistock Place, London, WC1H 9SH



Tel: (Direct) +44 (0)207 927 2458  
 E-mail: Marie.Sanderson@lshtm.ac.uk

Organisation number:

Staff member identification number for this study:

**CONSENT FORM**

Title of Project:

**THE CHALLENGE OF PROVIDING CO-ORDINATED DIABETES CARE IN AN INCREASINGLY DIVERSE NHS**

Name of Researcher: Marie Sanderson

Please initial box

1. I confirm that I have read, and that I understand, the Participant Information Sheet, dated 13 March 2011 (Version 1). I have had opportunity to consider the information, ask questions about the study, and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time from the study, without giving any reason.	
3. I consent to the interview being audio-taped.	
4. I understand that any quotations used in writing up the study findings will not be identifiably attributed to me.	
5. I do / do not* agree to quotes or other results arising from my participation in the study being included, anonymously, in any reports about the study. *(please delete as appropriate)	
6. I understand that the data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust for audit purposes. I give permission for these individuals to access the data relevant to my taking part in the research.	

I agree to take part in the study.

_____	_____	
Name of Participant	Date	Signature
_____	_____	
Researcher	Date	Signature

London School of Hygiene & Tropical Medicine  
(University of London)  
Department of Public Health and Policy  
Department of Health Services Research and Policy  
Tavistock Place, London, WC1H 9SH



Tel: (Direct) +44 (0)207 927 2458  
E-mail: Marie.Sanderson@lshtm.ac.uk

Meeting number:

Staff member identification number for this study:

## CONSENT FORM

Title of Project:

**THE CHALLENGE OF PROVIDING CO-ORDINATED DIABETES CARE IN  
AN INCREASINGLY DIVERSE NHS**

Name of Researcher: Marie Sanderson

Please initial box

1. I confirm that I have read, and that I understand, the Participant Information Sheet, dated 17 March 2011 (Version 1). I have had opportunity to consider the information, ask questions about the study, and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time from the study, without giving any reason.	
3. I consent to the meeting being audio-taped.	
4. I understand that any quotations used in writing up the study findings will not be identifiably attributed to me.	
5. I do / do not* agree to quotes or other results arising from my participation in the study being included, anonymously, in any reports about the study. *(please delete as appropriate)	
6. I understand that the data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust for audit purposes. I give permission for these individuals to access the data relevant to my taking part in the research.	

I agree to take part in the study.

\_\_\_\_\_  
Name of Participant                      Date                      Signature

\_\_\_\_\_  
Researcher                      Date                      Signature



**London School of Hygiene & Tropical Medicine**  
(University of London)  
Department of Public Health and Policy  
Department of Health Services Research and Policy  
Tavistock Place, London, WC1H 9SH



Tel: (Direct) +44 (0)207 927 2458  
E-mail: Marie.Sanderson@lshtm.ac.uk

Organisation number:  
Patient member identification number for this study:

## CONSENT FORM

**Title of Project:**  
**THE CHALLENGE OF PROVIDING CO-ORDINATED DIABETES CARE IN AN INCREASINGLY DIVERSE NHS**

Name of Researcher: Marie Sanderson

Please initial box

1. I confirm that I have read, and that I understand, the Participant Information Sheet, dated 17 March 2011 (Version 1). I have had opportunity to consider the information, ask questions about the study, and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time from the study, without giving any reason.	
3. I consent to the interview being audio-taped.	
4. I understand that any quotations used in writing up the study findings will not be identifiably attributed to me.	
5. I do / do not* agree to quotes or other results arising from my participation in the study being included, anonymously, in any reports about the study. *(please delete as appropriate)	
6. I understand that the data collected during the study may be looked at by individuals from London School of Hygiene and Tropical Medicine, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to access the data.	

**I agree to take part in the study.**

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## APPENDIX 3 – TOPIC GUIDES

### **The impact of incentives for competition and co-operation on the behaviour of health care organisations: a case study of the planning and provision of diabetes services in the English NHS**

#### **Interview topic guide - strategic level staff commissioner organisations**

Personal information (e.g name of interviewee, job title, length of time involved with the organisation, role in the organisation)

Can you describe the current patient pathways for diabetes in your area?

Who are the organisations who are involved in the provision of services?

Is the patient pathway monitored or co-ordinated in any way?

What has the process been for the commissioning of services?

#### **Establish**

- whether there was tender for part of service or whether ongoing competition on the basis of patient choice
- whether there have been any new entrants
- reasons for commissioning as they have done

What is the vision for the provision of diabetes services in the future? How will this be achieved?

Can you describe the nature of the competitive environment which exists in the provision of diabetes services?

#### **Establish**

- whether there is a difference between organisations and what this is thought to relate to
- What they feel the environment is due to (commissioning practices, PbR, type of organisations etc)

Does competition have an effect on the way organisations work together in the planning and provision of diabetes services?

To what extent is there perceived to be a tension between the need to compete with organisations and the need to co-operate?

If there is perceived to be a tension, has the commissioner taken any steps to address this?

Does competition effect their relationship with provider organisations in the planning and provision of diabetes services?

*Version1  
14/3/11  
p1/1*

**The impact of incentives for competition and co-operation on the behaviour of health care organisations: a case study of the planning and provision of diabetes services in the English NHS**

**Interview topic guide - commissioning staff in commissioner organisations**

Personal information (e.g name of interviewee, job title, length of time involved with the organisation, role in the organisation)

Can you describe the current patient pathways for diabetes in your area?

Who are the organisations who are involved in the provision of services?

What are the roles of these organisations?

What has the process been for the commissioning of services?

**Establish**

- whether there was tender for part of service or whether ongoing competition on the basis of patient choice
- whether there have been any new entrants
- reasons for commissioning as they have done

What kind of staff are involved in the commissioning of services in each organisation?

Can you describe the nature of the competitive environment which exists in the provision of diabetes services?

**Establish**

- whether there is a difference between organisations and what this is thought to relate to
- What they feel the environment is due to (commissioning practices, PbR, type of organisations etc)

Does competition have an effect on the way organisations work together in the planning and provision of diabetes services?

Is the patient pathway monitored or co-ordinated in any way?

To what extent is there perceived to be a tension between the need to compete with organisations and the need to co-operate?

If there is perceived to be a tension, has the commissioner taken any steps to address this?

Does competition affect their relationship with provider organisations in the planning and provision of diabetes services?

*Version1*

*14/3/11*

*p1/1*

**The impact of incentives for competition and co-operation on the behaviour of health care organisations: a case study of the planning and provision of diabetes services in the English NHS**

**Interview topic guide - operational staff in provider organisations (lead clinicians, nurses etc)**

Personal information (e.g name of interviewee, job title, length of time involved with the organisation, role in the organisation)

Could you describe the patient pathways for diabetic patients in the local area?

What part does your organisation play in the pathway?

**Establish**

- if there are multiple teams within the organisation
- Who teams are made up of
- Whether teams are all employed by the same organisation

How did the pathway and your teams role get decided?

*I want to find out about the relationships between the different organisations or teams who contribute to the patient pathway in more detail.*

Is the pathway monitored or co-ordinated in any way? Who by?

Do you have contact with people providing diabetes services in other parts of the pathway? What kinds of things do you discuss? Is this a formal part of your role?

Are there any resources ('hard' e.g. human/physical or 'soft' e.g. IT) that are shared between the providers involved in the diabetic pathway?

Is there a diabetes clinical network in place?

**Establish**

- Who members are (organisational and individual level)
- Whether it involves all of the pathway
- What its function is

How is best practice shared with other diabetic service providers?

As you are aware I'm interested in the impact of incentives for competition and co-operation on the planning and provision of services.

Are you aware of competition in relation to the planning and provision of diabetes services?  
How does this manifest itself?

Establish

- Who the competitors are
- Why competition is perceived to exist
- If appropriate – why competition exists with only some of the providers and not others

Does competition affect your role in relation to diabetes services?

Does competition affect the way you deal with other providers in the planning and provision of services?

**The impact of incentives for competition and co-operation on the behaviour of health care organisations: a case study of the planning and provision of diabetes services in the English NHS**

**Interview topic guide - strategic level staff provider organisations**

Personal information (e.g name of interviewee, job title, length of time involved with the organisation, role in the organisation)

*I'm looking at the impact incentives for competition and co-operation are having on the planning and provision of diabetes services. However I'm also interested in the impact across the spectrum of services. During the interview we can talk both generally and in relation to diabetes specifically if you wish.*

Who are the organisation's main contracts with for the provision of services? Is this the same in relation to diabetes services?

What has the process been for the commissioning of services?

**Establish**

- whether there was tender for part of service or whether ongoing competition on the basis of patient choice
- whether there have been any new entrants
- Is there a difference in approaches between different commissioners?

Has the commissioning approach taken had any impact on relationships between organisations when planning and delivering services?

- Relationships with commissioner
- Relationships with other providers

Who are the main competitors for your organisation?

- Other secondary care providers
- GPs/primary care providers
- In relation to diabetes (if known)
- What is the nature of the competition?

*There are a number of policy initiatives within the NHS at the moment which may effect organisational relationships in planning and delivering care, for instance by encouraging organisations to compete with each other.*

Does Payment by Results and patient choice change the working relationships between organisations?

Has there been a change in working relationships with GPs, particularly in relation to practice based commissioning, and QOF incentive structures.

If applicable (FTs) – has the achievement of foundation trust status and the financial freedom it brings had any impact on relationships with providers or commissioners?

Have these incentives had an impact on sharing between organisations:

- Sharing resources
- Sharing information, including best practice

To what extent is there a tension between the need to compete with organisations and the need to co-operate?

Does the organisation have a strategy for coping with this tension?

- Are co-operative/competitive activities dealt with by different parts of the organisation?
- Are they dealt with by different staff groups?

**The impact of incentives for competition and co-operation on the behaviour of health care organisations: a case study of the planning and provision of diabetes services in the English NHS**

**Interview topic guide - managerial staff in provider organisations**

Personal information (e.g name of interviewee, job title, length of time involved with the organisation, role in the organisation)

Could you describe your role in relation to the planning and provision of diabetes services?

What part does your organisation play in the diabetic patients pathway?

Establish

- if there are multiple teams within the organisation
- Who teams are made up of
- Whether teams are all employed by the same organisation

How did the pathway and your organisation's role get decided?

Who are your main contracts with for diabetes services?

On what basis are the services commissioned?

Establish

- whether there was tender for part of service or whether ongoing competition on the basis of patient choice
- whether there have been any new entrants

Are there multiple providers for the diabetic services which this organisation provides?

*I want to find out about the relationships between the different organisations or teams who contribute to the patient pathway in more detail.*

Is the pathway monitored or co-ordinated in any way? Who by?

Is there competition between your organisation and the other providers of diabetic services within the pathway?

- In what ways does this competition manifest itself in the planning and provision of services?
- Who are the competitors



- If appropriate – why competition exists with only some of the providers and not others
- Does competition interfere with the co-ordination of services in the diabetes pathway?
- Is competition dealt with by specific people in the organisation

How have relationships between organisations have been effected by incentives?

PbR

Introduction of diverse providers

Organisations financial freedoms

Do you have contact with people providing diabetes services in other parts of the pathway?  
What kinds of things do you discuss? Is this a formal part of your role?

Do you have contact with the commissioners of diabetes services? What kind of contact do you have with them?

Are there any resources (human/material/'soft') that are shared between the providers involved in the diabetic pathway?

**The impact of incentives for competition and co-operation on the behaviour of health care organisations: a case study of the planning and provision of diabetes services in the English NHS**

**Interview topic guide - GPs**

Personal information (e.g name of interviewee, job title, length of time involved with the organisation, role in the organisation)

Can you describe the current patient pathways for diabetes in your area?

What is the role of your GP practice in the patient pathway for diabetes?

Do you have competitors within the pathway?

Establish

- The nature of the competition

How does competition influence the way you participate in the planning and provision of services for diabetes?

Do you have any partners in the delivery of diabetes care?

Establish

- The nature of the partnership
- Relationship with other GP practices

How was your role in the patient pathway decided?

Establish

- Role of the commissioner

What factors figured in the decision making of the practice when they decided what role they wanted to play in the planning and provision of diabetes services?

Establish

- Effect of QOF payments
- Effect of practice based commissioning
- Resource availability

Is the patient pathway monitored or co-ordinated in any way?

What kind of contact do you have with the other providers in the patient pathway?

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GP topic guide

Is the co-ordination of the patient pathway more difficult with those organisations you are competing with?

If so, how do you handle this?

**The impact of incentives for competition and co-operation on the behaviour of health care organisations: a case study of the planning and provision of diabetes services in the English NHS**

**Interview topic guide – patient pathway mapping**

*Personal information* – age, length of time lived in case study area

*History of the patient's condition* – when developed diabetes , how diagnosed

What are the different elements of care that the patient receives for their diabetes?

Prompts : Footcare, eyecare, regular monitoring

What services have been accessed for diabetes in the last year?

*Checks to include:*

whether these were scheduled in advance or urgent

Patient initiated access or NHS

How did they know how to access services

Who provides the various elements of diabetes care that the patient receives?

How is the diabetes care for the patient organised?

In general, how well is the patient's diabetes care coordinated?

*Checks to include (from Gulliford):*

Patient given same information and advice by all professionals

Medical history known by all professionals

Medical notes correct and available at appointments

Patients' treatment plan known by all professionals

Professionals share an agreed plan of treatment with patient regarding diabetes

**How does the patient know what will happen next in the monitoring/treatment of their diabetes?**

## APPENDIX 4

### LIST OF ORGANISATIONAL INTERVIEWS CONDUCTED AND MEETINGS OBSERVED

<b>Organisation</b>	<b>Interview</b>	<b>Date</b>
<b>Primary Care Trust</b>	PCT Director PCT Diabetes Manager PCT Project Manager	June 2011 June 2011 and July 2012 September 2012
<b>Clinical Commissioning Group</b>	CCG Vice Chair	August 2013
GPs	GP PCT GP and Clinical lead	January 2013 December 2012
<b>Provider A</b>	Provider A General Manager Provider A Diabetes Consultant 1 Provider A Diabetes Consultant 2 Provider A Director (Strategy) Provider A Director (Community Services)	July 2011 July 2011 July 2011 August 2011 and April 2013 July 2012
<b>Provider B</b>	Provider B General Manager Provider B Director (Strategy)	October 2012 January 2013
<b>Provider C</b>	Provider C Director (Strategy) Provider C Diabetes Nurse	November 2012 January 2013
<b>Provider D</b>	Provider D Director (Strategy) Provider D Diabetes Consultant	January 2013 April 2013
<b>Provider E</b>	Provider E Director	January 2013
<b>Provider F</b>	Provider F Director (Strategy) Provider F Diabetes Consultant	April 2013 June 2013
<b>Provider G</b>	Provider G Manager Provider G Manager (Contracts)	May 2013 June 2013
<b>Provider H</b>	Provider H Director (Strategy)	October 2013

<b>Organisation</b>	<b>Meeting attended</b>	<b>Date</b>
<b>Shadow CCG</b>	Organisational strategy (public engagement) Diabetes Redesign Board Diabetes Redesign Board	July 2011 September 2012 October 2012

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