

CLINICIANS IN THE NEW CLINICAL COMMISSIONING GROUPS (CCGs) IN ENGLAND: MASTERS OF ALL TRADES?

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Abstract

The objective of this research is to discuss and explore the nature of General Practitioners (GPs) and other clinicians' involvement in the new Clinical Commissioning Groups (CCGs) in England. The institutional field studied is healthcare commissioning. To achieve the above objective, this paper asks the following research questions: 1) 'How appropriate is it for clinicians to be involved in CCG commissioning?' and 2) 'What institutional dynamics and interplay characterise this involvement?' The theoretical framework used draws on elements of the Institutional Logics Theory (ILT). To help answer the research questions, this study employs two research methods – documents' content analysis and semi-structured, in-person interviews. The interview subjects are NHS senior managers and accountants, as well as NHS clinicians (mostly GPs). The paper finds that there is no consensus on the appropriateness of clinicians' involvement in commissioning as its leaders. In conclusion, this study deliberates on the viability of the purchaser-provider split which originated in the early 1990s and which is still applicable today. This split between purchasers (commissioners or payers) and providers (medical doctors and hospitals) established the foundation and raison d'être of healthcare commissioning.

Keywords: England, clinicians, commissioning, CCGs, GPs, healthcare, NHS

1. Introduction

The healthcare field bears the brunt of numerous institutional forces – political, economic, and social. A diversity of competing priorities demands the attention of large public sector institutions, such as the National Health Service (NHS) in England (Lapsley & Skærbæk, 2012). This fact makes these institutions particularly intriguing to study. A controversial 2012 legislation of the UK Parliament mandated that all General Practitioners (GPs) in England be members of newly-legislated healthcare commissioning organisations called Clinical Commissioning Groups (CCGs). This piece of legislation, the *Health and Social Care Act of 2012* (HSCA, 2012), became effective on 1 April 2013 and is still in effect. Healthcare commissioning is complex and comprises a wide variety of activities – planning for local populations' healthcare needs, signing of contracts with healthcare providers (mostly hospitals), purchasing of healthcare services from these providers, contract monitoring, and many more. The objective of this research is to discuss and explore the nature of General Practitioners' (GPs) involvement in the new CCGs. GPs are not the only physicians involved in CCGs, although they are the majority. Because of this, the more encompassing term *clinicians* is used in this paper instead. This term designates all medical practitioners who may be involved, statutorily, in CCGs, in accordance with HSCA (2012). These are "member[s] of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002" (HSCA, §28(1E) (2012). Some specialist medical consultants and nurses may also commission for health in CCGs. Clinicians are not simply involved in CCG commissioning; they are its leaders.

This research seeks to contribute to knowledge and understanding by identifying and filling a number of research gaps in the extant accounting academic literature. Two gaps in the literature are identified next. First, since HSCA (2012) is a relatively recent piece of legislation, there have been few academic studies that simply mention or examine in detail the CCG commissioning reforms (Asthana, 2011; Conrad & Guven-Uslu, 2012; Gray & Higgins, 2012; Hodgetts, 2012; Petsoulas, Allen, Hughes, Vincent-Jones, & Roberts, 2011; Robinson, Williams, Dickinson, Freeman, & Rumbold, 2012). These reforms have mostly been addressed by the practitioner literature (the *British Medical Journal*, the *Health Service Journal*, and the *Lancet*).

This study tries to respond to Guven-Uslu and Conrad's (2011) call for further academic research on NHS clinicians and managers, many of whom are now also CCG commissioners. Second, some commentators have been sceptical of the commissioning leadership of the new clinician-commissioners (Gridley et al., 2012; Richardson, 2013).

While the changes to commissioning certainly mean that clinicians now have a leading role in, for instance, population-based budgeting, Robinson, Dickinson, Freeman, and Williams (2011) doubt that GPs will be able to meet their commissioning challenges on their own. Most likely, they will have to engage with other stakeholders, such as the government, interest groups, and civil society. Petsoulas et al. (2011, p. 185) express the concern that GPs "generally lack experience and expertise in large-scale, secondary care contracting." Devlin (2010, p. 1076) asks the important question:

[A]re we sure that GP commissioners will be better agents for patients (individually and collectively) than PCTs [Primary Care Trusts were the 'old' commissioners; note added]? While GPs may be 'closer' to what individual patients want, it is not obvious why this would make them more expert at weighing up the relative benefits to patients, and the opportunity costs of budget allocation decisions. Indeed, it seems unlikely that many GPs will currently have either the expertise or interest in making these decisions.

To the authors' knowledge, no other study has asked directly of NHS senior managers, accountants, and clinicians whether this lack of experience and expertise is just a perceived problem or an actual one. Besides, no other research has so far asked NHS managers, accountants, and clinicians about how they personally feel about clinicians' involvement in CCG commissioning. It is noteworthy that commissioning involves a very different knowledge and skill set from medicine – what clinicians have actually been trained for. The knowledge and skill set most needed in commissioning is business, management accounting, strategic, and altogether calculative in nature – population needs' planning, budget preparation and allocation, contracting, paying for services, de-commissioning of services, and so on.

Unlike the former practice-based commissioning (PBC) that placed the ultimate accountability for commissioning on PCTs, the most recent commissioning reforms placed the ultimate accountability for it on GP-led CCGs. Cox (2011) sees an ethical dilemma behind this shift since the new statutory duties of GP-commissioners would place them in the impossible position where caring for patients might no longer be their primary concern. This research will try to find out whether the above concern with the fitness of clinicians to be involved in CCGs is justified or not. Thus, the research questions are: 1) 'How appropriate is it for clinicians to be involved?' and 2) 'What institutional dynamics and interplay characterise this involvement?'

The National Health Service (NHS) is the general taxation-funded public healthcare service in the UK.¹ It is the biggest integrated (Crisp, 2011) and the largest publicly-financed healthcare system in the world (Asthana, 2011). The annual budget of the English NHS exceeds £100 billion (Crisp, 2011). All individuals living in England are entitled to NHS healthcare benefits, which are usually free at the point of access. Founded on 5 July 1948,² the NHS is a treasured symbol of pride and national unity (Llewelyn & Northcott, 2005) that is revered around the world. It is a national icon in the sense that it is by far the most popular of Britain's public services, "a jewel in the crown of welfarism ... and very much the envy of billions of people around the world whose health services are less developed, less accessible, more expensive and more exclusive" (Lister, 2008, p. 1). Thus, the NHS was proudly featured during the opening ceremony of the 2012 London Olympics.

The NHS has its own constitution which establishes its principles and values and sets out patients,' the public's and the NHS staff's rights. According to this constitution, the NHS belongs to the people and has lofty aspirations:

[The NHS] is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most (Department of Health [DH], 2013, p. 2).

The seven principles that guide the NHS in all that it does are: 1) that it provides a comprehensive service, available to all, 2) that, access to its services is based on clinical need, not on an individual's ability to pay, 3) that the NHS

¹ In 2001 for example, 86% of the NHS revenue came from general taxation, 12% from national insurance contributions, and 2% from user charges (Maynard, 2005).

² More on the history of the NHS may be found in Doetter and Götz (2011), in Dr. Charles Webster's *The National Health Service: A political history* (Webster, 2002) or in Timmins (1995).

aspires to the highest standards of excellence, 4) that it aspires to put patients first, 5) that it works across organisational boundaries, 6) that it is committed to providing best value for taxpayers' money given finite resources, and 7) that it is accountable to the public (DH, 2013).

The former Coalition government (May 2010 – May 2015) (Hickson, 2009; Painter, 2013) is the one that initiated and carried out the latest NHS reforms. This government consisted of the Conservative Party (right wing) and the Liberal Democrats Party (centre-right wing). Prior to the Coalition government, the UK was ruled by the Conservative Party for 18 years (1979-1997) and by the New Labour Party for 13 years (1997 – May 2010). The Coalition government needed to 'prove itself' quickly, so it acted quickly, writes Timmins (2013).

Over the five days in May 2010 when the Coalition was formed, something important happened – it was not just the case that the Coalition government agreed to eliminate the deficit over the lifespan of a Parliament (twice as fast as New Labour had planned it before), but it also agreed on fixed-term parliaments (*Ibid.*). This plan gave the Coalition only five years in which to govern, but possibly only five years in case the economy did not pick up, posits the author. Besides, the Conservatives had perhaps over-absorbed Tony Blair's statements in his autobiography that he had made the mistake of wasting his first term in office by not acting boldly enough on public service reforms, observes further Timmins. Thus, the Coalition became immensely bold in terms of such reforms and quickly

... launched the most ambitious programme for government since the Attlee administration of 1945. In three short years, the Attlee administration had introduced a national health service and a new social security system; nationalised the Bank of England and a clutch of utilities including coal and electricity ... The Coalition programme came close to matching that ambition. There was to be not just the NHS reform but a radical restructuring of tuition fees; the introduction of "free" schools ... a major restructuring of the Financial Services Authority and the Bank of England; a merger of the Competition Commission and the Office of Fair Trading; elected police commissioners; more elected mayors; a big reform of public sector pensions; a new "localism" offering individuals new rights ... and much else – all while eliminating the deficit, imposing by far the biggest cuts to government spending in living memory (Timmins, 2013, p. 46).

Again, as noted in the above quote, the most recent NHS reforms were not the only reforms hastily introduced by the Coalition government. These reforms are just one example of the numerous reforms adopted by the Coalition in its hopes to act fast, achieve results, and gain the public's trust. It seems that the 2008 world economic crisis, while creating an opportunity for a significant policy change (Doetter & Götze, 2011), was not the only driving force behind the recent NHS reforms. Political ideologies, drives, and aspirations also lie in the heart of this important institutional change.

The NHS reforms of 2010-2013 were mainly the workings of one person in particular – Andrew Lansley, a Conservative and the Coalition government's first Secretary of State for Health.³ He had previously held the post of Shadow Secretary of State for Health under the New Labour government for an unprecedented six and a half years (Timmins, 2013). The young Lansley was the principal private secretary of Norman Tebbit, the man who had privatised British Telecom (BT) at the time. Tebbit, Timmins notes, was one of Lansley's personal heroes. Due to his experience with BT's privatisation, which was based on the ideas of free markets and competition, Lansley developed a preference for market forces, such as the privatisation of the energy sector (Jupe, 2012), as a solution to the issues facing the NHS. Before entering politics in 1990 as head of the Conservatives' research department, Lansley was a director of the British Chambers of Commerce (Timmins, 2013). There, he worked with the young David Cameron and George Osborne (the current Chancellor of the Exchequer and Second Lord of the Treasury), both of whom are also Conservatives. In the summer of 1992, Andrew Lansley suffered a minor stroke. His experience in the NHS at the time reinforced his genuine attachment to the NHS (*Ibid.*).

2. Governance of CCGs and Commissioning Support Units (CSUs)

When should we stop funding cancer care for those who are terminally ill but might treasure a few extra months with their families? Dilemmas like this are within the scope of healthcare governance (Storey, Bullivant, & Corbett-Nolan, 2011) and commissioning in particular. Each option will attract advocates and opponents; so, 'Who should decide and how?' 'Should the amount for funding cancer care be decided by: the DH, civil servants, clinicians, patients, and/or the local community?'

³ Andrew Lansley's post was assumed by Jeremy Hunt in September 2012.

More than 90% of patient contacts in the NHS are said to occur in primary care via GP consultations.⁴ Except in emergencies or with specialist referrals, patients in England usually see their GP first (Hausman & Le Grand, 1999). “Modern political rationalities and governmental technologies” are linked to “the powers of expertise,” remind Rose and Miller (1992, p. 173). Besides, GPs are seen as “general health experts with strong links to their local populations and a good degree of trust within their local communities” (Geyer, 2013, p. 49). All these are reasons why GPs are considered by many to be ideally placed to understand the healthcare needs of their catchment areas. Clinicians are the conventional health experts, although patients have undergone a certain ‘proto-professionalisation’ or ‘medicalisation’ (De Swaan, 1988; Dent & Haslam, 2006). This is to say, in today’s information age, patients have learned how to communicate to their doctors what problems they experience, using medical vocabulary and knowledge usually found online.

Geyer (2013) purports that GPs have usually acted as patients’ advocates and that GP-led commissioning would respond to increasing demands for more and more localism and autonomy. Clinical commissioning would also shift decision-making closer to patients (Asthana, 2011, p. 815). Besides, Harradine, Prowle and Lowth (2011) found out in an empirical study that a clinical manager is able to make significant savings within his or her clinical specialty. While making savings may often seem to be a promising side of clinical involvement in management and commissioning, Gridley et al. (2012) question the assumption that GPs are the best placed agents to commission in ways that meet quality standards and lead to equitable outcomes. These commentators note that, “[t]here is little evidence to suggest that GPs will succeed where others have failed and a risk that, without top-down performance management, service improvement will be patchy, leading to greater, not reduced, inequity” (p. 87).

Geyer (2013) is aware of the fact that there are both pros and cons to GP commissioning: such commissioning could align clinicians’ financial and clinical responsibilities, encourage decentralisation, promote local accountability, and enable GPs to shape the healthcare system to better serve patients. Among the cons of GP commissioning, Geyer sees: 1) an increase in local variability of health outcomes (postcode lottery), 2) a growth of inappropriate relationships between GP commissioners and large providers, such as pharmaceutical companies which have a clear financial interest in influencing commissioners’ decisions, 3) threats of lawsuits around complex commissioning contracts, and 4) a loss of the traditional GP culture, and so on. Richardson (2013), among others, is also sceptical of GPs’ dual commissioner-provider role, a role imbued with conflicts of interest. In other words, GPs are to provide primary care and at the same time commission secondary (hospital) care for their patients. Would not this dual role of purchaser and provider at the same time incline GPs toward adjusting their referral practices to secondary care in such ways that would seem the most financially beneficial to them?

Commissioners in the new NHS are given the option to work with commissioning consultants. NHS England started by hosting nineteen CSUs⁵ whose role is to help CCGs by carrying out various functions, grouped into service lines,⁶ such as: service redesign, contract negotiations, management and monitoring, information analysis, and risk stratification (Davies, 2013). CSUs’ involvement in service redesign⁷ may be limited to an advisory or communications capacity, but it may also be extended to engagements in the redesign of healthcare services (Thiel, 2013). The redesign of healthcare services and care pathways is hoped to lead to significant cost savings in the long run (National Audit Office [NAO], 2012).

The idea of using commissioning consultancy is not new: the former commissioners, PCTs and Strategic Health Authorities (SHAs), also hired the services of consultants. If a CCG hires a CSU, the ultimate accountability for the quality of services received still rests with the CCG, not with the CSU. CCGs are under no obligation to use the services of CSUs. Generally, commissioning work may be retained in-house (within a CCG), shared with another CCG or delegated to a CSU (Williams, D., 2013). These three different options and the risks associated with each are explored in Williams, J. (2013). According to this author, the NHSCB’s ‘model constitution’ framework for CCGs, first published in April 2012 and superseded by the so-called ‘model constitution’ for CCGs in October 2012, explains further these three options.

⁴ Retrieved from <http://www.bmj.com/content/348/bmj.g2408/rr/692631> on 23.03.15.

⁵ CSUs were previously called Commissioning Support Services (CSSs) (Davies, 2013).

⁶ CSUs could exercise functions that were categorised into seven service lines during the early stages of the CSU assurance process. These service lines are now thirty (Williams, 2012a): business intelligence (such as data management and integration), business support (such as legal services, HR, and finance), clinical procurement, and communications services, among others (Williams, 2012b). These services follow the NHS Commissioning Board (NHSCB)’s assurance process guidelines. The NHSCB was later renamed to NHS England.

⁷ An example of a service redesign would be a change in the way health conditions (for example, diabetes) are treated.

CCGs and CSUs are currently linked contractually by service level agreements. The *Health Service Journal (HSJ)* notes that some CCGs opposed disclosing their service level agreements for reasons of commercial confidentiality. Some commentators are of the opinion that while confidentiality issues in the NHS are not new, resorting to closed doors appears to go against greater accountability and transparency in the commissioning function (Thiel, 2013). Besides, one should not forget that national and EU laws apply to commercial confidentiality. Another critique of CSUs, besides the one on reduced accountability and transparency, is the high cost of commissioning consultancy. Light and Connor (2011, p. 822) write:

With exceptions, expert commissioners and contractors will have to be hired from external consulting organisations that charge £400 an hour and shift control of the NHS into for-profit hands. Thus “commissioning” will be defined by corporate agents in diverse ways with much less accountability than national targets, tariffs, and guidelines imply.

It is still too early to tell what the future of CSUs will look like – whether they will continue to be hosted by NHS England or whether they will be opened up to privatisation, a process called ‘externalisation.’ There have already been several recent cases of CSU mergers (Welikawa, 2014).

3. The nature of commissioning

3.1. The ‘new’ commissioning

Over the past 20 years, the NHS has experienced many major reorganisations. Depending on one’s definition of the word ‘major,’ there has been at least one such reorganisation per year (Geyer, 2013). Every new Minister of Health, continues Geyer, announces how he will solve the NHS’s problems with a brand new reorganisation of some type. This tendency toward centralised reorganisation is amplified, according to the author, by critical and sensationalist UK mass media that revel “in exposing NHS incompetence, waste and mistakes (and the accompanying human tragedy) and ... [demand] instant answers, responsibility, change and, if possible, retribution” (p. 50). Thus, the newest changes to commissioning are not a stand-alone institutional reorganisation. Their roots go back more than twenty years, not just in the history of the New Labour government, but also in this of the Conservative government (Timmins, 2013).

The commissioning function has attracted the attention of academics both in the ‘old’ and the ‘new’ NHS. Commissioning in the new NHS has been examined by Asthana (2011), Currie, Lockett, Finn, Martin, and Waring (2012), Devlin (2010), Geyer (2013), Guven-Uslu (2012), Petsoulas et al. (2011), Quayle, Ashworth, and Gillies (2013), Robinson et al. (2011), and Whitehead, Hanratty, and Popay (2010), among others. It was the American Professor Alain Enthoven’s original idea to have all medical doctors share the responsibility for budgeting and organising integrated care (combining acute and social services), following the lead of the US healthcare company, Kaiser Permanente (Light & Connor, 2011). GPs and other clinicians, as the commissioning leaders of the reformed NHS, are the focus of several recent academic studies (Asthana, 2011; Devlin, 2010; Martin & Learmonth, 2012; Storey & Grint, 2012).

It has been claimed that in today’s complex world, leadership is increasingly conferred not just to those who hold positions of formal power, but also to clinicians, patients, and the public (Martin & Learmonth, 2012). The topics of leadership in GP-led commissioning are further elaborated in Storey and Grint (2012). Drawing on the distinctions these authors establish between leadership and governance, Storey and Grint conclude that in the reformed system, GPs will be expected to undertake certain elements of leadership and certain elements of governance. Three functions of leadership are presented – vision/direction setting, mobilisation, and scapegoating. With respect to the first function, note the authors, GP leadership will doubtlessly be sought to help endorse the efficiency savings of £15-20 billion that were recently announced by central government (the so-called ‘Nicholson challenge’). In exercising this first function of leadership, GP-led CCGs will be aided by NHS England, another new commissioning organisation. GPs will exercise the second function of leadership by mobilising their peers.

This way, the traditional, prevailing role of GPs as independent contractors of the NHS who exercise autonomous clinical judgement on a patient-by-patient basis will give way to a collective judgement about effective administrative/clinical practice and priorities within CCGs, write the authors.

Vis-à-vis the third function of leadership, scapegoating, Storey and Grint predict that GPs will turn into scapegoats when things go wrong, given that patients and the public tend to complain intensely about dismantled or reduced services. Yet, GPs will exercise an enhanced leadership role by virtue of being responsible for spending the bulk of the NHS budget on hospital and other services.

Holding the purse strings in this manner means there will be a strong expectation that they [GPs] must spend far more time than currently in helping to envision new and more effective care pathways ... They can no longer be mere service deliverers (p. 270).

Three functions of governance – legitimation, conformance and performance monitoring and regulation/accountability – are also presented by Storey and Grint (2012). Regarding the first function of governance (legitimation), GPs are expected to justify the new healthcare services redesign and priorities from a legitimation point of view. As to the second function of governance – monitoring – this function will be needed as GPs monitor new developments in commissioning. The third function of governance – regulation/accountability – will continue to be present within GP-led CCGs due to newly-legislated regulation and accountability relationships.

In addition to leadership and governance theories, CCG commissioning has been analysed in the literature through complexity theory. Geyer (2013) uses a modified Stacey diagram to compare the situation of GPs before and after CCG commissioning. He found out that the position of GPs before the introduction of CCGs was relatively stable and orderly, in the sense that much of GPs' daily activities was well structured, stable, and repetitive: patient flows were relatively stable, salary rates were established through a structured bargaining process, and so on. Yet, due to CCG commissioning, GPs would move closer to the complexity zone of the modified Stacey diagram, claims Geyer. The reasons behind this shift are the increasingly political and judgemental role that CCG commissioning implies and the increased uncertainty of CCG-commissioned outcomes, posits the author.

A commissioning expertise deficit and a lack of interest in commissioning among GPs are not the only risks confronting the new NHS. In line with Devlin (2010), Asthana (2011) sees a lack of appetite among the British public and GPs for such a radical market reform. She identifies a number of unintended risks (large transitional costs and organisational turbulence) resulting from a further NHS reorganisation and sees a potential financial risk in the proposed at the time NHS reforms. Tallis (2013, p. 144) calls the commissioning reform a “blatant deception ... [and a] contempt for the electorate” and then writes about the passage of the *Health and Social Care Bill of 2011* (HSCB, 2011) to the statute book. Further, Tallis observes that the bill became law because good men did nothing or, with a few exceptions, very little to oppose it. This delivery of the

planned destruction of the NHS says something shocking – about the condition of the nation ... the debased state of the national conversation about matters of supreme importance, and the marginalisation of professionals who, when faced with the greatest threat for generations to the institution and the values for which they claimed to stand, in most cases preferred appeasement to confrontation (Tallis, 2013, pp. 149-150).

The same source, on p. 125, calls the HSCB (2011) “a toxic bill that few had foreseen and no one other than its proponents saw as desirable ... had got on to the statute book.” Now that the reforms have been legislated, they need to be abided by, like any other law. There are indeed some attendant risks in giving more decision-making power to frontline clinicians and patients (Devlin, 2010). Devlin states that “encouraging patients to think of the NHS as having a duty to offer unlimited choices of where and how to be treated will, in a budget-constrained NHS, result in disappointment” because “[n]ot all effective treatments can be afforded: GPs have been passed the poisoned chalice of reconciling demand and supply ... and the way they engage patients and the public in prioritising spending” (p. 1076).

3.2. Prior forms of commissioning

As noted earlier, the NHS in England has been experiencing quick and multiple restructurings (McMurray, 2007). On the average, there has been about one structural change in the NHS every two years, to the point that “organisation, re-organisation and re-disorganisation” could have become emblematic of this large institution (Timmins, 2013, p. 16). The commissioning function has mirrored this trend.

There have been several attempts to devolve commissioning responsibilities to the clinical level prior to the CCG reforms (Naylor & Goodwin, 2011). Detailed accounts of the history of commissioning may be found in the House of Commons Health Committee (HCHC, 2010) and Timmins (2013).⁸

⁸ Timmins' study is a study in government, the Coalition government's politics in particular. Although the reforms are widely known as 'Lansley's reforms,' the actions of both governing parties, the Conservatives and the Liberal Democrats, have had a deep impact on the unfolding of events and the shape of the changes (Timmins, 2013).

3.2.1. The period 1948-1991

In the early years of the NHS, an entirely nationalised healthcare system was established, in which secondary care was provided by NHS-owned hospitals, while primary care – by independent GPs, contractors of the NHS (HCHC, 2010). The period between 1948 and 1974 was a period of stability that experienced no material changes (Timmins, 2013). From the mid-1970s onwards, one could observe a pronounced need to limit the public expenditure growth within the NHS: how to make the NHS more efficient became a priority (HCHC, 2010). Due to the absence of market mechanisms in the UK healthcare system, a system provided and financed mostly by the government, there was no natural pricing mechanism in the NHS through which the supply of healthcare could be matched efficiently to the demand thereof (Donaldson, Gerard, & Mitton, 2005).

In 1989, the absence of such pricing mechanisms led to the most important cultural shift since the birth of the NHS – the so-called ‘internal market’ of the Conservative government (HCHC, 2010). How the internal market would work was outlined in Kenneth Clarke’s⁹ January 1989 white paper, *Working for patients* (DH, 1989). One year later, this white paper was passed into law as the *NHS and Community Care Act of 1990*. The changes took effect in 1991. In theory, claim Donaldson et al. (2005), the lack of market mechanisms in healthcare may be overcome by ‘quasi-markets’¹⁰ or ‘internal markets,’ created via rules and regulations. This way, continue the authors, incentives may be set up to reward providers and consumers for being efficient. Williams (2005) argues that the perception of an internal market as a value-neutral way of purchasing is an illusion because the ways in which efficiency is measured is not value free.

The internal market is seen by some as a type of ‘managed competition’ within the new ‘managerialist’ philosophy (Light, 2001; Pettersen & Solstad, 2014), also known as ‘New Public Management’ or ‘NPM’ (Hyndman & Liguori, 2016; Kelly, Doyle, & O’Donohoe, 2015). NPM is primarily based on ideas suggested by Prof. Enthoven from Stanford University’s Business School and Alan Maynard, Professor of Health Economics at the University of York (Kay, 2001). In the mid-1980s, Prof. Enthoven visited the UK and argued that NHS hospitals lacked incentives for improving the quality and efficiency of the services they provided (*Ibid.*). Prof. Maynard argued, the same source notes, that general practice in the NHS did not incentivize GPs to control their costs and use public resources efficiently; besides, he suggested that a budgetary system and associated incentives be introduced into UK general practice for certain secondary care and pharmaceutical services. Prof. Maynard’s ideas influenced Kenneth Clarke to embrace quasi-markets in 1989.

In the internal market legislation, hospitals were made to compete with one another for resources, just like in a competitive market environment, and involve medical doctors in management decisions more effectively (HCHC, 2010). According to Kay (2001), during the early 1990s, the publicly-funded healthcare systems in many Western countries, not just in the UK, experienced similar market-driven reforms:

Such reforms were designed to exert greater control over state spending on health care and to improve the efficiency with which these systems operated. To help meet these aims, attempts were often made to stimulate competition between hospitals that provided publicly funded services and to encourage doctors and other professionals to control public expenditure on health (p. 561).

This new system created a new set of key players and a new incentives’ structure for hospital policy making – now the most sought after employment position was not to be in charge of a Regional or District Health Authority (DHA), but to be the CEO or Director of Finance of a NHS hospital (Pollock, 2004).

This, writes Pollock, could later be a stepping stone to even more powerful job positions in or outside the NHS. Derek Smith, for example, a former CEO of the King’s College Hospital in London, later became the CEO of the London Underground. The internal market is such a fundamental idea that Timmins (2013, p. 17) sees it as “the first building block” of Andrew Lansley’s reforms.

3.2.2. Genesis of the purchaser-provider split: The 1991 reforms and GP fundholding

⁹ Kenneth Clarke was the Secretary of State for Health at the time.

¹⁰ The word ‘quasi’ is used because it is hard to subjugate the healthcare field entirely to market logics, at least in a democratic society like the UK which takes care of its vulnerable groups. Hart (2010, p. 6) for instance notes that healthcare is a field “in which Adam Smith’s invisible hand cannot operate without introducing a potentially lethal infection, the profit motive. We may learn to cope with this from car salesmen, but from doctors and nurses it is surely intolerable, both for them and their patients.” At the same time, a hospital that does not take account of keeping its costs within reasonable limits would be considered unsustainable and might be forced to close down or become an undue drain on the rest of the healthcare system.

Elkind (1998) applies several metaphors, in line with Morgan (1986), to her study of the NHS: the images of machine, organism, religion, and marketplace are found to be particularly relevant to the NHS as an organisation. The religious connotation alludes to the mission of the NHS as a universal and comprehensive service; likewise, the mission of many religions is to provide salvation to humanity. Besides, the NHS is machine-like since it is based on technocratic rationality, just like a machine. Being likened to a living organism reminds of the NHS as an open system: a living organism is participative and responsive to its environment, not closed to itself. Last but not least, the health service resembles a marketplace because of the presence of competition and the internal market of the post-1991 period. The idea of internal market is closely linked to another innovative idea of the early 1990s – the purchaser-provider split. This split, with its separation of commissioning from the provision function, was the cornerstone of the 1991 NHS reforms (Klein, 2005).

The purchaser-provider split characterises the period 1991 to the present and consists of changing the role of healthcare providers. Whereas previously, providers (hospitals) were determining themselves what services to provide to their patients, under the reformed system of 1991, the newly-established commissioning bodies (not hospital doctors) had to purchase the needed healthcare services from providers on behalf of their patients (HCHC, 2010). Thus, commissioning was born in 1991. In order to become providers in this internal market, the source continues, hospitals first needed to become NHS trusts, i.e. “separate organisations with their own management” (*Ibid.*).

Farlie, Fitzgerald, McGivern, Dopson, & Bennett (2013) draw on the concept of *managerialism* in healthcare when talking about the Thatcher years. The ‘professional dominance’ era (Jackson, Paterson, Pong, & Scarparo, 2014) of the pre-1979 period had now given way to the era of neo-liberalism. Under the very first commissioning model, there were two types of commissioners – 192 District Health Authorities (DHA) and GP fundholders.¹¹ According to Wilkinson (2011), GP fundholding was a voluntary commissioning model in which participating family practitioners were allocated a portion of the secondary care budget. With these funds, fundholders could buy healthcare services from NHS trusts and from the private and voluntary sectors on behalf of their patients (HCHC, 2010). Initially, GP fundholders could buy just a limited range of care – the budgets covered, for instance, elective (waiting list) surgeries, physiotherapy, and GPs’ own prescribing (Timmins, 2013). Although GPs could buy care from whomever they wanted, they were free to establish new services themselves, writes Timmins.

The idea was that at least for some treatments “money would follow the patient” so that hospitals that did more work would earn more. Hospitals that failed to attract patients would earn less – the hope being that they would up their performance in response to competitive pressure (p.17).

It was often the case that the patients of GP fundholders were able to obtain healthcare treatment more quickly than patients of non-fundholders (HCHC, 2010). Consequently, there were some accusations that fundholding was violating the fair and equal access of all people to healthcare (Laudicella, Cookson, Jones, & Rice, 2009). By 1997, observe Donaldson et al. (2005), half of the population was covered by fundholding practices that controlled over 10% of hospital and community health service spending. Besides, GP fundholders tended to enjoy better resources and were located in more affluent areas than non-fundholders, remarks the same source. Despite fundholding’s shortcomings, its proponents, such as Croxson, Propper and Perkins (2001), argued that separating the roles of purchasers and providers helped improve the efficiency of the NHS in productive and allocative terms.

3.2.3. Primary Care Groups (PCGs): 1997-2001

In May 1997, the newly-elected New Labour government decided to put an end to the internal market (HCHC, 2010). GP fundholding was abolished in the same year. In December 1997, the white paper, *The new NHS – modern, dependable* (DH, 1997) was published. It retained the purchaser-provider split of the early 1990s but DHAs were renamed to Health Authorities (HAs) and became the new commissioners (HCHC, 2010). The purchaser-provider split, initiated by what tended to be a business-minded Conservative government, became increasingly important also under what tended to be a socially-minded New Labour government.¹² Klein (2005, p. 55) notes a dramatic reversal in the usual anti-market inclinations of New Labour:

After initially cold-shouldering the private sector on coming into office in 1997 (in line with traditional party ideology), the Government three years later enfolded it in a warm embrace. Having decided that extra billions of public funds would need to be poured into the NHS, the Government came up against the realisation that capacity, as much as money, was the main constraint on improving services in the short term (i.e. before the next General Election).

¹¹ Please consult HCHC (2010) for a detailed table of the different commissioning models since 1991.

¹² A good summary of the post-1991 developments in the NHS is found in Petsoulas et al. (2011).

Thanks to short-term considerations like the ones evoked in the above quote, the New Labour government embraced the cooperation of the private sector in a much neo-liberal manner, just like the Conservatives had done up to 1997. Besides, growth in spending on healthcare increased significantly during the New Labour administration (Ham, 2004). Four hundred eighty-one Primary Care Groups (PCGs) were established in 1999 in conjunction with the HAs (HCHC, 2010).

3.2.4. The recently overthrown system: PCTs and SHAs (2002 – 1 April 2013)

Ferlie et al. (2013) divide the New Labour government's era into three parts: the early phase of networks and lateral working (1997-2002), the middle period of choice and diversity (2002-2006), and the later period of 'targets and terror' (2006-2010), a period during which some providers' boards and senior management were dismissed for poor performance. During the early period, *The NHS Plan: A plan for investment, a plan for reform* (DH, 2000) announced that by April 2004, all PCGs were to become PCTs but this date was later brought sooner – to April 2002 (HCHC, 2010). The 100 HAs were abolished and turned into twenty-eight SHAs that oversaw PCTs. In 2006, the SHAs were reduced to ten. The 2002 budget announced an increase in funding for the NHS and Alan Milburn (the then Secretary of State for Health) published, *Delivering the NHS Plan: Next steps for investment, next steps for reform* (DH, 2002; HCHC, 2010).

In 2004, a new type of GP commissioning was announced as 'practice-based commissioning' (PBC) in the policy document, *The NHS improvement plan – putting people at the heart of public services* (DH, 2004). PBC was launched in 2005 and was meant to "reignite clinical enthusiasm and engagement" (HCHC, 2010, p. 13). Adopting PBC was voluntary, just like GP fundholding had been. "Unlike ... GP fundholding, which gave GPs the money, PBC ... [gave] GPs only "indicative" budgets to commission services on behalf of their patients, while the PCT still ... [did] the contracting" (*Ibid.*).

CCG commissioning goes further than GP fundholding and PBC by giving GPs a "complete financial responsibility for commissioning a comprehensive range of services. Whereas, fundholders and practice-based commissioners were supported by health authorities and PCTs respectively, under the new proposals commissioning will be fully devolved to consortia" (Naylor & Goodwin, 2011, p. 154). Besides, another important difference is that CCG membership is obligatory for all GPs, not voluntary like GP-fundholding used to be: "One of the many shocks contained in *Liberating the NHS* was that all GPs were going to have to be involved in commissioning from a set date – whether ready, willing or able; whether they liked it or not" (Timmins, 2013, p. 31). A recent report by the King's Fund (Ham, Baird, Gregory, Jabbal, & Alderwick, 2015, p. 4) argues that even though the "squeeze on public finances may not have affected the NHS as much as most other public services" and even though "international surveys showed the NHS to be performing well" (p. 11), the reforms were legislated and their "effects were both damaging and distracting" (*Ibid.*). These are just "tentative" (p. 7) conclusions that may need to be revised as more evidence is gathered in the future, the source warns.

4. Theoretical framework

The theoretical take of this research is based on some concepts from the Institutional Logics Theory (ILT) (Friedland and Alford, 1991; Scott *et al.*, 2000; Thornton, 2004; Thornton, Jones, & Kury, 2005; Thornton and Ocasio, 2008; Thornton, Ocasio, & Lounsbury, 2012). The ILT concepts used in this paper are: the business logic, the professional/medical logic, the governance logic, the political logic, and the dynamic interplay among them. The ILT is a relatively new theory which represents a development of the neo-institutional theory (DiMaggio and Powell, 1983; Meyer and Rowan, 1977). To the researchers' knowledge, no other study on CCGs has so far used elements or concepts of the ILT. Reay and Hinings (2005, 2009) have discussed similar healthcare reforms from the ILT perspective but in the Canadian context.

The institutional logics theory (ILT) was pioneered by Friedland and Alford's (1991) paper, "Bringing society back in: Symbols, practices, and institutional contradictions" published in the so-called *Orange Book* edited by Powell and DiMaggio – *The New Institutionalism in Organizational Analysis*. This book is a direct critique of the very popular at the time neo-institutional theory (Lounsbury & Boxenbaum, 2013). The Friedland and Alford (1991) article begins by criticising rational choice and economics-based theories, as well as organisational theories, that do not take into account the broader societal context of organisations. The ILT sees society as a "potentially contradictory interinstitutional system" (p. 240). This theory quickly gained momentum after 1991 (Townley, 1997; Wilhelm & Bort, 2013), a trend which accelerated especially in the later parts of the 2000s (Lounsbury & Boxenbaum, 2013). *Institutional logics* is a term that has become a 'buzz-word,' that is, its meaning has been 'distorted' and 'overextended' (Thornton & Ocasio, 2008). As it is common in institutional work, the definition of terms and their usage may vary.

Institutional logics dictate the goals and values that agents pursue in a societal context and specify what means for achieving goals are appropriate; thus, logics have both a culture-cognitive and a normative dimension (Scott, Ruef, Mendel, & Caronna, 2000).

Thornton and Ocasio (2008) refer to three possible definitions of the term *institutional logics*: Alford and Friedland's (1985) definition, Jackall's (1988, 2010) definition, and the definition of Thornton and Ocasio (1999). This paper assumes the third definition, according to which institutional logics are "the socially constructed, historical pattern of *material practices, assumptions, values, beliefs, and rules* [our emphasis] by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (p. 804). At least four types of institutional logics may be observed in CCGs: the professional/medical, business, governance, and political logics. Included in these logics would be practices (for example, leading CCGs, participating in business and commissioning meetings), assumptions (for instance, assuming that GPs should first focus their attention on curing patients and preventing disease), values (acting in the best interest of patients and the public), beliefs (believing that GPs may be well positioned to lead commissioning), and so on. In the literature, institutional logics have been found to co-exist within an institutional field, conflict with one another, complement one another, experience shifts in their dominance within a field, and many more (Dunn & Jones, 2010; Glynn & Raffaelli, 2013; Goodrick & Reay, 2011; Kury, 2007; Pache & Santos, 2010; Smets et al., 2015).

Institutional change has been the object of many other studies in the management and accounting literatures (Cooper, Greenwood & Brown, 1996; Greenwood et al., 2002; Leblebici et al., 1991; McNulty & Ferlie, 2004; North, 1990). This change often displays itself as a reform that may be radical or mild in nature. It may affect the public, private or voluntary sector. Healthcare and other public sector fields have certainly not been exempt from institutional change (Macfarlane et al., 2011; Scott et al., 2000). Institutional change in the NHS has been examined through the lens of various types of institutional and other theories (Checkland et al., 2012; Macfarlane et al., 2013).¹³ Early neo-institutional theory research on the NHS examined how the healthcare field changed as a result of coercive, normative, and mimetic influences (Currie & Guah, 2007; Currie & Suhomlinova, 2006).

To reiterate, HSCA (2012) brought radical institutional change to the healthcare sector in England. Besides neo-institutionalism, the ILT has also proved to be a useful lens for the study of the plurality of norms and beliefs in institutional theories and the processes that underline institutional formation and change (Cloutier & Langley, 2013; McDermott et al., 2013), be it in healthcare or elsewhere. The introduction of institutional logics into institutional theory attempted "to move institutional thinking forward by incorporating an explanation for institutional change" (Greenwood et al., 2008, p. 21). These authors remind that modern capitalist societies are composed of central institutions that are permeated by 'potentially incompatible' logics (Friedland & Alford, 1991). Namely, the incompatibility of these logics is what provides the dynamics behind potential change: institutional actors may recognise opportunities for change thanks to their location at the intersections of logics in conflict. Such actors 'at the interstices' (Ibid.) is the 'doctor in the lead' in the Dutch context (Witman et al., 2011). Thus, medical doctors may bridge the worlds of medical expertise and managerial acumen. Llewelyn (2001) calls these medics, in the English context, 'two-way windows.'

From the Canadian perspective, Reay and Hinings (2005) develop a theoretical model that attempts to bring more understanding to change in mature fields, such as healthcare. The authors investigate a large-scale, government-led reform in the healthcare field in Alberta via a qualitative case study to understand the process of field re-composition. Rather than trying to explain the sources of institutional change, they investigate how a field may become re-established after the implementation of radical institutional change. The Alberta healthcare field experienced a shift from the dominant institutional logic – medical professionalism – to another institutional logic called 'business-like' healthcare. Since the government wanted change to occur at the field level, posit the authors, it implemented legislation, so that the field's structure itself might change. Something similar happened with the HSCA (2012) reforms and the ensuing re-organisation of the NHS. Due to different funding mechanisms in Alberta, new actors appeared, while others were re-arranged. Both the field structure and the institutional logic changed, so that the new structure and the desired new institutional logic could be consistent with each other, opine the authors. In a later study (Reay & Hinings, 2009), the same authors see institutional change in Canada's healthcare as set within competing, co-existing logics. Their review of documents shows that the government and physicians were espousing different logics.

¹³ Institutional theory, claim Greenwood and Hinings (1996), sees organisational behaviour as a response not only to market pressures, but also to pressures from institutions – regulatory agencies (the state, the professions, etc.). Pressures coming from social expectations and from leading organisations in the field also may require organisational responses.

The documents from the Canadian physicians' association examined in the study accentuated on the physician-patient relationship. It is clear from the study that physicians were reluctant to being controlled by the government's logic of demanding more efficiency.

Changes in the strength, content, and permanence of logics-identity relationships among 'hospitalists' (physicians who specialise in the provision of care in hospital settings) in the US are examined in Pouthier et al. (2013). The term *hospitalist* emerged in the 1990s. At first, the hospitalist identity was theorised in terms of the previously existing logic of 'managed care.' In the following decades, the authors share, the term became dis-associated from managed care. They develop a process model of detachment or dis-association from an undesired identity. The trigger for this detachment process is found to be "a set of identity threats (Dutton & Dukerich, 1991; Elsbach & Kramer, 1996) and opportunities, which challenged the ability of hospitalists to maintain a positive identity in the eyes of other key stakeholders in the health-care field, and in their own estimation" (Pouthier et al., 2013, p. 205). In this study, hospitalists were found to respond to identity pressures via 'cultural differentiation' and 'social realignment' with key stakeholders, such as hospital executives and 'quality of care' movements.

Hospitalists' identities in the NHS are enshrined in a complex web of macro-level service and policy (Eve & Hodgkin, 1997): some hospitalists interact with politicians, local communities, managers, and patients. Hospitalists' leadership patterns and the resulting organisational outcomes, as well as the creation of new orders of disease worth, also shape identities and have attracted the attention of recent academic studies (Fitzgerald et al., 2013; Mason, 2014). In her study, the latter shows how commissioning practices in the post-HSCA (2012) world changed the valuation of public goods through the reframing of the notions of *sickness* and *health*. Feeling pressured to provide the 'most valuable' healthcare services, rather than a 'comprehensive' range of such services, Mason believes, clinicians doubtlessly face the identity challenge of being the ones deciding which health conditions in their areas are worth spending resources on.

In her study of clinical directors' (senior clinicians who have assumed managerial responsibilities over their colleagues) role in management and healthcare, Llewelyn (2001) opens up the debate on 'boundary' role identities and 'increased interchange' and communication between managers (with their logic of economic consequences) and clinicians (with their logic of professional appropriateness). Mintzberg's (1987) three main activity groups that characterise managers – interpersonal, informational, and decisional – all apply to the role of clinical directors. CCG commissioners, as well, engage in these three types of managerial roles: they meet with the public (interpersonal activity group), provide information to other parties (informational activity group), and make commissioning decisions (decisional activity group). The ILT, thanks to its concepts of institutional logics (business, governance, political, professional, and others) and the dynamic interplay among these logics (co-existing, competing, conflicting, complementing, etc.) naturally feels like an appropriate choice of theory for this research in which clinicians are found to be undertaking, statutorily, substantial administrative responsibilities.

5. Research methodology and methods

This paper employs a qualitative research methodology and assumes the interpretivist ontology. It uses a multiple method approach (Horn, 2009) and primary and secondary research data. The primary data come from twenty-one semi-structured, individual interviews with NHS clinicians and senior managers and accountants working for the NHS in England. The two different groups of interviewees may help shed different light on the possible answers to the research questions. The interviews were conducted in-person between September 2012 and September 2014 at the interviewees' places of work. The secondary data come from two government documents – DH (2010) and HSCA (2012). The secondary data are used for documents' content analysis. Official government documents, including white papers and pieces of legislation, are a good source to consider when trying to understand for example the appropriateness of clinicians' involvement in CCG commissioning. Such documents are often readily available online and represent the government's official views on a topic of interest.

5.1. Research design

The text of the white paper, DH (2010), and this of HSCA (2012) were analysed in terms of their content. Keyword searches were performed to find occurrences of words, such as 'GP,' 'consortia' (the original name of CCGs), 'general practice,' etc. The pertinent excerpts will be quoted in the data presentation and analysis section. They will also be analysed in light of the research questions. As to the interviews, Table 1 provides the interview guide. The researcher who conducted the interviews tried to ask most of the questions in this guide of each interview participant. Not all questions were actually asked of each interviewee due to time constraints, conversation flow, and relevance. Since the interviews were semi-structured, some additional questions not listed in Table 1 were also asked of some interview participants, mostly for clarification purposes.

The questions asked changed somehow during the fieldwork as time went on (some new questions were added and others deleted from the original guide) in order to accommodate new knowledge acquired by the researchers. A contributing factor to this flexibility of the guide was the relatively long time span of the fieldwork – about two years.

Table 1

Interview guide

Ice breakers:

- 1) Please tell me about your involvement in the NHS.
- 2) What was your involvement in commissioning before the most recent NHS reforms, if applicable?

Interview questions:

- 3) What is your involvement in the current commissioning system?
- 4) Do you think the reforms to clinicians' involvement in commissioning were necessary in this form and at this time? Why or why not?
- 5) In your opinion, how can the CCG system improve in the future?
- 6) What challenges have you experienced in CCG commissioning so far? Please provide some examples from your own (or others') experience.
- 7) What are the advantages of clinical involvement in commissioning? Please provide some examples from your own (or others') experience.
- 8) Do you think clinicians are in a good position to be the leaders of acute care (and other types of) commissioning? Why or why not?
- 9) Do you think clinicians are in a good position to handle duties, such as: priority setting, strategic planning, budget rationing, other accounting-related tasks, contract monitoring, etc.? Why or why not?

Concluding questions:

- 10) Anything else you would like to share?
- 11) Any personal contacts that you think might be interested in giving an interview for this research?

The interview subjects were categorised into two groups: 1) NHS clinicians and 2) NHS senior managers and accountants. A later section presents the chosen quotes from the clinicians as 'Views from the NHS clinicians' and the chosen quotes from the non-clinicians as 'Views from the NHS managers and accountants.' It was determined beneficial to interview both groups, as opposed to just clinicians, to have wider views on clinicians' involvement in CCGs. Besides, the response rate among the clinicians invited for an interview was rather low (about 8%). This was another reason why NHS managers and accountants were invited to give interviews, as well. Moreover, it was interesting to see whether the two groups shared the same or had differing views on the interview questions asked. Table 2 provides more anonymised details on the interview subjects, their organisations, and the dates of the interviews.

Table 2
Anonymised list of interviews

Interview number	Organisation (type)	Interviewee (type)	Job title	Date of interview
1	a (provider)	A (clinician)	Director of Clinical Finance	19 Sept. 2012
1	a (provider)	B (accountant)	Chief Financial Officer	19 Sept. 2012
2	b (provider)	C (manager)	Director of Business Development	20 Sept. 2012
3	c (provider)	D (manager)	Associate Director of Major Capital Developments	25 Sept. 2012
4	d (provider)	E (clinician)	Retired GP	28 Feb. 2013
5	f (commissioner)	F (clinician)	GP	22 March 2013
6	g (commissioner)	G (clinician)	GP, CCG Board Member	25 June 2013
7	h (commissioner)	H (accountant)	Head of Financial Strategy	5 July 2013
8	i (provider)	I (manager)	Former Chairman	29 July 2013
9	i (provider)	J (manager)	Current Chairman	29 July 2013
10	i (provider)	K (accountant)	Director of Finance and Deputy Chief Executive	29 July 2013
11	h (commissioner)	H (accountant)	Head of Financial Strategy	15 Oct. 2013
12	j (provider)	L (clinician)	Former Nurse, current Educator in Public Health	28 Oct. 2013
13	k (commissioner)	M (clinician)	Retired M.D., current Health Forum representative of the local population to a CCG	9 Dec. 2013
14	l (commissioner)	N (manager)	Head of Service Development, former CCG employee	19 Dec. 2013
15	m (commissioner)	O (clinician)	GP and Accountable Officer	23 Jan., 2014

16	n (commissioner)	P (accountant)	Director of Finance and former Director of Finance of a SHA	11 Feb. 2014
17	o (commissioner)	Q (clinician)	GP and Chair and Clinical Lead	28 Feb. 2014
18	p (commissioner)	R (manager)	Chief Officer (Accountable Officer)	5 March 2014
19	h (commissioner)	H (accountant)	Head of Financial Strategy	17 Apr. 2014
20	q (commissioner)	S (clinician)	Retired GP and CCG Governing Board member	19 May 2014
21	r (commissioner)	T (clinician)	GP and CCG Chair	3 Sept. 2014

The NHS managers interviewed were six, the NHS accountants – four, and the NHS clinicians (mostly working or retired GPs) – ten. Based on the literature review, the intuitive assumption is that the professional/medical, business, governance, and political logics are all at play in CCG commissioning. Common sense might dictate that the clinicians would adhere mostly to the professional/medical logic, while the NHS managers and accountants – to the business logic. The research data will shed more light on this issue.

5.1.1. Sampling, data collection, coding, and data reduction

This study is slightly longitudinal in nature since the data were collected over two years (see Table 2). It covers the time before and after the CCG reforms became effective – 1 April 2013. It has been recognised that while in quantitative research sampling is usually random, in qualitative research one should try to select a sample that represents the concepts, rather than the population (Maylor & Blackmon, 2005). Sampling is a technique used with many methods in order to reduce the amount of data that need to be collected down to a practicable amount. In other words, sampling makes research more manageable. Maylor and Blackmon recommend the use of either ‘theoretical’ or ‘purposive’ sampling where the maximum variety of responses, rather than the uniformity of responses, is valued. Similarly, this research uses purposive sampling as described next.

Regarding the quote selection from the secondary data, this stage involved reading through DH (2010) and HSCA (2012) and, for example, identifying instances that conveyed the government’s official views on the appropriateness of clinicians to be involved in CCG commissioning (Research Question 2). Only the most relevant parts of the two documents will be either cited directly or paraphrased below. With respect to the interviews, each of them lasted about forty-five minutes. All interviews were recorded with a digital voice recorder and transcribed verbatim using the Express Scribe software. This software was chosen since it allowed for the slowing down and fast forwarding of the MP3 recordings, to facilitate transcribing. As to the selection of the interview subjects themselves, interview invitations describing the research topic, the researchers’ affiliation at the time (the University of Essex in Colchester, England), the approximate length of the interviews, and a list of sample questions to be asked were sent out by email or first-class mail to potential interviewees. These were members of the governing bodies of CCGs in Essex, Suffolk, Norfolk, London, the Midlands, Cambridgeshire, Sussex, and other parts of England. These areas were judged to be at a reasonable distance from the location of the researchers. Interview invitations were also sent out to GPs working in GP practices near Colchester. CCGs and GPs’ contact information was found to be readily available online.

The invitations were sent out at intervals, just in case a large number of people from the last mailing batch responded positively to the interview invitation. One of the researchers tried to arrange an interview soon after an invitation was accepted. The interviews were conducted by this same researcher. Most invitations did not result in an answer, nor an interview. After each interview, the researcher conducting the interviews asked the interview subjects to provide some personal contacts who might also be interested in an interview.

A couple of these referrals did give an interview. The acceptance rate among clinicians and non-clinicians was about 10% (20 individuals actually gave an interview, while about 200 individuals were invited for an interview). This low acceptance rate was perhaps due to the fact that CCGs were still new at the time. Perhaps, most individuals invited did not feel prepared enough to answer the sample questions from the invitation letters. Or, given that GPs

and NHS managers and accountants have very busy schedules, it was probably difficult for them to accommodate a forty-five minute, in-depth interview. In fact, one GP responded that she could not participate in an interview due to her tight work schedule.

The interview transcripts were coded with the computer-assisted qualitative data analysis (CAQDAS) software MAXQDA10. This software allows the user to highlight text excerpts and assign to them codes by using colours and code descriptions. The coding was done in two stages (Saldaña, 2013). Descriptive coding was used. About eight descriptive codes were identified. Table 3 presents a sample list of the descriptive codes. Two levels of descriptive codes are sometimes used in the table. They are designated by the ‘_’ punctuation mark.

Table 3

Partial list of structural and descriptive codes

Structural codes	Descriptive codes
Research Question 2 Appropriateness of Involvement	Very appropriate_GPs know best; Inappropriate_GPs lack business training; Appropriate but not to this extent; etc.

After coding the interview data (Maylor and Blackmon, 2005; Crowther and Lancaster, 2009), data reduction was performed. Data reduction may be challenging – too much data reduction takes away from the richness of the data and too little data reduction might bring difficulties in analysis. Crowther and Lancaster (2009, p. 195) observe that data reduction is a subjective process; however, subjectivity is not a weakness in qualitative research. It adds depth to the analysis. In this paper, the data reduction was done with the help of data segment ‘weights,’ tools available in the MAXQDA10 software. The higher the weight assigned to a segment of transcribed text during the coding stage, the more likely this particular segment was to be used, as a direct quote or paraphrased, in the data presentation and analysis section. High weights were assigned to segments that either represented opinions shared by several interview subjects, or represented a unique, diverse view.

5.1.2. Data analysis rationale

Table 4 visualises the data analysis rationale of this research. The possible answers to Research Questions 1 and 2 are grouped according to: 1) the two government document examined, 2) the NHS managers and accountants, and 3) the NHS clinicians interviewed. This division was judged necessary because the intuitive expectation at the beginning of this research was that there would be fundamental differences among these three groups. The actors representing each group are generally thought to be guided by different rationales (the government – by the idea of ruling optimally a large and complex health service, the NHS managers and accountants – by the idea of achieving a value-for-money health service, and the NHS clinicians – by the idea of caring well for patients).

Table 4 contains two columns. The first column (on Research Question 1) lists ‘appropriate/somewhat appropriate/inappropriate’ as possible answers to the first research question. Of course, there may be nuances – very appropriate, appropriate, inappropriate, etc. In the second column (on Research Question 2), dotted cells were placed, so that to keep track of the various institutional logics entailed in GP commissioning. The ‘..... logics’ part in the second column is reserved for the type of logic (business, professional, governance and/or political) at play and the ‘..... nature of the relationship among them,’ i.e. among the logics, part in the same column is reserved for the particular interplay and dynamics among these logics.

Table 4

Data analysis rationale

Answers to Research Question 1	Answers to Research Question 2: Business, professional/medical, governance, and/or political logics (dynamics and interplay among the institutional logics)
1) According to the two government documents – appropriate/somewhat appropriate/inappropriate logics (..... nature of the relationship among them)
2) According to the NHS managers and accountants – appropriate/somewhat appropriate/inappropriate logics (..... nature of the relationship among them)
3) According to the NHS clinicians – appropriate/somewhat appropriate/inappropriate logics (..... nature of the relationship among them)

For example, if the research data were conducive to concluding that the professional/medical logic and the business logic were in a conflicting relationship with each other according to the NHS clinicians interviewed, then the appropriate cell in the second column of Table 4 would be filled in like this (see Figure 1):

Figure 1

Example of data analysis for Research Question 2

Professional/medical and business logics (conflicting logics)

This research presents an elaboration of existing theory, the ILT, and an empirical application of certain elements of this existing theory, to increase understanding of the subjects studied – clinicians (mostly GPs) in the newly-formed CCGs. It does not therefore attempt to contribute to theory development in any major way. Table 4 and Figure 1 facilitate theory application to a particular context in the English healthcare sector.

5.1.3. Research validity, reliability, and limitation

Research validity is “concerned with whether the findings are really about what they appear to be about” (Saunders, Lewis, & Thornhill, 1997, p. 82). These authors refer to a 1991 study by Easterby-Smith and colleagues, according to which the question ‘Will similar observations be made by different researchers on different occasions?’ may be used to assess the reliability of research findings. Given that the NHS is a big institution with 210 CCGs, each with very diverse populations, locales, practices, and outcomes, the answer to the above question will probably be ‘Maybe.’ It is hard to compare a CCG from London or Manchester with a CCG from a small rural area in Norfolk on a like-to-like basis. However, in qualitative research, research reliability is not such a highly treasured concept as it is in quantitative research. Qualitative research values mostly variability, depth of analysis, and subjectivity. In this kind of research, diversity, not consistency among populations, is valued more (Saunders et al., 1997).

According to the same source, there are four threats to research reliability: subject error, subject bias, observer error, and observer bias. Regarding subject error, one may find, claim the authors, that a questionnaire completed on different days of the week by the same subjects may generate different results. For example, a questionnaire filled out on Friday just before the end of the workday may show more optimistic attitudes than the same questionnaire filled out by the same person in the middle of the week when job duties often tend to be the most stressful. With respect to subject bias, one may notice that research subjects give the answers that they believe their bosses would like to hear, write the authors. Finally, observer bias is reduced when more than one researcher is involved in interpreting the results. The researchers made a genuine effort to reduce observer bias by trying to look as

objectively as possible at the data and analyse them free of personal biases. For example, when two contrary views were presented, the researchers quoted the two contrary views, not just the one they personally favoured.

Research limitations are an inherent weakness of any research, no matter what methods, methodologies or theories are used. This research also has its own research limitations. First, if different people had accepted the interview invitations, perhaps their answers to the interview questions would have been different from those of the people who actually gave an interview. Moreover, if the same people who were actually interviewed were asked the same questions at a different time or place, maybe their answers to these same questions would have varied, too (an example of the subject error discussed above). Second, CCGs are new and highly complex entities that involve a multitude of actors and structures; therefore, only certain of their aspects were studied here – the appropriateness of clinicians' involvement in CCGs and the dynamics among institutional logics in CCGs. Third, not all views expressed during the interviews were cited or paraphrased in this paper, just a selection of the most representative, interesting, diverse, controversial and/or thought-provoking ones. By no means does this mean that the views left uncited or un-paraphrased were unimportant. Lastly, as any other qualitative research, this research assumes a certain degree of researcher bias in terms of the analysis and conclusions drawn.

6. Data presentation and analysis

6.1. Views from the documents

The views presented here are these of the Coalition government expressed in the white paper (DH, 2010) and the new legislation – HSCA (2012). The government's rationale for adding healthcare commissioning to the usual duties of GPs and other clinicians in England was first announced in that white paper. The white paper and the resulting legislation are expected to have a long-lasting and profound impact on the English NHS.

The white paper states that,

Doctors and nurses must ... be able to use their professional judgement about what is right for patients. We will support this by giving frontline staff more control ... Of course, our massive deficit and growing debt means there are some difficult decisions to make ... But far from that being reason to abandon reform, it demands that we accelerate it. Only by putting patients first and trusting professionals will we drive up standards, deliver better value for money and create a healthier nation (DH (2010, p. 1); **Quote 1**).

It also states:

The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia [the original name of CCGs] (p. 4; **Quote 2**).

Moreover,

In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning services to local consortia of GP practices. This change will build on the pivotal and trusted role that primary care professionals already play in coordinating patient care ... Primary care professionals coordinate all the services that patients receive, helping them to navigate the system and ensure they get the best care (of course, they do not deliver all the care themselves). For this reason they are best placed to coordinate the commissioning of care for their patients while involving all other clinical professionals who are also part of any pathway of care ... Commissioning by GP consortia will mean that the redesign of patient pathways and local services is always clinically-led and based on more effective dialogue and partnership with hospital specialists. It will bring together responsibility for clinical decisions and for the financial consequences of these decisions. This will reinforce the crucial role that GPs already play in committing NHS resources through their daily clinical decisions – not only in terms of referrals and prescribing, but also how well they manage long-term conditions, and the accessibility of their services. It will increase efficiency, by enabling GPs to strip out activities that do not have appreciable benefits for patients' health or healthcare (p. 27; **Quote 3**).

Based on these three quotes, one can see that the Coalition government really trusted clinicians, NHS frontline workers, in a time of deficit and growing national debt. It saw them as 'best placed to coordinate the commissioning of care' for patients.

The second document, the HSCA, s. 25(1) (2012), mandates that “each provider of primary medical services ... [be] a member of a clinical commissioning group” (**Quote 4**). According to the same subsection, each CCG must have a constitution of its own and a governing body. The main functions of the governing body are “to ensure that the group has made appropriate arrangements for ensuring that it complies with ... its obligations ... and ... such generally accepted principles of good governance as are relevant to it” (**Quote 5**). A GP-led CCG may have its own employees and may also hire others (for instance, non-employees from CSUs) to provide services on its behalf.

The legislated duties of CCGs, according to the HSCA, s. 26 (2012), are various in nature and cover a wide spectrum of issues. A CCG, among other things, needs to: promote the *NHS Constitution*, “exercise its functions effectively, efficiently and economically” (**Quote 6**), improve the quality of services “in connection with the prevention, diagnosis or treatment of illness” (**Quote 7**), obtain appropriate advice “from persons who (taken together) have a broad range of professional expertise” (**Quote 8**), advocate public involvement and consultation, publish commissioning plans and annual reports on a regular basis and present the annual report to members of the public. The business emphasis of CCG duties is evident in the HSCA, s. 27 (2012) which states that a CCG “must ensure that its capital [and revenue] resource use in a financial year does not exceed the amount specified by direction of the Board [i.e. NHS England]” (**Quote 9**).

According to Schedule 2 of HSCA (2012), a CCG must have an Accountable Officer appointed by NHS England. One of his duties is to ensure that the CCG “exercises its functions in a way which provides good value for money” (**Quote 10**), another requirement inspired by business reasoning processes. Schedule 2 also provides for an optional auditing provision: the “[the] accounts prepared ... must be audited in accordance with the Audit Commission Act 1998 by an auditor or auditors” (**Quote 11**). Based on the above quotes from HSCA (2012), one can see that clinicians were entrusted with many important commissioning duties by the government at the time. HSCA (2012) is more technical and procedural in nature than the white paper and does not go into details about the rationale for choosing clinicians to be involved in CCGs the way the white paper does.

6.2. Views from the NHS managers and accountants

GPs were perceived by several managers and accountants as not being strategic enough to commission well. It was implied that being strategic was a key skill for a good commissioner. Interviewees H, N, and J shared the perception that GPs were not very strategic in CCGs due to the fact that their professional training was not business training, but one based on a medical doctor-patient, individual-level relationship.

Interviewee H said:

Hm, in theory it’s a good idea [for GPs to be involved in commissioning] because they would be the clinical leaders of the system and all healthcare starts with primary care. In practice, it’s extremely variable because the quality of primary care is extremely variable and hasn’t really been addressed through the new contract (Interview 7; **Quote 12**).

Interviewee H also shared:

No, they [GPs]’ve had no [business] training whatsoever other than some kind of corporate development support, but it’s no way near enough. So, a lot of them don’t really know how to run a legally-constructed public organisation and what the governance rules are, how boards should operate, how conflicts of interest should work, the roles of the Chair, the Accountable Officer, CFO ... So, quite a lot of them are quite inexperienced and it will take some time for them to gain that experience. And they also’ve got a tendency to do what are called ‘silo gazing.’ They look inward to their own organisation, not outward, at strategic level (Interview 7; **Quote 13**).

Interviewee N said the following:

I think GPs ... their professional culture is one of independence. So ... managing large organisations is quite difficult for them. I also think there are gaps in their knowledge and skill in terms of some of the managerial aspects of commissioning. Hm, but on the positive side, I think they do bring, they certainly bring some practical experience to the discussion. And they tend to, they also, in some cases, bring some analytical skill, as well. But I don’t think, generally, they are very strategic (**Quote 14**).

Interviewee J expressed the following opinion:

I think they, the whole CCG lacks vision and strategy, so I think that’s an area where management would help them develop. I think it was always going to be the case that the CCGs would have to have managers and a Chief Executive who is experienced and so on. And I think Andrew Lansley really in initiating the changes didn’t make that plan. So, people got very concerned about GPs running a huge budget and never having any experience (**Quote 15**).

From the four quotes above, one can see that some managers and accountants expressed sceptical views on the issue of how appropriate it is for clinicians to be involved in CCG commissioning. They mentioned that clinicians lacked management training and skills, that ‘they ... [were] not very strategic,’ and that they were too engaged in ‘silo gazing.’ Besides, GPs were perceived to be not ‘all at one voice.’ The interview data seemed to suggest that there was a lack of consensus among clinicians with respect to how to commission care. Interviewees B, J, N, and R all agreed that GPs were not always in agreement with one another in terms of commissioning practices. Interviewee B shared:

And they are making collectively decisions about commissioning, I think they find amongst themselves ... that would be really challenging because they haven’t really had to think in that way collectively before. I think that those who are leading the CCGs are starting to find that particular challenge. They’ve got GPs who aren’t all at one voice (**Quote 16**).

Interviewee N disclosed that “not all the GPs [in his area] ... [got] on [well] with each other [laughing]. So, they decided to have two groups” (**Quote 17**). Interviewee J mentioned:

Hm, one other thing is there is a general consensus, a general view, that CCGs are being run by GPs, represent GPs’ views generally, and can get GPs to do things. That’s not true. You know, the CCG struggles more to get the GPs to align to their commissioning intentions than they do to get acute hospitals to. So, we are very keen to introduce for example integrated care for the elderly but the GPs are not so keen. When the commissioners (the CCGs) commission a pathway, the GPs don’t all buy into it. They do their own thing (**Quote 18**).

Interviewee R shared:

[T]here’s quite a lot of rivalry between practices. They are very competitive with each other ... Or, actually, for micro-businessmen [they are] quite competitive between each other ... But I find it causes me more problems managing ... between them [GPs] ... This does cause friction between them (**Quote 19**).

It seems that even if it may be appropriate for clinicians to be involved in commissioning, *how* exactly they are involved and *how* exactly they commission are other issues that bring with themselves more complexities – disagreements among clinicians, competitiveness, and sometimes friction. Now, let us turn to the clinicians’ views.

6.3. Views from the NHS clinicians

Interviewee A, a hospital medical specialist, shared:

[I]t’s an experiment ... And that’s quite a high risk experiment, one of the higher risk things that the government have done. If it works, what it will allow is GPs, potentially, to redesign care pathways, so that patients always don’t go to secondary care which is generally quite an expensive option. And so, if an elderly patient is having multiple falls, they often come to the hospital and spend a week in hospital, whereas they would be better managed in a non-hospital setting. So, the ideal is the people who know when it’s best to design a pathway are in charge of it; whereas, previously there was a lot of inertia in the system because the GPs didn’t really have much financial responsibility and therefore were doing what was the easiest thing which is to send the patients to hospital. Now they’ve got financial incentivisation, not necessarily personally, but because they have to live within a constrained budget, they might do something differently (**Quote 20**).

Interviewee O, a GP, suggested that it was appropriate to build a ‘synergy’ between clinicians and managers in order to have a successful commissioning system:

Hm, I think ... the big advantage of clinical commissioning is it says to the clinicians, ‘You are responsible for the whole of your health system.’ So, if it’s not working, you are able to do things to put it right, you are able to take control, whereas previously in PCTs, it was not necessarily just the PCT that stepped back from engaging clinicians. It was sometimes the GPs and other professionals who stepped back from their responsibility. So, by putting it on the shoulders of the clinicians and saying, ‘You use the tools that you need to sort it out’ ... and what we find is that it is a partnership between clinical leaders and expert managers and it doesn’t work with one or the other on their own. It has to be that synergy (**Quote 21**).

Interviewee O shared:

So, I would much rather have inherited the end-to-end responsibility of the PCT but with that requirement that it is the responsibility of the local clinicians to make it work. And then we would make sure that we have the managerial expertise in the organisation to discharge that responsibility. But we would then have been able to influence the whole system, whereas now we can only influence parts of it ... [F]or example we don't commission general practice, we don't commission specialist services, we don't commission forensic services, things like that. And all of those have an impact. It's not, none of these exist in isolation, they all interrelate. The problem at the moment is that my priorities as a commissioner may not align with the priorities of the commissioners for the other system (parts of the system) but impact my population. So, public health going off to local government for example has created a big dis-connect in what was a very successful strategy between public health and health services' commissioning, where the PCT quite rightly had chosen to put more investment in public health than elsewhere. But what's happened is that then disappeared out of our control (**Quote 22**).

Interviewee G, a GP, said:

When CCGs were formed, one of the key reasons for its formation was that NHS was running with cash starvation. And they had to find new ways to control the cost but at the same time make sure that the quality and services are well preserved and I think that giving it in the hands of clinicians addresses that focus and especially at our CCG level, the clinicians *are* in charge and they think more rationally, innovatively, to find the quality of care and to produce efficiency, so when there is like a war, people are at their best. So, when you have less money, to produce the same results, you have more innovation, and you think more differently to address those problems (**Quote 23**).

Interviewee E, a retired GP, said:

But I mean most doctors will say, 'I am the clinician. I've been trained to treat people and care for people. Somebody else should be dealing with how all this is funded and how it might maximise the value of the service at the lowest cost level to the organisation ... I think, probably two aspects of that, really. Doctors by and large have sort of common sense financial management you might get from running your own home. Doctors are not trained in financial management and therefore I think they probably have only a limited capability in these Clinical Commissioning Groups 'cause they are not used to dealing with, you know, multi-million pound budgets. I think most doctors see their skills as treating their patient population and knowing what the needs of their own patients, individual patients are, rather than knowing the needs of a wide population, you know, in a big city. I think the other thing that is starting to come out of this really is that if you have the GP as a service provider and also the GP as the purchaser of the services, you've got the GP trying to act in both roles. They are trying to provide the service at the coalface, if you like, for their individual patients. But that same GP may be involved in budget allocation. And I think there is a potential conflict of interest there that you are both a provider and a purchaser, the person who's deciding what sort of service provision needs to be bought from various health areas (**Quote 24**).

In agreement with the NHS managers and accountants from above, Interviewee E doubted the 'financial management' skills of clinicians. This interview was conducted in early 2013, before CCGs became operational, so the reference to 'conflict of interest,' conflict which has been somehow mitigated later on, was a relevant issue at the time. Interviewee G was more optimistic about clinicians' aptness to commission well – in his CCG, 'the clinicians ... [were] in charge and they ... [thought] more rationally, innovatively.' Interviewee A suggested that GPs would be careful commissioners due to the fact that now they were given more 'financial responsibility.' Interviewee O accentuated on the fact that a 'partnership' between clinicians and managers would be appropriate in commissioning and lamented the fact that now clinicians could only 'influence parts of it [the system],' unlike PCTs which could influence bigger parts of the system.

7. Discussion

The objective of this research was to discuss and explore the nature of GPs and other clinicians' involvement in the new CCGs in England. The institutional field studied was healthcare commissioning. The first research question was 'How appropriate is it for clinicians to be involved in CCG commissioning?' Three possible answers to this question were provided according to: 1) the two government documents examined – DH (2010) and HSCA (2012), 2) the NHS managers and accountants, and 3) the NHS clinicians interviewed. First, according to the two government documents, the answer to this research question would most likely be that it is *very appropriate* for clinicians, most of whom GPs, to be involved in CCG commissioning. Family doctors were found to be 'best placed' for commissioning, according to the 2010 white paper.

This document stated that doctors and nurses had to use their ‘professional judgement about what ... [was] right for patients’ and that trusting these professionals would ‘drive up standards.’ Besides, GPs were seen as ‘the healthcare professionals closest to the patients.’ Additionally, GPs ‘coordinate all the services that patients receive, helping them to navigate the system...’

By mandating a membership in a CCG for all GPs in England via HSCA (2012), the Coalition government once again expressed the idea that it was highly appropriate for clinicians to be involved in healthcare commissioning. The government did not loosen its stance on commissioning by possibly allowing GPs to opt out of CCG membership (Timmins, 2013). On the contrary, it reinforced its idea that clinicians were very appropriately placed to commission care. By ensuring that a CCG’s ‘capital [and revenue] resource use ... [did] not exceed the amount specified by direction of the Board...,’ the Coalition government pledged its faith in the calculative abilities of CCGs. Moreover, CCGs should provide ‘good value for money’ and its accounts should be ‘audited,’ according to HSCA (2012).

Second, according to the NHS managers and accountants interviewed, the answer to the first research question would be less straightforward than this according to the two documents examined. The answer would perhaps be that *it is questionable* whether clinicians should be involved in CCG commissioning to the extent that they are in fact. Clinicians, mostly GPs, are in the driving seat of commissioning. They are the leaders of CCGs. The reason for the above use of the word ‘questionable’ is that GPs were seen by several managers and accountants as having ‘no business training,’ as ‘quite inexperienced’ in commissioning, as involved in ‘silo gazing,’ as not ‘all at one voice,’ and as ‘very competitive’ with one another. Interviewee H saw this involvement as good in theory, but not in practice. Thus, based on the interview data, the managers and accountants interviewed did seem to share the view that it was highly challenging and perhaps *not very appropriate* for clinicians to be involved *in leadership roles* in CCG commissioning.

Third, according to the clinicians, the answer to the first research question would be that it is *not very clear whether it is appropriate* for clinicians to be involved in CCG commissioning. This is to say, there were views that evoked either perceptions of appropriateness or inappropriateness of involvement. For example, Interviewee A suggested that it would be appropriate for clinicians to be involved in commissioning because more ‘financial responsibility’ was now placed in their hands than before. Because of this, now clinicians thought more carefully before referring a patient to expensive hospital care. Interviewee O also spoke about clinicians’ responsibility for the ‘whole ... health system’ and emphasised the fact that partnerships among ‘clinical leaders and expert managers,’ not just among clinicians, were vital to CCG commissioning. Clinicians, therefore, were found not to be alone in commissioning. Interviewees O and E, respectively, spoke about a major challenge that made clinicians’ involvement difficult – the disintegration of commissioning. Interviewee O said: ‘[N]ow we can only influence parts of it [commissioning].’ Interviewee E shared about the lack of management training among GPs: ‘Doctors are not trained in financial management and therefore ... have only a limited capacity in these Clinical Commissioning Groups.’

The conclusions drawn from the use of the two research methods (document analysis and interviews) seem to be divergent. First, the Coalition government categorically tended to lean toward appropriateness, while the people directly affected by CCG commissioning – the NHS managers, accountants, and clinicians – had more diverse or polarised views. This is perhaps due to timing – the white paper and HSCA (2012) date from 2010 and 2012, respectively, while the interviews took place in 2012-2014. The two documents had laid out the *theory* behind CCG commissioning before it actually became operational. It is only natural then that these two documents tended to be more optimistic and idealistic than the views of the interviewees expressed later.

The second research question was ‘What institutional dynamics and interplay characterise clinicians’ involvement in CCGs?’ The NHS managers and accountants tended to be the most sceptical ones of the three groups (the two documents, the NHS managers and accountants, and the NHS clinicians) in terms of the nature of the institutional dynamics unfolding in CCG commissioning. According to the two documents, there were *harmonious* dynamics among the four institutional logics examined. Based on the interviews with the NHS managers and accountants, the traditional professional/medical logic which GPs have always adhered to seemed to be perceived as being mostly *in conflict* with the business and governance logics (Quotes 13, 14, and 16). GPs have not been trained to handle, in a governance capacity, millions of pounds of healthcare budgets. Besides, Quotes 17, 18, and 19 suggested that there were also internal conflicts among GPs themselves, i.e. conflicts within the professional/medical logic itself.

The NHS clinicians tended to see themselves in a more positive light, as agents of change who would do something differently once there is a financial incentive to do so (Quotes 20 and 21). A more pessimistic view was expressed in Quote 24, in which the interview subject saw a *conflict* between the medical and the business logic in CCG commissioning. Quote 23 was more optimistic and put more faith in clinicians as commissioners since they were perceived as more innovative thinkers than managers are. Table 5 presents a summary of the research findings.

Table 5**Summary of research findings**

Answers to the Research Question 1	Answers to Research Question 2 Dynamics and interplay amongst institutional logics (business, medical, governance, and political)
According to the government documents – <i>very appropriate</i>	Business, medical, governance, and political logics (Clinicians' involvement in CCGs is very appropriate – <i>harmony</i> among all four logics.)
According to the NHS managers and accountants – <i>unclear or not very appropriate</i>	Business, medical, and governance logics (It is questionable whether clinicians' involvement is the right thing to have – mostly <i>conflict</i> between the medical and the business and governance logics.)
According to the NHS clinicians – <i>unclear or not very appropriate</i>	Business, medical, and governance logics (It is not very clear whether clinicians' involvement is appropriate – <i>harmony</i> and <i>conflict</i> between the medical and the other three logics.)

An important foundation of CCG commissioning, as it was demonstrated earlier, is the purchaser-provider split. GP-commissioners and CCGs would not have existed in the absence of this split. “The division of the health service into purchasers and providers has been a cornerstone of governments’ health policies for almost three decades. However, recent months have seen its value called into question by several high profile individuals within the NHS” (Clover, 2013). According to this source, the *Health Service Journal*/Capsticks Hospital Chief Executives Barometer survey asked the leaders of English hospital trusts to rate how useful the purchaser-provider split was to their health economies. The average rating of all forty-five respondents was 3.1, with 1 being ‘not at all useful’ and 10 being ‘very useful.’ No respondent gave more than an 8 rating. A chief executive of a NHS foundation trust wrote in this survey that while leaders of NHS hospitals wanted to focus on delivering the best services to their patients, they were often “frustrated by the amount of time they ... [had] to spend negotiating contracts with commissioners and navigating the added complexity this ... [brought]” (*Ibid.*). One has to bear in mind that this survey was administered in the early years of CCGs. The CCG landscape might have experienced a lot more changes since then.

In a 2013 interview with the *Health Service Journal*, Sir David Nicholson said that NHS England was already “thinking about the possibility of mutual [organisations and] social enterprises, and also about whether the straightforward commissioner-provider split ... [was] the right thing for all communities” (West, 2013). He also called on the service to look more closely at the U.S. healthcare organisations, Geisinger and Kaiser Permanente, which served as both an insurer *and* provider for a defined membership. He added “We need to be much more creative about those sorts of models of integration, which go beyond simple provider integration” (*Ibid.*).

8. Conclusion and suggestions for future research

This paper discussed the topic of the degree of appropriateness of clinicians to be part of CCG commissioning in a leadership capacity in England according to: 1) two government-issued documents – DH (2010) and HSCA (2012), 2) NHS managers and accountants, and 3) NHS clinicians, most of whom GPs. There was a noticeable variability of answers to the two research questions. The government tended to lean toward high appropriateness of involvement, while the NHS managers and accountants gave differing opinions. The clinicians themselves were somehow polarised regarding this issue that directly affected their work. They were not all at one voice.

So, what is the future of CCG commissioning? If indeed the English NHS moves to a privatised, insurance-based system like the one in the U.S., the duties of CCG commissioners, whether performed by clinicians or not, will most likely transfer to health insurance companies and/or provider hospitals. Perhaps, the early signs that the English NHS is moving toward a U.S.-inspired private model of care provision are not too far from sight. It is probably too early to speculate when exactly this would happen. HSCA (2012) is a piece of law, not just a Department of Health policy. Legislation is hard, but not impossible, to undo.

It is recognised that this research may be extended in the future, so that it may cover other important issues besides the question of the appropriateness of clinicians' involvement in CCG commissioning. Issues, such as: the localism agenda of neo-liberalism embodied in CCGs, the changing work identities and practices of clinicians in CCGs, the way CCGs are implicated by the work of the new Health and Wellbeing Boards and NHS England, and many more. Another area of future research may be to examine the contemporary state of commissioning in other public sector fields and countries, not just in English healthcare. Social care, education, and infrastructure would be interesting to explore, to list just a few. Besides, the issue of the eventual full-blown privatisation of the tax-funded and free at the point of service English NHS is never too unengaging a research topic.

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