PRIMARY CARE TRUSTS AS COMMISSIONERS OF SECONDARY CARE: THREE CASE STUDIES

by

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Abstract

This thesis considers the commissioning of secondary care by Primary Care Trusts (PCTs). It provides an in-depth analysis of the commissioning relations and decision-making between PCTs and NHS Trusts using the underlying assumptions of principal-agent theory as a lens for investigation.

This qualitative research adopted a range of methodological approaches including the use of observation, interviews and documentary evidence in the analysis of three case studies. The case studies each comprised an NHS Trust and up to four PCT commissioners. Commissioning-related meetings were observed in order to gain an understanding of the ways in which PCTs and NHS Trusts acted as principals or agents, and how these relations were managed. These were followed by interviews with managers and clinicians from primary and secondary care to complement the observational data and to investigate additional issues such as the impact of multiple principals and tiers of principals and agents. Service and Financial Framework documents and Service Level Agreements were also examined.

Analysis shows that commissioning was approached in a different way in each case study. The factors affecting the approaches to commissioning were perceptions of local and national pressures, accountability, a public service ethos, leadership, trust and local history.

Incentives were not used in Service Level Agreements. In each case study, there was a weak link in the principal-agent chain of commissioning that had the potential to result in non-compliance with decisions. This weakness arose either between commissioner and provider, or between managers and clinicians. In either case, the greater use of incentives is suggested as a solution. Some PCTs did not appear to accept the legitimacy of their roles as commissioners. In addition, and unusually, the principals had an agent role; PCTs were providers as well as commissioners. These dual roles created conflicts of interest.

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Chapter One: Introduction

1) The research question

This research is concerned with the National Health Service (NHS) in England. The aim is to provide an in-depth analysis of primary care trusts (PCTs) as commissioners of secondary care services using the underlying assumptions of principal-agent theory as a lens for investigation. The specific objectives include an evaluation of how (and indeed whether) PCTs and NHS Trusts act as principals and agents respectively, an investigation of the importance of key elements of principal-agent theory to the commissioning process, an analysis of how PCTs align NHS Trusts' objectives with their own, and an illustration of the impact on commissioning styles of external and contextual factors such as multiple principals and vertical tiers of principals and agents.

Principal-agent theory deals with problems associated with delegated choice. Delegated choice involves one individual (the agent) having the responsibility for decisions that are in the interests of one or more others (the principal) in return for some form of payment. As well as being in the interests of the principal, the agent's actions affect their own welfare. The challenge for the principal is to set payment schedules or devise other forms of incentives that encourage the agent to make decisions in the best interests of the principal.

Principal-agent relations in the NHS and elsewhere are ubiquitous. The population in general can be viewed as the ultimate principal, electing a government on a mandate to deliver its promises. The government is therefore an agent for the electorate. The government, however, being a management body without the capacity to provide what the population desires, must in turn play the role of principal. It must contract with other agencies to deliver services. These other agencies become agents for the government. In the case of the NHS, a chain of such principal-agent relations exists. The tiers of this chain have been reduced recently with the abolition first of regional offices and then Directorates of Health and Social Care. From the Department of Health, the chain now proceeds directly to Strategic

Health Authorities (StHAs), through PCTs and NHS Trusts to clinicians and other frontline staff. At the end of this principal-agent chain, however, are more principals, in the form of patients. That is, patients enter into informal contracts with doctors as their agents to deliver appropriate health care. The patient-doctor relationship is referred to commonly in research as a principal-agent relationship. When viewed in this way, one could turn upside down the chain just described. Doctors and other frontline staff could be viewed as principals, demanding of their employing bodies the finances and capacity necessary to deliver care. To add to the complexity, the relationship between a doctor from a PCT and one from an NHS Trust could be viewed as a principal-agent or agent-principal relation, depending on the nature of the request and the individual making the request. For example, when a general practitioner (GP) makes a referral request, the NHS Trust doctor acts as agent. After discharge from hospital, an NHS Trust doctor will request that the GP carries out certain aspects of care; in this case, the GP is the agent.

Principal-agent theory's central concern is how a principal can persuade an agent to perform in a way that satisfies the principal's requirements. Similarly, for commissioning in the NHS, a foremost point of interest is influence; how can a PCT use negotiation, contracts, incentives, and monitoring to ensure providers shape their services to reflect the needs of the PCT? In this case it is the PCT that is the principal and the NHS Trust its agent.

There are many parallels between theory and policy. As I will demonstrate, the assumption is made in policy documents that PCTs are principals with both NHS Trusts and GPs as their agents. The methods PCTs are expected to use to influence their NHS Trust agents are contracts and collaboration. PCTs are expected to set contracts, labelled Service Level Agreements (SLAs), with NHS Trusts for the delivery of services. In particular, *Reforming NHS Financial Flows* (Department of Health, 2002c) refers to contract negotiation, target setting, the provision of incentives and monitoring as the means for managing the continuous cycle of commissioning between PCTs and NHS Trusts. PCTs are expected to do this within an environment of collaboration and partnership working whilst remaining accountable to the centre through a hierarchical structure.

Whilst large-scale surveys are essential for the insights they can offer about the scope and pace of change, and they can help NHS organisations to compare their

own development with those of others, they do less to help immature organisations such as PCTs learn how to improve in their roles or indeed to understand the impact of local contexts and other organisations on their development.

This research addresses these issues; it demonstrates to PCTs and NHS Trusts, in detail, the ways in which their counterparts in three case studies relate to each other with respect to commissioning secondary care services. It draws out the common factors that affect the attitudes towards and processes of commissioning. It is a time of transition in the NHS. Newly formed organisations are finding their way and learning new roles. This thesis provides new insights by applying a principal-agent perspective using qualitative methods to the evaluation of commissioning. This is an attempt to look inside the black box and consider how organisations play out their roles. PCTs, NHS Trusts and other organisations that take part in commissioning processes will be able to use the findings of this research to develop their own commissioning styles in an informed manner.

2) The format of the dissertation

Chapter two has five main sections. Section one begins with an outline of the formal model of principal-agent theory. This is followed by a discussion of its empirical application, which is through models of hidden-action and hidden-information. Each of the key elements of principal-agent theory is then described, followed by an overview of how its main assumptions bring these elements together. These elements and assumptions form the basis of investigations in the thesis. The second section of chapter two gives an overview of NHS policy and draws parallels between the principal-agent framework and current policy. Next, a section shows how, although principals and agents are treated as if they exist within market-like structures, the language of principal-agent theory can be applied to organisational structures other than markets and quasi-markets, namely hierarchies and networks. The remainder of the chapter reviews the research literature to date, in section four, on how principal-agent and other theories have been used in evaluations of health care organisations and, in section five, on commissioning by primary care organisations in the UK.

Chapter three gives the aims, objectives and methods of the thesis. It begins by detailing the general aims and specific objectives of the research, and shows how this research adds to current levels of knowledge. The majority of the chapter describes the research methods. The overall research strategy is explained. This strategy consisted of case study analysis using qualitative methods encompassing observations, interviews and documentary analysis. The details of and the reasons behind the selection and recruitment of the three case studies are then given. The next section presents the data collection methods and participants. It details the purpose, format and attendance at commissioning meetings, how subsequent interviewees were selected, and gives the characteristics of these interviewees. The content of the interview guides and the documents provided by the case studies are reported. Chapter three finishes with descriptions of the data coding and analysis techniques.

Chapter four presents the main findings from this research. These results arise directly from investigations guided by the assumptions of principal-agent theory given in chapter two. The first section asks whether PCTs set incentive-based contracts for their NHS Trust agents. This question is answered through examination of Service Level Agreements for 2002/3 and interviewees' beliefs about the purpose of these contracts. Section two examines how NHS Trusts' objectives are aligned with those of their PCT principals by investigating the decision-making within, and the format of, commissioning meetings. The third section considers how, why and how successfully groups of PCTs work together to commission services from a single NHS Trust. The data in this section are derived from interviews with managers and clinicians, supplemented with observations of meetings. Finally, the effects on commissioning of multiple tiers of principals and agents are considered through the analysis of interview data. Sections three and four include also a discussion of why there are differences and similarities between the case studies.

Chapter five offers a summary and discussion of the results. It begins with an overview of the findings and draws out the elements of each case study that conform to the expectations of a principal-agent model and those that do not. Section two discusses the main influences on the commissioning relationships in these case studies and places the findings in the context of the broader literature. Policy

recommendations based on these findings are then suggested. The following section discusses what constitutes a successful commissioning process, how successful these case studies were in that process, and speculates on the impact on each case study of the proposed policy recommendations. The chapter finishes with some limitations of the research.

Chapter six offers a brief conclusion. This summarises the study and sets out its contributions to knowledge. A final section offers some thoughts about areas where further research would be advantageous.

Chapter Two: Principals, Agents and Commissioning

This chapter reviews the appropriate literature. It gives first an account of principal-agent theory, both as a formal model and an empirical framework. The second section offers an overview of the commissioning-related reforms in the NHS since 1991 and shows how current policy parallels closely a principal-agent approach. Section three considers the relevance of the language of principal-agent theory to non-quasi-market structures, that is, to hierarchies and networks. In the fourth section, recent research is reviewed that has used a principal-agent framework as a lens for analysis. The use of new institutional economics and trust as frameworks of analysis are also discussed in brief. Finally, section five reviews knowledge to date about commissioning by primary care organisations in the form of fund-holding practices, total purchasing pilots and primary care groups and trusts.

1) Principal-agent theory

Problems associated with delegated choice form a large and important area for economic analysis (Rees, 1985a) and other disciplines (see Kiser (1999) for a review from political science and sociological perspectives). Delegated choice involves one individual (the agent) having the responsibility for decisions that are in the interests of one or more others (the principal) in return for some form of payment (Arrow, 1986; Rees, 1985a). As well as being in the interests of the principal, the agent's actions affect their own welfare. The challenge for the principal is to set payment schedules or devise other forms of incentives that encourage the agent to make decisions in the best interests of the principal. Rees (1985a) notes that the theory is applicable to a wide class of problems. He suggests as examples situations where formal delegation relationships are not involved explicitly (a firm handling dangerous chemicals will take decisions which affect the likelihood and extent of damage which would be caused to others by an accident, despite there being no formal relationship with those potentially affected) or where the term contract is defined broadly (some employment relations may be characterised by implicit contracts).

Principal-agent theory can be interpreted both descriptively and normatively. Descriptively, it can be interpreted as an attempt to explain the characteristics of exchange relations observed between principals and agents in the empirical world (Arrow, 1986; Rees, 1985a). Normatively, it can be used to illustrate the optimal forms of contract that should be devised under differing assumptions about the information available to or acquired by the principal or agent (Rees, 1985a), that is, it can be interpreted as advice in the construction of contracts to influence principal-agent relations (Arrow, 1986).

Principal-agent theory is used in this thesis descriptively, that is, to explain and evaluate the characteristics of exchange relations observed between primary care trusts and NHS Trusts.

This section of the review summarises first the formal model of agency and theoretical analysis in mainstream economics. Second, the empirical interpretation of agency theory is considered. The key elements of the empirical model of agency are discussed, in particular their relevance to the NHS and, finally, the key assumptions of the theory are presented.

a) The formal model of agency

Mainstream economics has concentrated on theoretical modelling to devise optimal payment schemes given various extensions to the basic model. It is not the purpose of this thesis to devise optimal payment structures, and this extensive literature is not described here. Instead, a brief explanation of the standard, formal model is offered.

Rees (1985a; 1985b) explains the theory of principal and agent and extensions to the basic problem. The theory is intended to apply to any situation with the following structure.

The agent (an individual A) chooses an action (a) from a given set of actions ($\{a\}$). The outcome resulting from this choice is x. However, this outcome depends also on the state of the world (θ) at the time the action is taken. The state of the world is uncertain. The outcome (x) affects not only the utility of A, but also the utility of the principal (P). P defines a contract in which s/he agrees to reward A an amount y in return for output x. The utility of A depends on the value of y and that of a.

P is assumed to be risk neutral or risk averse and to have a utility function $u(x,y)$. That is, P's welfare depends on the money value of the outcome they receive from A and the payment they make to A for that outcome. P would prefer not to take risks. A is also risk neutral or risk averse and has a utility function $v(y,a)$. A's welfare depends therefore on the payment they receive from P and the effort that is expended to produce the output for P (Dixit, 2002). Action (a) is assumed to have a negative effect on A's utility, but a positive effect on P's utility. The positive effect on P's utility arises from the probability of achieving any given outcome being higher the higher the level of effort (action) by A (Arrow, 1986). A acts to maximise his/her own utility. P is indifferent to A's choice of a; P is concerned only about the net value of the outcome, that is, the value of the outcome minus the payment made to A. The difference between P's welfare when there is full information or where P and A have identical objectives, and when this is not the case, is known as the agency cost (Dusheiko *et al.*, 2001).

The state of the world (θ) is taken from a set of states of the world ($\{\theta\}$). An important assumption of principal-agent theory is that both P and A have identical beliefs about the probability of the state of the world (Rees, 1985a). This is potentially restrictive as A may in fact have better information about the state of the world than P (Rees, 1985a). Outcome (x) is dependent on both the state of the world, and the action taken by A. That is, $x=x(\theta,a)$. In addition, other (often imperfect) information (z) is used. This additional information may be acquired from monitoring, which is costly.

The basic principal-agent problem can therefore be stated as follows. The principal must choose a payment schedule that depends on outcome, the state of the world, the action taken by the agent and other available information. In the notation used above, $y=y(x,\theta,a,z)$.

A further assumption of principal-agent theory, according to Rees, is that payment schedules can depend only upon variables that both P and A can observe (Rees, 1985a). It is assumed that A knows a and can observe x and θ. It is assumed that P knows the relationship of outcome to the agent's action and the state of the world ($x(a,\theta)$). P can always observe outcome x. Given these assumptions, as long as P can observe either a or θ, s/he can deduce the other.

Rees (1985a) gives two basic principal-agent relations of interest as follows:

(i) P can observe or deduce a and θ, therefore further information z is not necessary. In this case, there is no information asymmetry. The principal can then pay the agent his/her minimum expected utility. This is known as reservation utility (Rees, 1985a). That is, the P can pay the A the minimum level of reward the A requires in order to produce the outcome.

(ii) P can observe neither a nor θ. In this case, for any fee schedule devised by P, A will choose a (action) in order to maximise his/her own expected utility, not that of P. P must take account of the fact that his/her choice of payment schedule will affect A's actions by adding a constraint (the incentive constraint) to the optimisation problem. What this means is that the way in which risk is shared between P and A is not optimal; P must give an additional incentive (that is, pay an additional amount) to A in order to influence A's choice of action (a). Additional information (z) can be incorporated into a contract to increase optimality, although the effect of this will depend on the cost of acquiring z (Rees, 1985a).

The principal-agent relationship as defined by choice of optimal fee structures is a significantly different approach to that usually considered by economic theory: that is, the arms length, fixed price approach to obtaining goods or services in the competitive market (Arrow, 1986). In the principal-agent approach, the competitive market does not set the price of an agent's services, and the principal does not simply buy a fixed quantity of output from the agent. The variable to be determined is not a price but an optimal payment scheme that is a complex functional relationship (Arrow, 1986). However, the optimal payment scheme may involve the payment of a fixed price to the agent per item of outcome, for example a piece-rate scheme (Petersen, 1993).

It is not the aim of this thesis to devise optimal payment structures. The thesis addresses instead the issue of *how* principal-agent relationships in the NHS are managed. The underlying assumptions of the basic principal-agent model are used as a framework for analysis of these relationships. It is appropriate therefore to describe how principal-agent theory has been used in this way in empirical work.

b) The empirical model of agency

In the empirical literature, two basic models are specified: the hidden-action model and the hidden-information model (also called hidden-knowledge) (Barrow, 1996; Petersen, 1993). Both consider information asymmetry within principal-agent relationships. Arrow (1986) first introduced these distinctions (Petersen, 1993). This section describes each of these models.

In both the hidden-action and the hidden-information models, five central elements of the principal-agent setting are described, each impacting on the way in which the relationships operate:

(i) Agent type – some agents are more able to perform particular tasks, more willing to undertake additional training to improve their ability, are more trustworthy, or more dedicated than others.

(ii) Agent action – agents can choose the action (method and level of effort) required to carry out the task (a as described above).

(iii) Exogenous, random factors – the "state of the world" is uncertain and can have a positive or negative impact on outcome (θ as described above).

(iv) Outcome – the goods or services are produced by the agent, and are usually observable by both principal and agent (x as described above).

(v) Asymmetric information – not all information is observable by both principal and agent all the time. Only the agent observes the agent type and level of effort. The principal has a cost of observing agent effort (comparable to z in the notation used above). The agent may sometimes observe exogenous, random factors; the principal does not.

i) The hidden-action model

The hidden-action model describes a situation where the principal observes outcome but not action. Action (effort) is a disutility to the agent but of value to the principal (Arrow, 1986). A typical example is that of patient and physician, with the physician being the agent for the patient. The physician has superior knowledge and so the patient is unable to verify whether the actions of the physician are as diligent as they could be.

In such situations, the principal must choose how to control the agent to ensure that the principal's objectives are met. The choice is between rewards based solely on outcome or rewards based on outcome and monitoring. Monitoring refers to the collection of data that conveys information about the unobserved action of the agent in addition to that revealed by the outcome (Arrow, 1986). Fees schedules can then be made dependent upon both outcome and monitored action. The choice between rewarding the outcome, or monitoring and rewarding the action in addition to outcome, depends on both the cost and accuracy of monitoring and the relationship between the agent's actions and outcome.

For a fixed payment reward, the agent will have an incentive consistently to decrease effort and hence to decrease output, perhaps to zero, without intervention from the principal. The reason for this is that the agent will be paid the same no matter what level of output s/he produces. This situation is called moral hazard, a term borrowed from the insurance literature (Arrow, 1986). Any gains in terms of excess output (that is, over and above that required by the principal) go to the principal, but it is likely that there will be no excess because the agent has no incentive to produce above the minimum.

An alternative system is for the agent to pay a fixed fee to the principal, and to keep any output additional to that required by the principal. This removes the moral hazard, giving incentives to the agent to increase effort. All gains in this case go to the agent. However, all the risk is placed also with the agent (Petersen, 1993).

Hybrid schemes whereby the principal pays a low fixed sum independent of outcome to the agent, plus additional payments related to outcome, attempt to solve the moral hazard problem by sharing the gains (and risk) associated with production (Barrow, 1996; Petersen, 1993).

ii) The hidden-information model

The hidden-information model describes the situation whereby the agent has made some observation that the principal has not made (Arrow, 1986). The agent uses this information in making its decisions, but the principal cannot check whether or not this information has been used wisely from the principal's perspective. For example, the principal can observe the agent's action, but not the exogenous random factors and, where agent types differ, not the agent's type (Petersen, 1993). Again, the

principal must choose how to control the agent. In this case there is a danger that the principal may over reward the agent for output that is due to favourable exogenous factors rather than agent effort (Walker, 2000). This arises because the exogenous factors are visible only to the agent who chooses his/her action based on these *a priori* observations. The agent has no incentive to share the real situation with the principal, that is, s/he has no incentive to let the principal know whether it is favourable conditions or high effort that is producing the output (Walker, 2000). The principal in effect must solve two problems: first, s/he must select the most desirable type of agent, and second, must induce that agent to choose the right action (Petersen, 1993).

To solve this problem, the principal can do one of two things. First, the principal could screen potential agents in an attempt to choose the most suitable type of agent, and then set a reward structure such that the agent will perform in the principal's best interests. Examples include the selection of employees based on interviews, references and probationary periods (Petersen, 1993).

Alternatively, the principal may devise a choice of payment schemes that encourage agents to self-select into the most appropriate scheme for their type (Barrow, 1996; Petersen, 1993). One scheme would attract high producers that are risk neutral or risk loving (for example a piece rate scheme); the other would attract lower level producers that are risk averse (for example a straight salary scheme). In this way, agents are forced into being honest about their own type and in addition have no incentive to hide what they know about the state of the world.

c) Key elements of principal-agent theory

This section discusses each of the five key elements of the principal-agent model described above. In addition, the concepts of monitoring and risk sharing are discussed. Each element is explained and then its relevance to PCTs' relations with NHS Trusts and GP practices is discussed.

i) Agent type and choice of agents

Agent type refers to the capacity of the agent to perform the tasks contracted (Petersen, 1993). The issue of importance is that an agent may be more or less capable of carrying out the tasks required by the principal, and the principal must

select the agent s/he considers most suitable. Where the principal cannot see in advance the type of agent, the principal must devise a contract that attracts an appropriate agent. The assumption is that the agent then has a choice of whether or not to accept this contract. There is also an implicit assumption that there is more then one agent with whom the principal can contract. These are important points when considering principal-agent relations in the public sector. Certainly in the NHS, neither of these assumptions is true.

PCTs do not have a choice of general practitioner agents; they are defined by geographical boundaries and cannot select particular agent types. Neither can general practices choose whether or not to accept a contract to work in a PCT. The parent trust is fixed. The situation is similar for NHS Trusts as agents for PCTs. Although in theory PCTs have a choice of NHS Trusts with which to contract, in reality they do not exercise this choice, being constrained by other factors such as loyalty, local politics or geography. Neither can NHS Trusts choose to reject a contract. Although hospitals have relationships with more than one PCT principal, the loss of trade with a PCT could damage the viability of the NHS Trust. Furthermore, the community ethos and political environment would not allow an NHS Trust to refuse to supply services to the local population. As a result, both GP practices and NHS Trusts are tied to PCTs, and vice versa.

Robinson (1997) makes this point in considering contractual networks between physicians (as principals) and hospitals (as agents) in the United States. He defines a contractual network in health care as a virtual rather than vertical integration of primary care-based medical groups with hospitals. He characterises virtual integration as integration through contracts and vertical integration as that through ownership. Robinson's point is that the advantages of contractual networks over ownership arise from the relative ease of switching between agents in the search for better quality or lower prices. These advantages are undermined in health care (Robinson, 1997). They are undermined by the lack of choice of hospital. Even where there is choice, the cost to primary care physicians and patients of building up new relationships is prohibitive. This lack of effective choice of agent increases the mutual dependency of physicians and particular hospitals.

Coleman Selden *et al.* (1999) also raise this issue of interdependency between principals and agents in exploring the relationships between city councillors (as

principals) and city managers (as agents) in the USA. Councillors have responsibility for developing and setting policy for their cities, managers for carrying out the chosen policy. They suggest that each is dependent on the other to exercise judgement in prioritising information and sharing that which is most crucial. Their belief is that sharing information both ways (from principal to agent and agent to principal) can work to the advantage of both parties. The question then is, without explicit incentives to do so, what would motivate the agent to share information, given what has been considered about the advantages to the agent of hiding information (particularly in relation to the state of the world and the agent type) from the principal? The answer may lie in Robinson's argument; a limited choice of principals or agents creates mutual dependency, and where both parties are in essence "locked in" to a relationship, information sharing may be more advantageous than arms length contract setting (Robinson, 1997). The impact of mutual dependency on commissioning secondary care in the NHS is not known.

ii) Agent action and objectives

Whilst the effort of an agent is a key element of the hidden-action and hidden-information models, the principal and agent's utility functions are not mentioned explicitly. The different ways in which they maximise their utilities is a fundamental component of agency relationships. If the principal and agent's utility functions coincide, with or without information asymmetry, there will be no problem of control. The agent will choose a level of action that maximises his/her own utility; this level of action will automatically maximise the utility of the principal. If the principal and agent's objectives are different, and there is information asymmetry, the control of the agent becomes more problematic. It is assumed also in these models that all individuals act in their own best interests (Petersen, 1993; Rees, 1985a), gaining utility from the money income received from the principal and disutility from the effort expended to produce the output (Dixit, 2002).

When considering relationships between primary care trusts and NHS Trusts, their utility can be seen as maximised when they meet their main objectives. Both may aim to improve the health of patients, but their beliefs about the best ways of achieving this may differ. It is possible that these objectives might conflict. For example, primary care trusts may prefer to concentrate their efforts on prevention

and care in the local community, whereas acute trusts may prefer more highly technical treatments that build on and increase scientific expertise; both would improve patient health. Similarly, general practitioners and primary care trusts may have a joint but conflicting objective of improving the health of their patients; for GPs, this would be their practices' patients, whereas for the PCT, it is the health of the wider population for which they are responsible.

In the public sector, Barrow (1996) questions the independence of the principal's and agent's objectives. The profit motive is the driving force of the private sector, with both principal and agent wishing to maximise their individual profits. Profits are not important in the public sector, although in keeping with the principal-agent model, principals and agents may aim to maximise different non-financial objectives. Objectives in the public sector may, however, have a degree of interdependency. Public sector organisations work for the public good (Barrow, 1996) and as such, individuals working within any given organisation are more likely to have a common purpose. It may be, however, that principals and agents within a particular public organisation have improving the public good as their objective, but their beliefs about what constitutes "the public good" are quite different.

Likewise, Walker (2000) suggests that where principals and agents are part of the same organisation, similarity of their objectives, understanding of procedures and adherence to a common culture are likely to be greater. The example he uses is local authority Direct Labour Organisations: in-house providers that compete for local government contracts with private firms. He claims that it seems reasonable to assume that the Direct Labour Organisations have similar objectives to the local authority and understand the systems better than private, external providers. This begs the question, however, of the extent to which separate "firms" within a far larger umbrella organisation can be considered similar. Some public sector organisations are divided into quite distinct component parts, each with their discrete tasks. The NHS is a prime example, with the purchaser/provider split designed to mimic a market situation with individual firms working to maximise their own best interests. Although primary care trusts, general practitioners and NHS Trusts are all part of the NHS organisation, and all have improving patients' health as one of their objectives, they cannot be considered to adhere to a common culture or to understand common (administrative) procedures. One of problems that total purchasing pilots

had to overcome was that of different cultures: the GPs had to learn the culture of the health authority bureaucracy, far removed from that of the general practice "small business" (Mahon *et al.*, 1998).

In contrast to Barrow and Walker, Robinson (1997) assumes that principals and agents may have divergent interests but at the same time be dependent on each other due to their different competencies. Unfortunately, Robinson does not go on to explain what these divergent interests might be. It is possible that there are some elements of managers' and doctors' objectives that do coincide, for example, the desire to produce high quality care, but others that are quite separate, for example, meeting target throughputs. Managers are certainly dependent upon clinicians to achieve both.

iii) Exogenous, random factors

Exogenous, random factors (the state of the world) are factors that influence the outcome produced but are beyond the control of either the principal or the agent. Both principal and agent have the same *a priori* beliefs about the probabilities of exogenous, random factors. Walker (2000) defines a "strong" form of the principal-agent problem as one in which the agent can observe the state of the world as it happens and adjust action accordingly. A typical example of a random exogenous factor is rainfall in a principal-agent setting comprising a landlord and tenant farmer; although both landlord and farmer may have the same expectations of rainfall, only the farmer knows what actually falls (Sappington, 1991). Petersen (1993) gives the example of a salesperson as agent with his/her sales being affected by the (exogenous and random) number of potential customers arriving in a store.

Analogous situations in the NHS may occur when GP practices or an NHS Trust can observe an event or series of events that impact on their ability to provide agreed care, but which the PCT cannot observe. If such events are detrimental to the achievement of the agents, they will inform the principal. If the events are advantageous, the agent is able to achieve its agreed outcome with a smaller amount of effort than anticipated and is therefore unlikely to inform the principal. An example of an unfavourable factor for an NHS Trust might include an outbreak of a virus within the hospital that results in closed wards. A favourable factor might be a decrease in referrals from primary care.

In many cases in the NHS, both principal and agent will be able to observe exogenous factors, often in advance. For example, policy changes are announced in advance and visible to both principals and agents; recommendations by the National Institute for Clinical Excellence (NICE) are also visible to both.

iv) Outcome

Outcome refers to the goods or services produced by the agent for the principal. Outcome is assumed to be visible to both principal and agent (Rees, 1985a). Indeed, this assumption is essential given that rewards are based on knowledge of either outcome alone or outcome plus other information derived from monitoring. The visibility of outcomes to the principal and their measurability is discussed in the literature in relation to monitoring. In general, where some outcomes (or indeed actions) are more visible or more measurable than others, it is these that will be rewarded and thus the agent may transfer effort from valuable non-measurable outcomes to less valuable but easily measured ones (Coast, 2001; Goddard *et al.*, 2000; Walker, 2000). (These issues are discussed in more detail in the section on monitoring.)

In the NHS, outcome is not easy to specify or observe. The final outcome of NHS Trusts and GP practices is healthy patients, or at least patients with improved health. However, these are difficult to measure. Combined with the multi-faceted nature of health care and the ill-defined relationship between health and health care, it is unlikely that PCTs or their agents will be able to observe the final outcome. Intermediate outcomes such as the number of patients treated are more easily measurable, but are also more easily observed by the agent than principal. In fact, PCTs are reliant upon NHS Trusts to provide the information by which NHS Trusts are monitored. This opens up the option for potential abuse by the NHS Trusts; they are in a position to manipulate monitoring figures provided to the PCTs.

v) Information asymmetry

Information asymmetry between agent and principal is a fundamental component of principal-agent theory. Without information asymmetry, there would not be a principal-agent problem. The principal would be able to observe the agent's action, type, objectives and the exogenous random factors. The principal would then be

able to devise a payment scheme that encouraged the agent to achieve exactly the principal's wishes.

Information asymmetry is important in the NHS setting if any of the above factors as they relate to NHS Trusts or GP practices are not observable by the PCT.

vi) Monitoring

If an agent's effort is not observable directly by the principal, the principal may decide to undertake monitoring in order to acquire at least some information about effort (Mooney & Ryan, 1993) and to allow a degree of direct control. We can begin by assuming that agent effort is not observable and the contract is based simply on overall performance (Taylor, 2000). If the introduction of monitoring increases the principal's knowledge about effort and the principal can alter the contract to take account of this new information, then both overall performance and this new information on effort will be used (Sappington, 1991). However, monitoring is not without cost. In particular, where the interests of principals and agents are diverse (Coleman Selden *et al.*, 1999), or where the nature of the activity being monitored is complex (Taylor, 2000), these costs are highest and monitoring least effective. As monitoring becomes less effective and more high cost, principals are likely to offer incentive contracts that induce effort but at the expense of direct control (Taylor, 2000).

If monitoring becomes more expensive as the nature of the monitored activity becomes more complex, then one must question whether general practitioner and hospital based services can be monitored effectively. These services are not only multifaceted and not easily understood by non-medics, but neither is there an agreed appropriate level of provision, nor a fully understood relationship between health care and health. A danger in attempting to monitor output, where output is multifaceted, is that those facets that are most easily observed will be monitored, at the expense of those that may be equally or more important but more difficult to observe (Barrow, 1996). Walker (2000) agrees that the multidimensional nature of "white collar tasks" does not fit easily with monitoring. The result can be that production effort is transferred to those observable outcomes that are being measured and rewarded (Goddard *et al.*, 2000). In addition, and particularly important in health care where self-interest may not be the only driving factor behind decision-

making, extensive or inappropriate monitoring may result in reduced motivation (Walker, 2000).

Zhang (1998) looks at the size and openness of the public state in China and offers a solution to the monitoring problem. He suggests the principal sets a contract that provides him/herself with their minimum required welfare and allows the agent to retain any additional output. As long as the agent desires this output, or can sell it to acquire value, the agent will produce at least the level that the principal requires. Zhang claims that this negates the need for principals to monitor their direct agents, even within a long chain of principal-agent relations. What Zhang is describing is the agent paying the principal for the right to produce as much output as possible; that is, the agent pays the principal with a fixed level of output and retains any additional output. This system was discussed in the hidden-action model; one problem is that all the risk is borne by the agent.

In a health care system based on care free at the point of consumption, and where there are ill-defined property rights, this system is not an option. For such a system to work, agents (hospitals or general practitioners) would have to buy from the PCTs the right to provide services, and then sell those services for a profit. Services in the NHS are not provided on a profit-making basis, although within and between agencies, funds are exchanged. With a fixed budget constraint in the NHS, neither is there a ready supply of buyers who could purchase the surplus output and enable the agents to acquire value in exchange.

vii) Risk sharing

The extent to which a principal or agent enjoys taking risks affects the type of incentive contract that will give optimal results. Few enjoy taking risks; most individuals are averse to risk if the potential losses are high enough. Principal-agent theory therefore assumes both parties are either risk neutral or risk averse. Payment schedules should aim to pool risks and not to leave the residual risk with the most risk averse (Barrow, 1996). For example, if an agent is risk averse, a fixed price contract removes any risk of losses from the agent, leaving all the risk associated with lower than expected output with the principal. The principal would also however keep any additional gains, but as discussed above, this contract type introduces the problem of moral hazard and so reduces the likelihood of gains.

In the NHS, many early contracts between purchasers and providers were block contracts: fixed payments made to hospitals in return for access to specific services (Chalkley & Malcomson, 1996). An important point here is that the amount of services is not specified in advance and depends on patient demand. Block contracts remove all incentives from a hospital by promising to pay a fixed amount no matter what level of service is required. The financial incentive for the hospital is to offer fewer rather than more treatments. However, the risk of losses as well as potential gains is borne in this case by the hospital. Should there be an unexpected rise in the number of patients needing treatment, the hospital has agreed already to provide access to services and must treat the extra patients; conversely, any fall in expected patient numbers will lead to a gain by the hospital.

A further type of contract common in the NHS was a cost-and-volume contract in which a baseline level of activity was funded and any additional activity funded on a cost-per-case basis (Bartlett & Le Grand, 1993). This provided some security to the hospital but also some incentive to increase activity.

Alternatively, a cost-plus contract would pay a hospital its costs plus an additional amount as profit (Barrow, 1996). This contract type would remove all risk from the hospital and give some incentive to treat more patients, as each additional patient treated would result in a proportional increase in profits.

An additional contract type, cost-per-case, involved payment on a case-by-case basis and placed all risk from variations in activity with the purchaser (although a provider had to be confident that total income would be sufficient to maintain a full range of services). The incentives for the provider were again to treat additional patients. GP fund-holders used cost-per-case contracts in the NHS for much of their care (Raftery *et al.*, 1996).

d) Key assumptions of principal-agent theory

The previous section discussed the main elements of agency theory. This section summarises the main assumptions of agency theory, that is, how these elements are assumed to interrelate. These main assumptions are detailed in the following papers in particular: Dixit (2002), Sappington (1991), Petersen (1993).

i. Objectives are aligned through incentive contracts. This is the basic rationale of principal-agent theory. Principals desire an outcome that they are not able to produce themselves and so contract with an agent to produce the good for them.

ii. Both principals and agents act in their own self-interest, that is, they attempt to maximise their own utilities. The utilities of both are a function of output and rewards. The agent's utility is dependent also on action. Self-interest in the private sector is defined usually as profit maximisation. In the public sector, self-interest may include also consideration of others' interests.

iii. There is a trade-off between risk and incentives. A high level of risk-aversion by the agent dictates weak incentives. In contrast, a high level of risk-aversion by the principal necessitates strong incentives. For example, if the principal cannot tolerate output below a certain level, the agent will be rewarded for attaining or exceeding that level but punished for failing to do so.

iv. The principal is indifferent to agent's choice of action (as long as it is diligent and efficient), that is, the principal is concerned only with the outcome, not with the way in which that outcome is achieved.

v. Where there are multiple actions that produce multiple outcomes, and where the measurability of actions is different, principals will try to reward those actions most closely aligned with the most desired outcome. A danger is that high-powered incentives based on an easily observed outcome or action will lead an agent to neglect less easily observable goals.

vi. Multiple principals will collude in given circumstances. If principals share a common set of information and can commit to share outcomes, they would further their interests by offering a joint contract. If they are unable to do this, then they should act independently.

vii. Many principal-agent relationships are hierarchical; in such relationships, lower principal-agent pairs may collude against higher principals. This results if the lowest agent can offer rewards to its direct principal that are higher than the rewards for truth telling offered to that principal-cum-agent by its direct principal.

viii. Where a principal controls a team of several agents and their output is measured jointly, the team as a whole is rewarded. However, this can introduce free riding. To solve this problem, the principal can set incentives according to tournaments, that is, the best/worst-performing agent in the team is rewarded/punished respectively. These incentives apply only to multiple agents where those agents are part of the same organisation or team. Where a principal contracts with a number of agents but each agent and its outcome is independent, then incentives should be set individually.

ix. In long-term relationships where principals observe outcome over many time periods, the principal can learn about the agent's type and action and set payments accordingly. If the agent can be punished for past actions, that threat of punishment may be sufficient to discourage poor outcomes. If agents cannot be punished (that is, they can quit), long-term reputation may serve as an incentive. Long-term reputation is important for both agent and principal; a poor reputation for a principal will decrease the number of agents willing to act for that principal. Likewise, an agent with a poor reputation will find few principals offering a contract.

2) Policy background

This section reviews briefly policy in relation to commissioning in the NHS pre-1999 and, in more detail, that relating to primary care organisations (PCOs) post-1999. The review of policy pre-1999 draws on that in Baxter *et al.* (2000). Parallels between current policy and principal-agent theory are presented.

Hospital services comprise emergency (unplanned) care and elective (planned) care. Pre-1991, GPs were free to refer their patients (as emergency or planned cases) to any secondary care provider for specialist outpatient review or inpatient admission. GPs therefore managed some of the demand for secondary care and their decisions had a direct impact on costs. Although GPs acted as gatekeepers to secondary care, there was no direct monetary link between the GPs making the referral and the payment for the care subsequently received. Not only did GPs refer where and in what quantity they chose, they also varied widely from each other in the extent to

which they made referrals (De Marco *et al.*, 1993; Fertig *et al.*, 1993; Hutchinson, 1993; Wright & Wilkinson, 1996). Therefore, GPs in their traditional gatekeeper role managed the demand for care, either by treating patients themselves, or by referring them for specialist care. (Once in the secondary care system, the management of care transfers to the hospital doctors, who then make treatment decisions on the patient's behalf.)

Meanwhile, health authorities funded hospitals to provide services. However, health authorities were funded through a complex capitation formula based on their catchment populations, and there was no real relationship between the funding hospitals received from health authorities and the variable demands from GPs. In effect, health authorities were acting as independent insurers, funding care but having no influence over the level of demand (Bevan *et al.*, 2001).

In 1989, the Government White Paper *Working for Patients* (Secretary of State for Health, 1989) changed these roles. The internal market was introduced, purchaser and provider roles were split, and a new scheme called GP fund-holding began. This scheme gave large general practices the option to manage some budgets, including cash limited general medical services (GMS), prescribing and the funds for a proportion of elective secondary care. In the first instance, the services were restricted (to reduce financial risk from random fluctuations in demand) and budgets were small relative to total hospital and community health services (HCHS) budgets. Nonetheless, this was a first step towards integrating the two sides of the NHS equation – bringing together the management of patient demand and payment for care. Simultaneously, the purchaser/provider split and internal market created a system dependent on contracts for the provision of secondary care services; health authorities and GP fund-holders agreed contracts with hospital trusts to provide services to their patients. Over the following decade, the fund-holding scheme was expanded, with the types of services for which budgets could be held increasing and the sizes of practices eligible to hold a budget decreasing. Other formal and informal schemes, such as locality commissioning, multi-funds and GP commissioning groups, developed over the years, each taking a slightly different stance on the basic premise of GPs managing their own budgets for secondary care services (see Mays & Dixon, 1998 for a full discussion of these schemes).

In 1994, an NHS Executive letter (NHS Executive, 1994) entitled *Developing NHS Purchasing and GP Fund-holding* announced the expansion of GP fund-holding and the start of a new pilot scheme – total purchasing (TP). TP gave single or multiple groups of general practices the opportunity to hold a budget for and purchase *all* HCHS for their patients. This meant that total purchasing pilots (TPPs) could buy elective care that was outside the GP fund-holding scheme and buy emergency care. This scheme was another major step in integrating the GP demand manager/gatekeeper role with the traditional health authority role of insurer. In fact, TPPs did not choose to manage all HCHS, but instead managed only the budgets for those services to which they wanted to make changes (Mays *et al.*, 1997).

One feature of the TPP scheme was that the aims, objectives and methods to be used by the pilots were not stated in advance. There appeared to be a general belief that to give GPs more influence over NHS purchasing through a budget was beneficial, but beyond that, there was no indication of what TPPs were expected to achieve (Mays *et al.*, 1997). Unlike standard fund-holding, TPPs were not permitted to hold health authority money in their own right; co-operation between TPPs and health authorities was therefore essential. In addition, there was to be no virement of funds between standard fund-holding and total purchasing budgets.

With the change of government came another White Paper on the NHS in England in 1997 (Secretary of State for Health, 1997). This paper, *The new NHS: modern, dependable*, announced a further restructuring, building upon the experiences of the previous decade. The aim was to keep the systems that appeared to work (for example the purchaser/provider split), but abolish those that were perceived as not working or not aligned with New Labour's philosophies (for example, fund-holding, which was perceived as creating a two tier service within the NHS). Although the purchaser/provider split was maintained, competition was removed in favour of co-operation (although markets are still contestable in some areas) and annual contracts were replaced with Service Level Agreements.

Instead of voluntary fund-holding, the new NHS comprises large groups of general practices, between them holding budgets for GMS infrastructure, prescribing and the majority of HCHS. These groups were known as primary care groups (PCGs) or primary care trusts (PCTs). Through their budgets, these primary care groups and trusts (PCG/Ts) had responsibility for providing some care themselves (for example,

primary care services) and commissioning additional care from other providers (for example, secondary care services). These new bodies could choose to function at one of four levels:

1. To advise the health authority in its commissioning of care;
2. To take responsibility for a delegated budget, as a sub-committee of the health authority;
3. To become a free-standing body for commissioning health care, accountable to the health authority; and
4. To become a free-standing body for commissioning health care, accountable to the health authority and in addition, to be responsible for the provision of community health services.

The first two levels were known as PCGs, the latter two as PCTs. PCGs were sub-committees of health authorities and had boards with a GP chair and a GP majority membership. PCTs however, as public bodies accountable to their health authorities, had a lay chair and a lay majority on their board.

It was expected initially that groups would progress through each level until reaching level 4 (Secretary of State for Health, 1997). In practice however, the majority of groups began in April 1999 at level 2 PCGs, and many planned to move directly to level 4 PCTs in April 2001.

Health Service Circular (HSC) 1998/228 (NHS Executive, 1998b) sets out three core functions for which primary care groups and trusts have responsibility:

- the improvement of the health of their community
- the development of primary and community health services
- the commissioning of secondary care services.

In giving primary care groups and trusts responsibility for these functions, and a budget from which to provide them, the government placed these primary care organisations at the centre of NHS decision-making.

In 2000, the government announced its intention in the NHS Plan (Secretary of State for Health, 2000) that all PCGs would become PCTs by 2004. In fact, further guidance from the Department of Health (Department of Health, 2001) saw the

restructuring of local and regional health authorities and greater devolution of power to primary care. As a result, all but one primary care organisation became a PCT by April 2002 (Wilkin *et al.*, 2002). PCTs were set to become the lead NHS organisations for assessing need, planning and securing all health services, and improving health. They were to do this through control of up to 75% of the NHS budget.

The relationships between PCTs and NHS Trusts can be viewed through the lens of principal-agent theory, the central concern of the theory being how a principal can persuade an agent to perform in a way that satisfies the principal's requirements (Sappington, 1991). As Ross (1973: 134) indicates, a principal-agent relationship...

> *...has arisen between two (or more) parties when one, designated the agent, acts for, on behalf of, or as representative for the other, designated the principal, in a particular domain of decision problems.*

This can be rephrased in the context of secondary care commissioning as follows.

> *A principal-agent relationship in commissioning has arisen when* ***an NHS Trust****, designated the agent, acts for, on behalf of, or as representative for the* ***primary care trust****, designated the principal, in* ***the provision of secondary care services****.*

Wilkin *et al.* (2002) state the principal-agent problem in commissioning as one of leverage, with the following factors being important: negotiation, persuasion, target setting, contractual demands, incentives, and monitoring of standards and outcomes. They maintain that an essential part of the commissioning process is to ensure providers "shape their services to reflect the wishes of PCG/Ts", and define commissioning as "a means of procuring, and paying for, high quality community and hospital services primarily by way of partnership working between the commissioners and providers" (Wilkin *et al.*, 2002: 73).

The parallels between current policy and principal-agent theory are accentuated further in policy documents. HSC 1998/198 (NHS Executive, 1998a) discusses the allocation of risk (a key concept in principal-agent theory) between a PCT and NHS Trust. The suggestion is that the organisation that is able best to control risk should bear the financial consequences of such occurrences.

> *Activity Fluctuations and Risk Management. Agreements should apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event. The financial arrangements should reflect this. For elective inpatient care, financial and clinical risk should be borne by the NHS Trust clinical and management team for the specialty or condition. (paragraph 16.4)*

Later, HSC 1998/228 (NHS Executive, 1998b) introduces the concept of incentives in SLAs, stating that SLAs...

> *...will incorporate incentives for improving quality, cost effectiveness, and appropriateness together with clear responsibility for risk management, ensuring activity does not get out of kilter with funding. (paragraph 84)*

The guidance given in these circulars has been reinforced recently in *Reforming NHS Financial Flows* (Department of Health, 2002c). Here, the definition of commissioning includes specific reference to contracts, incentives and monitoring.

> *[Commissioning is a] continuous cycle of activities that underpins and delivers on the overall strategic plan for healthcare provision and health improvement of the population. These activities include stakeholders agreeing and specifying services to be delivered over the long-term through partnership working, as well as contract negotiation, target setting, providing incentives and monitoring. (page 56)*

Annex 5 of *Reforming NHS Financial Flows* (Department of Health, 2002c) states that Service Level Agreements between PCTs and NHS Trusts should...

> *... clearly set out the understanding between commissioners and providers about all of the key dimensions of commissioning. With the shift of power and resources to PCTs, the SLA becomes a critical agreement for driving performance and change in service delivery. The SLA should also be the starting point for enacting financial flows and for setting out clear agreements about resources, activity, and risk.*

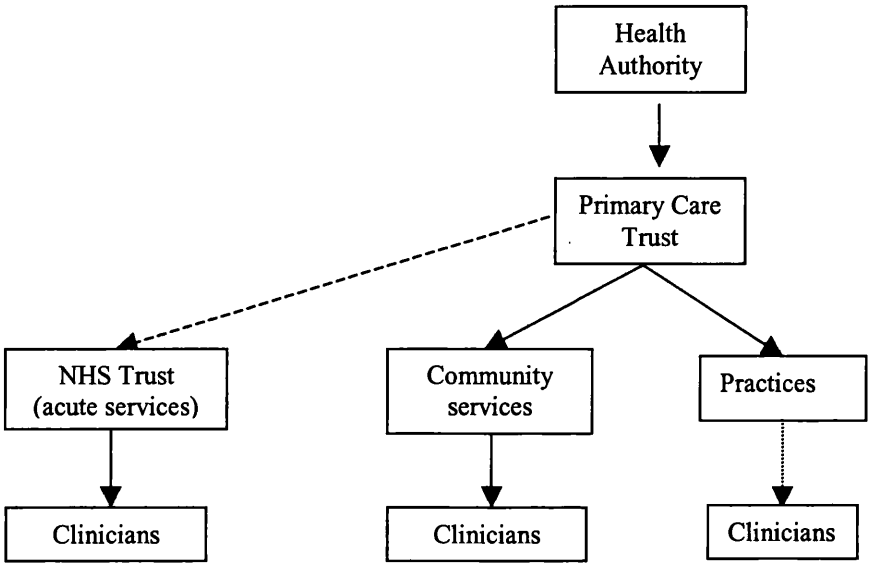
These excerpts from policy documents demonstrate clearly that one part of the government's policy for the NHS is to create contractual relationships between PCTs and NHS Trusts along the lines of principal and agent.

In addition, the White Paper (Secretary of State for Health, 1997) introduced unified budgets for HCHS, prescribing and GMS infrastructure. The largest element of this budget was for HCHS (over 80%) with prescribing accounting for 14% (Regen *et al.*, 2001). Prescribing budgets have been managed by primary care for many years and financial incentives are common. Managing the whole commissioning budget is new; even total purchasing pilots, that were intended to manage the whole of the budget, in fact selected which portions of the budget to control (Mays *et al.*, 1997). The management of the commissioning budget by PCTs is therefore a new area for research.

PCTs can be seen as both agents and principals. They are agents for their health authorities; health authorities (and ultimately government) have responsibility for the health of the resident population, they are the body to which PCTs are accountable and they delegate some of their responsibilities to PCTs. PCTs are also principals; they are tasked with providing care for their populations, but need to contract with medical professionals as agents to provide that care. It is helpful to conceptualise health care as primary care (delivered by GPs and other general practice staff), community care (delivered by staff in the community or in community hospitals) and secondary care (delivered by staff employed by acute hospitals). PCTs as principals therefore enter into relationships with two distinct sets of agents: general practices and community staff for the provision of primary and community care respectively, and NHS Trusts for the provision of secondary and tertiary care. The former are both internal agents, the latter external.

Diagrammatically, these relationships can be viewed as in Figure 1 below. The arrows indicate the direction of the principal to agent relation. The dashed lines represent contractual relationships; the solid lines represent direct control. There are also relationships between GPs and NHS Trust clinicians: both are agents, but also interact with each other.

Figure 1: Principal and agent relationships around PCG/Ts



3) Principals and agents in markets, hierarchies and networks

The previous sections have shown the main elements of principal-agent theory and its parallels with policy. Implicit in discussions of the principal-agent framework is its location within a market or quasi-market structure; principals and agents are treated as if they are in a quasi-market. But the language is relevant equally to other structures. This section discusses the relevance of the principal-agent language to other forms of exchange relations, specifically, hierarchies and networks.

A market is a system of coordination within which buyers and sellers interact to exchange goods and services. Quasi-markets differ from conventional markets in at least one of the following ways: organisations are non-profit making and compete for public contracts, sometimes with for-profit organisations; purchasing is often through a single agency or consumer vouchers; and consumers may be represented by agents rather than representing themselves (Le Grand & Bartlett, 1993). The transactions that take place within such markets are often complex and multi-dimensional (Robinson & Le Grand, 1994).

Despite its implicit location within a quasi-market structure, the language of the principal-agent framework can be applied equally to a hierarchical structure or a network and to between or within firm coordination. The language can be the same; it is the methods of influencing the agent that are different in the different structures.

A hierarchy exists where there is a superior-subordinate relationship, or a chain of such relationships (Williamson, 1975). Hierarchies are usually associated with bureaucracies and characterised by a high degree of central control with limited autonomy for the periphery (Exworthy *et al.*, 1999; Thompson *et al.*, 1991). The markets and hierarchies debate derives from the work of Coase (1937) in discussing the nature of the firm. Organisational hierarchies replace market structures in an attempt to reduce transaction costs. A transaction cost is "any activity which is engaged in to satisfy each party to an exchange that the value given and received is in accord with his or her expectations" (Ouchi, 1980). Transaction costs are either *ex-ante* or *ex-post* (Bartlett & Le Grand, 1993). *Ex ante* relate to drafting and negotiating an agreement, *ex post* to monitoring and dispute resolution. Coase's original work has been developed and expanded into theories of organisational behaviour and new institutional economics (see, in particular, Williamson (1975; 1981; 1985) and Ouchi (1979; 1980)).

Hierarchies, however, still comprise principals and agents. In a hierarchical model, the principal controls the agent via direct measures; in a market model, the principal controls the agent through incentive contracts. As Simon (1991: 26) suggests, a "fundamental feature of the new institutional economics is that it retains the centrality of markets and exchanges. All phenomena are to be explained by ... negotiated contracts, for example, in which employers become 'principals' and employees become 'agents'". Indeed, Pitelis (1991) (quoted in Dowling 2000: 17) proposed that certain aspects of market relationships are in fact hierarchical and so the real choice is between market hierarchies and non-market hierarchies.

A network is less well defined. Networks can be seen as characterised by informal organisational forms and a common outlook, based on mutual trust and reciprocity (Exworthy *et al.*, 1999) and extended chains of connections and linkages (Flynn *et al.*, 1996). Networks are often considered to exist within the "grey, intermediate area" between markets and hierarchies (Exworthy *et al.*, 1999). Uzzi (1997) considers agency theory is unable to explain network forms as the roles of principal

and agent are shifting and blurred. He concludes that agency theory is focused mainly on "self-interested human nature, dyadic principal-agent ties, and the use of formal controls to explain exchange" (Uzzi, 1997: 37), and these methods do not conform to network models. Likewise, Toonen (1998) believes that although the network concept brings about important insights it has, at the same time, limitations; not just any contact or relation should be considered a network. The network concept should be "restricted to relations and institutions that imply a form of interdependency" (Toonen, 1998: 250). However, Thompson *et al.* (1991) suggest that "if it is price competition that is the central coordinating mechanism of the market and administrative orders that of hierarchy, then it is trust and co-operation that centrally articulates networks". If this is the case then the principal-agent language, if not contractual tools, is certainly appropriate.

Networks can be "wheel" or "all-channel" (Williamson, 1975: 45-6). A wheel network is a series of simple hierarchies where a single superior controls a number of different subordinates. This kind of network is often referred to as a hub-and-spoke system in the context of the coordination of organisations. In an all-channel network, everyone is connected to everyone else and the absence of hierarchy prevails. Goodwin (2000) also makes a distinction between different types of network. He discusses research on the centrality of information flows. In networks based on authority, the flow of information is from those in the positions of authority to their subordinates. In networks based on information, the information flows upwards from those providing it to those collecting it for use in decision-making. This description implies that networks can be hierarchical, perhaps in line with Williamson's wheel network. An expansion of the wheel network from a single superior with subordinates to a chain of such relations, that is, where subordinates are superiors to other subordinates, is akin to a series of chains of principal-agent relations.

The use of the principal-agent language is more difficult to apply to an all-channel network as it is not as clear which individuals play the roles of principals or agents. However, for a network to be instigated, there must be a reason for its instigation. The members of the network must have an aim, and each member must either desire the end product, or be able to supply it (at least in part), or perhaps a combination of both. Therefore, the individual or organisation desiring the product could be called

the principal (there may be more than one) and the individual or organisation able to supply the product (again, there may be more than one) could be conceived of as the agent.

The methods of control within each of these structures differ. Within a quasi-market structure, the methods of control of agents by principals are financial incentives. The principal sets an optimal payment schedule for its agent. Within a hierarchy, the method of control is generally not through incentives alone but, in addition, through bureaucratic rules and procedures associated with approval and decision-making (Lapsley & Llewellyn, 1998; Whitley, 1999). Parties to a transaction are able to deal with uncertainty and complexity in a sequential and adaptive fashion (Le Grand & Bartlett, 1993) and thus limit the effects of uncertainty. In a network, key methods of influence have been suggested as altruism, trust, alliance, collaboration, co-operation, partnership and reciprocity (Exworthy *et al.*, 1999; Thompson *et al.*, 1991) rather than financial reward or authority.

Simon (1991) considers in detail the relationships between organisations and methods of exchange, asking why there appears to be larger organisations and fewer market transactions than might be expected. He believes the assumption in principal-agent theory that agents will shirk unless their actions increase their own self-interest is unrealistic. Moreover, McMaster (1998) questions the completeness of agency theory's assumption that there is a conflict of interest between principals and agents with low trust. He argues that convention and trust are important influences on agents' motivations and effort.

Simon (1991) offers thoughts on a number of mechanisms of influence: authority (the employment relation), rewards (motivations), loyalty and identification with organisational goals, and coordination ("rules of the road"). His conclusion is that the new institutionalists' attempts to explain organisational behaviour solely in terms of agency, asymmetric information, transactions costs, opportunism and other neoclassical concepts is seriously incomplete as a result of ignoring mechanisms such as authority, identification and coordination.

Quasi-markets, hierarchies and networks each employ at least one of the methods offered by Simon. There is an argument that each of these elements is integral to the more general principal-agent framework. As discussed, the methods by which a

principal can influence an agent's actions are not restricted to financial incentives. The formal model may assume that this is so, but the application of the framework in the empirical world suggests otherwise. For example, Simon's discussion of the authority of the employment relation as a controlling factor sits neatly within the principal-agent framework. Indeed, it is well established that within organisations control of agents by principals can be implemented via the authority of commands and rules.

Loyalty and identification can be treated likewise. Particularly for skilled and managerial employees, organisational loyalty and pride are widespread (Simon, 1991). In the language of principal-agent theory, organisational loyalty and identification should bring the objectives of the agent closer to those of the principal. An agent's personal interests (for example pride) could be served by serving the organisation's interests. In this way, the problems associated with principals' and agents' differing objectives could be reduced.

Finally, coordination. Simon refers to coordination as the removal of the indeterminate nature of decisions under uncertainty. He gives an example of this indeterminacy as a motorist taking the decision to drive on the same side of the road as other drivers, whichever side of the road that is. The side of the road is neither correct nor incorrect; it is the coordination between drivers that is correct. He expands the argument to justify the growth of large firms within which there is division of labour. Each task is interdependent with others and must be coordinated to enhance production and efficiency. Simon's argument is that coordination between firms depends almost wholly on economic motivations and rewards whereas coordination within organisations depends on loyalty and identification. Using the language of principal-agent theory, coordination is what the principal is trying to achieve from the agent. In a quasi-market, this is achieved through incentives to align objectives. In a network, Simon's concepts of loyalty and identification may be important influences, with key players identifying with the network rather than their individual organisations. In a hierarchy, both methods of coordination may be used.

In summary, there are different views about what constitutes a principal-agent relation and in which types of structures they exist. Exworthy *et al.* (1999) describe the current structure of the NHS as moving away from principal-agent relationships

between purchasers and providers towards more relational or soft contracting. However, as discussed, relational or soft contracts are still methods of managing agency relations. Others view principal-agent relationships more broadly. Goddard and Mannion (1998) see the use of co-operation and trust as an attempt to solve the problems inherent in a principal-agent relationship. Smith *et al.* (1997) consider the methods of aligning objectives in principal-agent relationships as either behavioural (through hierarchical chains of command) or outcome-based (through incentives). The challenge is to integrate institutional, managerial and network concepts in the study of public administration (Toonen, 1998). A principal-agent framework offers this degree of integration.

If principal-agent relationships are viewed within the broad framework described above, rather than being restricted to the formal model in which financial incentives within payment schedules are the only form of agent control, and if they are envisaged in different structural forms, then, whether purchasers and providers are separated or exist within a single organisation, principal-agent relationships are still present.

4) Principal-agent and other theories as frameworks for evaluation

This section reviews first the use of principal-agent theory as a framework for evaluation, and, second, considers briefly two other frameworks, those of new institutional economics and trust.

a) Principal-agent theory as a framework of analysis

Petersen (1993: 289-290) suggests that agency theory...

> *"... has much to offer in the study of organisations. ...[the] selection of agents..., motivation devices, output-based versus input-based reward systems, direct incentives such as piece rates versus indirect incentives such as bureaucratic career incentives, risk sharing and more."*

However, it has not generated as large an empirical literature as other areas of the economics of organisations. Petersen suggests that this may be because the formal theorising of agency problems uses complex mathematics, something that is not

readily accessible. For a contract to work, it has to be understood by both the principal and the agent. If it is not understood, then the incentives within the contract will not have the intended effect. Few principals, he suggests, would consider taking advice from optimal contracting formulae; few are applied mathematicians and neither are their agents. Arrow (1986) agrees that even where a principal-agent model seems clearly applicable, there is little trace of it in reality.

Despite these concerns, many analysts believe that the basic structure and the logic behind the formal model do provide a useful framework to illustrate a range of issues relevant to everyday relationships (see Dixit, 2002; Sappington, 1991; Audit Commission, 2000). Others also are confident that agency theorists are moving beyond sparse mathematical models with unrealistic assumptions towards more "complete and nuanced" pictures of organisations and are accepting the complex and hybrid nature of organisations (Kiser, 1999; Shortell, 1997). Recent developments within agency theory include inter-temporal aspects, multiple outcomes, team working and multiple principals (see Dixit, 2002 for a review).

The general framework has been used extensively in the literature for the evaluation of a variety of relationships. These include publicly provided services (Barrow, 1996; Coleman Selden *et al.*, 1999; Walker, 2000; Zhang, 1998), health care organisation (Coast, 2001; Goddard *et al.*, 2000; Hagen, 1997; Propper, 1995; Robinson, 1997; Sheaff & Lloyd-Kendall, 2000; Smith *et al.*, 1997) and patient-doctor relationships (Gafni *et al.*, 1998; Robinson, 1999; Scott & Vick, 1999). In the latter, it is notable that formal contracts do not exist, yet the framework is still applicable (Mooney & Ryan, 1993; Rees, 1985a). The ubiquitous nature of principal-agent relationships means that the framework has been applied in the evaluation of less obvious interactions as well (see Munro, 2001 for an example of agency relations within families).

Whilst mainstream economists have analysed agency theory formally, in health economics it had been used more often to describe relationships rather than to devise optimal contracts (Mooney & Ryan, 1993). Few studies have used a principal-agent framework explicitly to investigate commissioning relationships in the NHS. Many use the terms principal and agent as labels to refer to organisations, patients and their doctors, and relationships between them. Others use the general nature of agency relationships to assess incentive structures. Propper (1995) assessed the structure

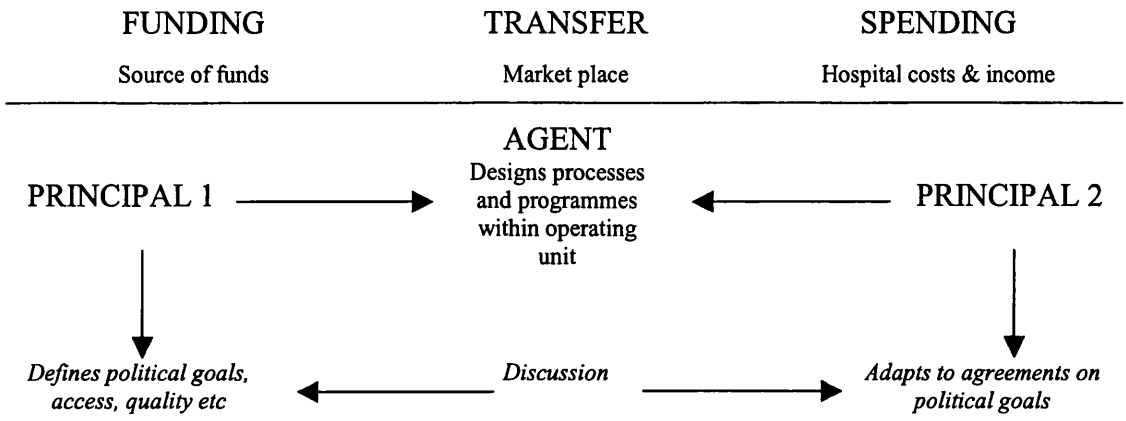
and potential effect of incentives created by the quasi-market reforms in the NHS in 1991. She visualised the reforms as creating a series of overlapping principal-agent relationships with the government as principal. Similarly, Hausman and Le Grand (1999) compared the incentive structure with respect to the primary-secondary care interface under the fund-holding system with that created by the 1997 White Paper (Secretary of State for Health, 1997).

Principal-agent theory has been used explicitly as a framework for analysis of commissioning by the following authors: Smith *et al.* (1997), Goddard *et al.* (2000), Sheaff and Lloyd-Kendall (2000) and Levaggi (1996; 1999). Levaggi uses a formal model of agency to develop optimal contracts under risk and information asymmetry. The others use a principal-agent framework to help understand and categorise relationships between health care organisations.

This remainder of this section discusses how these papers use principal-agent theory as a framework for analysis.

Smith *et al.* (1997) use principal-agent theory to analyse the transfer of funds between different sections of health care systems in different countries. They look at three issues around finance: the raising of finance, the transfer of funds to hospitals, and spending by hospitals. In their descriptive model, they define two principals and one agent. Principal 1 is the government or other fund raising body. Principal 2 is the governing board of hospitals. In some cases, for example health maintenance organisations, principals 1 and 2 are the same body (Smith *et al.*, 1997). The agents in this model are the hospital operational managers and doctors. They are treated as a single agent although in reality this is not the case. A natural source of conflict in their model is that the agents serve two principals: the funder and the hospital board (Smith *et al.*, 1997). A further source of conflict is that clinician and management agents themselves have different objectives (Crilly, 2000). Figure 2 is a simplified version of Smith *et al.*'s model of these relationships.

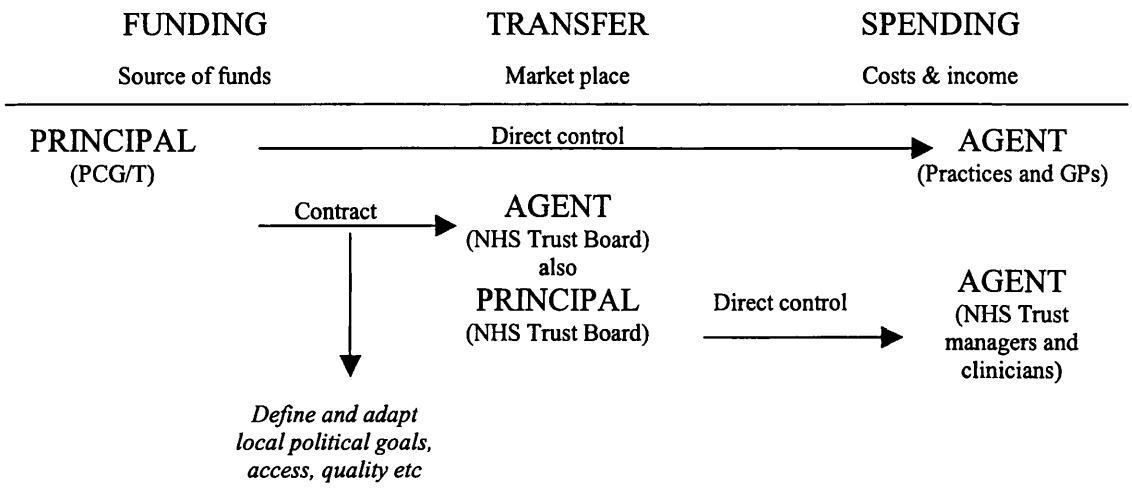
Figure 2: Funding, financing and typical principal-agent relationships (adapted from Smith et al. (1997))



Applying this model to the current English system, although PCTs do not raise their finances directly from patients, they could be regarded as principal 1, defining political goals, access and quality for their local populations. Principal 2 would be the NHS Trusts' governing boards. When considering community services, PCTs, which provide these services in addition to primary care services, would act as principals 1 and 2 jointly. The agents would be the clinicians and directorate managers within hospitals; these would be under direct control of principal 2. Smith *et al.* look only at the funding and provision of care by hospitals. Their model could be expanded to include the provision of primary care services. This would add an additional agent to the model. General practices and GPs would be agents (equivalent to hospital operational managers and clinicians). Their principal (the PCT to which they belong) would be a single body that would have a dual role: as funder and governing body.

In the model shown in Figure 2, there is no direct relationship between principal 1 and principal 2. When transposing this model onto the English system, principal 1 and principal 2 are involved directly with each other. If principal 1 is the PCT, and principal 2 the NHS Trust, then principal 2 is in fact an agent for principal 1. (This relationship is acknowledged by Smith *et al.* but not shown.) That is, principal 1 raises funds to provide services for its patient population, but contracts with principal 2 (now an agent) to supply these services. These relationships are therefore more realistically modelled as a series of overlapping principal-agent relationships as shown in Figure 3.

Figure 3: Funding, financing and principal-agent relationships in the English NHS



Smith *et al.*'s (1997) paper was written before the 1997 White Paper "*The new NHS: modern, dependable*" (Secretary of State for Health, 1997), so considers the UK NHS of the internal market/fund-holding era. However, because they look at relationships between funder and hospitals (in effect purchasers and providers), and because the purchaser/provider split has been kept in the new NHS, their observations are still relevant. As well as considering the principals and agents in the system, they suggest a number of ways of characterising the possible objectives of hospital boards/managers (principal 2 in their terminology):

1. "Surplus maximising" – Hospital boards are keen to win contracts for which marginal price is greater than marginal cost. They expose the hospital to some degree of financial risk and are keen on cost-per-case contracts.
2. "Stability seeking" – Here the hospital is keen to retain existing contracts and seeks to gain purchasers' trust. There is considerable concern by the hospital with quality, less with costs. The hospital is happy to earn "normal profits".
3. "Revenue maximising" – These boards seek out as much new business as possible, perhaps offering "bargain contracts" to attract new purchasers. By doing this, they burden their existing purchasers with the extra costs of attracting new purchasers.
4. "Health rationing" – Such hospitals would deliver care only to patients satisfying some cost/benefit ratio. They would look similar to purchasers that operate under a fixed budget.

5. "Resource use maximising" – These hospitals would attempt to win business that maximised the use of existing resources whilst disposing of unwanted resources. Cost-per-case work may be sought to use up slack capacity.

They conclude that a full analysis of the incentives implicit in current remuneration schemes (that is, contracts) would require an examination of hospital objectives, something that at the time had not received much attention (Smith *et al.*, 1997). Since then, Crilly (2000) has examined the objectives of hospital managers and doctors. She concludes that their objectives are different, with managers placing more emphasis on achieving financial balance and doctors on maintaining service quality, with doctors' objectives being dominant in times of conflict with managers. This may suggest that hospitals' objectives are wider than the purely financial ones suggested above by Smith *et al.* (1997). It may mean also that the agents within hospitals (doctors) are more powerful than their principals (managers). The approach emphasised in the academic literature is for principals to design optimal incentive schemes. Perhaps an equally productive way forward is to align more closely principals' and agents' objectives through co-operation and behavioural rather than contractual means (Goddard *et al.*, 2000; Smith *et al.*, 1997).

Whilst Smith *et al.* (1997) use principal-agent theory as a framework for describing relationships and comparing methods of transforming funds into services, Sheaff and Lloyd-Kendall (2000) and Goddard *et al.* (2000) use the theory in slightly more formal, although still descriptive, ways. Both Sheaff and Lloyd-Kendall (2000) and Goddard *et al.* (2000) use qualitative data collection methods. Goddard *et al.* (2000) are more formal in their use of agency theory; they set out a simple model that illustrates the effects of the issues they wish to consider, and then explore whether or not these issues are embodied in practice. Sheaff and Lloyd-Kendall (2000) do not make predictions in advance, but analyse through interviews and documentation the content of contract agreements.

Sheaff and Lloyd-Kendall investigate Personal Medical Service (PMS) pilots to see how far they embody principal-agent relationships, and consider the implications for relational and classical theories of contracting. PMS pilots were new ways of paying GPs for providing primary care. They entailed a contract being agreed between the health authority or PCT, and general practices. PMS has now been adopted as part of policy. Goddard *et al.* (2000) look at NHS performance measurement and use a

formal model to illustrate the effects that such measurements have on principals and agents. Their main question is whether using measurable targets to increase standards will detract effort from non-measurable but equally important performance. They conclude that this is the case.

In addition to this finding, Goddard *et al.* (2000) use a framework of organisational control mechanisms set out by Ouchi (1979). This is given in Table 1.

Table 1: Information requirements and efficient governance conditions (adapted from Goddard et al. (2000))

		Knowledge of transformation process	
		Perfect	**Imperfect**
Ability to measure outputs	**High**	Markets/hierarchies	Markets (rely on prices and purchasers)
	Low	Hierarchies (rely on rules and bureaucratic procedures)	Clans (rely on traditions and peer review)

The rows show the extent to which outputs are measurable. The ability to measure output would be high, for example, for vaccinations given. It would be low for an outcome such as "improvement in health status". In the columns, knowledge of the transformation process can be perfect or imperfect. Perfect means that the way in which inputs are transformed into outputs is known, that is, the mix of the factors of production and the process of production is well known. If it is not clear, then this is imperfect. Goddard *et al.* describe the NHS as having moved from clan and hierarchical control pre-1991, through market and hierarchy from 1991 to 1999, to a mix of all three modes from 1999. It is noticeable that although the principal-agent language is used in this paper, it is applied equally to markets, hierarchies and clans.

Sheaff and Lloyd-Kendall (2000) describe PMS contracts as the shifting of GP contracts from a form of reimbursing GPs to a means of constructing and managing a principal-agent relationship between the NHS and GPs. It should be noted, however, that even where GPs are reimbursed directly for providing care, there is still a principal-agent relationship between the funding body and the GPs. Sheaff and Lloyd-Kendall explore whether these principal-agent relations are managed through classical or relational contracting, that is, through contracts that are complete (specifying all eventualities in advance) or more flexible ('agreeing to agree' about

changes in circumstances). One would expect that, using Ouchi's terminology above, if these principal-agent relationships are organised in a hierarchical or clan system, then contracts may be more relational than classical. Sheaff and Lloyd-Kendall (2000) come to similar conclusions to Goddard *et al.*; the NHS today is a mix of previously tried methods, with neither classical nor relational theories describing fully NHS contracting.

Smith *et al.* (1997), Goddard *et al.* (2000) and Sheaf and Lloyd-Kendall (2000) use principal-agent theory descriptively. Levaggi (1996) is the only author to date to model principal-agent relationships formally for the NHS, although Dusheiko *et al.* (2001) are in the process of exploring formal models of the impact of budgetary devolution on NHS activity and expenditure through principal-agent and public choice models.

Levaggi's most recent work of direct relevance to the NHS is from 1996, prior to the introduction of the current NHS system. She assumes purchasers and providers can be modelled as single entities (rather than organisational groups) and that purchasers are neutral agents, that is, they pursue the interests of the population for whom they buy health care. Levaggi looks at risk and information asymmetry, then at optimal contracts when there is a budget constraint on the purchaser's side. She then considers competition between agents (hospital providers) and shows that it is advantageous for the purchaser to hold a lottery to choose their agent. Within the NHS, this is not a realistic scenario; choice of agent is often not exercised. She concludes also that the choice of contract depends on risk aversion and contracting experience. Block contracts can result in the lowest levels of output (Levaggi, 1996). If block contracts are used in the long-term, the purchaser will not be able to observe the state of the world, even ex post, and that may limit contracting power in the future (Levaggi, 1996).

In more recent work on government procurement, Levaggi (1999) shows that with a binding budget constraint, output may be reduced. In traditional principal-agent settings this is not a problem, as the principal aims to maximise net gain, that is, the difference between the value of the output and the reward paid to the agent. In government procurement this is more of a problem as the principal aims to maximise output for a given budget, not net gain.

Commissioners in the NHS can now negotiate long-term agreements with their providers. This should mean that there is a move away from the annual contracting round towards more long-term planning. Commissioners and providers are expected to work together, in partnership, to fund and provide services. It is hard to say which of the assumptions underlying Levaggi's models is most appropriate. Are PCTs procuring services – aiming for maximum quantity perhaps at the expense of efficiency? Are they working within fixed budget constraints, or are budgets more flexible? Can purchasers and providers be treated as single entities? It seems unlikely; they consist of managers and clinicians each with their own agendas.

b) Other frameworks as analytical tools

Many researchers have evaluated the NHS reforms according to policy aims such as efficiency, quality, equity, accountability and responsiveness (see Le Grand *et al.*, 1998b for a review). Others have taken specific frameworks as their starting point. One trend has been the use of new institutional economics to understand transaction costs and classify contract types. More recently some commentators have begun to use the concept of trust to evaluate interactions between organisations. This section reviews briefly the use of these two frameworks.

New institutional economics is a comparative institutional approach to the study of economic organisations in which the transaction is the basic unit of analysis and in which special emphasis is given to the study of governance (Williamson, 1985). It can be applied to a wide range of problems. Transaction cost economics is related closely to the principal-agent problem. The agency problem is how to control the agent; the transaction costs problem is to assess the costs of choosing and controlling external versus internal agents. If the costs and risks associated with trade are too high, then an organisation will choose vertical integration rather than trade.

The new institutional economics framework has dominated the analysis of quasi-markets in the UK welfare sectors (Roberts *et al.*, 1998). The main topics of concern have been the impact and content of contracts and associated transaction costs (see Allen *et al.*, 2002; Allen, 2002a; Dawson & Goddard, 1999; Flynn *et al.*, 1995; Place *et al.*, 1998; Posnett *et al.*, 1998; Raftery *et al.*, 1996; Robinson *et al.*, 1998; Robison *et al.*, 1998; Robison, 1998; Street *et al.*, 2001).

The costs and risks of transactions can be affected by interactions between uncertainty, bounded rationality and opportunism. Bounded rationality refers to the inability of players to take into account uncertain future events. Opportunism refers to self-interest with guile; that is, breaking the rules of the game in order to further self-interest. As a result of these problems, fully defined contracts are rare. More often, contracts are relational, that is, parties "agree to agree" later in the event of unforeseeable circumstances (Sheaff & Lloyd-Kendall, 2000).

The consensus with respect to contracts in UK quasi-markets is that they cannot be complete due to the problems of bounded rationality, uncertainty and opportunism. However, despite this incompleteness, contracts are considered instrumental in achieving change. Robison's (1998) study of total purchasing pilots and Allen *et al.*'s (2002) evaluation of the management of infectious disease-related risk both concluded that contracts provided a basis for building relationships through initiating dialogue and also provided purchasers with the financial leverage to meet their objectives. Allen (2002a) found in addition that relational contracts were not an appropriate representation of NHS contracting in district nursing. Contracts were incomplete, but a lack of trust between the parties suggested that relational contracts were not evident. Instead, relationships between purchasers and providers were continuing within a hierarchical structure on which a market system had been imposed.

There is currently a shift towards long-term contracting in the NHS. Whilst Chalkley and Malcomson (1996) believe this will make the alignment of objectives between provider and purchaser easier because of the provider's concern to maintain a reputation for high quality, Dawson and Goddard (1999) have questioned its economic justification. They conclude that the move may be a way of reinforcing the government's commitment to partnership and collaboration. They suggest that a danger may lie in the trade off between the benefits of such collaboration and the difficulties of managing the price adjustment mechanisms necessary in long-term commitments. Moreover, if contracts are not complete but rely on some form of relational contracting that to date has not been evident, the transaction costs in terms of continuing negotiations associated with long-term contracts are likely to be high.

In their study of community health services, Flynn *et al.* (1995) conclude also that market contracts are not suitable due to high levels of uncertainty and associated

transaction costs. Furthermore, they suggest the hierarchical model, often assumed to be an effective replacement for the market in such situations, is not appropriate either. They decide that network models describe best relationships between purchasers and providers in community health services. Others agree that there is a move towards more relational networks of organisations, or "soft" quasi-markets (Roberts *et al.*, 1998: 276).

Evaluations using the framework of trust to explore these networks are beginning to emerge. Trust-based relationships substitute for the need to use sophisticated governance arrangements in contracting (McMaster & Sawkins, 1996). The development of trust enhances co-operative behaviour so that providers deliver high quality services without the need for costly monitoring (Bartlett *et al.*, 1998b). Bartlett *et al.* (1998a) bring together papers relating to different welfare sectors that conclude, amongst other things, the importance of trust and collaboration.

Many authors debated the role of trust and collaboration within networks soon after the election of the New Labour government in 1997 (Exworthy *et al.*, 1999; Kirkpatrick, 1999; Toonen, 1998). No UK health care-related research using trust as an evaluative lens has been published to date, although there are studies underway (Eastham & Ferguson, 2003; Kuhn *et al.*, 2003). It seems, however, that where trust is being used as an evaluative framework, it is being applied to either purchaser or provider networks rather than networks that bring purchaser and provider together in a commissioning context.

This section has illustrated how principal-agent theory and other frameworks have been used to provide insights into health care organisations. Although the language of principals and agents has been used extensively in research, agency theory as a framework for evaluation has been little used in the analysis of health care systems. It has not been used yet to analyse relations between PCTs and NHS Trusts. However, the literature to date has shown the number and complexity of, and different organisational settings for, principal-agent relations in health care, and illustrated the use and effect of different contract types. In addition, although the theory of trust relations is immature in terms of evaluative research in health care, the use of a transaction cost framework to evaluate health service reforms in the UK

has been extensive. The insights most pertinent to a principal-agent analysis of PCTs' commissioning relations are as follows: there a numerous overlapping relationships that may result in conflicts, possibly as a result of different objectives; direct and contractual relations exist; organisations are hybrids, containing elements of hierarchies, clans, networks and quasi-markets; incomplete contracts are the norm; block contracts may not be advantageous; and the transaction costs of managing long-term contracts may be high.

5) Commissioning by primary care organisations

This section discusses first, briefly, the evidence about the roles of standard fund-holding practices as principals and NHS Trusts as their agents in the purchasing of secondary care services. The majority of the section reviews the evidence from total purchasing pilots and evidence to date about PCG/Ts as commissioners of secondary care.

a) Fund-holding

With regard to a principal-agent view of fund-holding, GPs were the principals and NHS Trusts their agents. GP fund-holding was not subject to national evaluation but has been researched extensively (see Dixon & Glennerster, 1995; Glennerster *et al.*, 1994; Glennerster & Matsaganis, 1993; Goodwin, 1998; Gosden & Torgerson, 1997; Yule *et al.*, 1994). A large proportion of the literature evaluating fund-holding has focused on what changes were made rather than how changes were made, and debating the pros and cons of the scheme (see Bain (1994); Bowie and Harris (1994); Iliffe and Freudenstein (1994); and Keeley (1993)), but offering little in the way of evidence.

One area in which there is evidence about change and the use of incentives in fund-holding is prescribing (Gosden & Torgerson, 1997; Paris *et al.*, 1994; Stewart-Brown *et al.*, 1995). Practices managed prescribing within cash-limited budgets. The freedom to retain savings from that budget acted as an incentive to decrease expenditure. The national incentive scheme for prescribing is now well established. The use of incentives in this and other clinical areas has been shown to be effective (Gross *et al.*, 1996; Hillman, 1990; Hillman, 1991; Iliffe & Munro, 1993; Mooney, 1994). If incentives are effective in these areas, then they may also be so in others.

However, the effectiveness of incentives per se is not in question here. The relationship between principals and agents (including how incentives are used to help manage these relations) is the focus of interest.

Another major topic of research, and one where there has been a confused story, is GP referrals to outpatient care (see Faulkner *et al.*, 2003; Goodwin, 1998; Gosden & Torgerson, 1997). The conclusion to date has been that there is not enough evidence to make a judgement about the impact of fund-holding on referral patterns or costs. Some studies have shown an increase in referrals (Howie *et al.*, 1993), others have shown few or no changes (Corney, 1994; Dixon & Glennerster, 1995). The majority of referrals have remained at the local hospital (Whynes & Reed, 1994). However, a recent study by Dusheiko *et al.* (2003) shows that the fund-holding related incentives of a budget and explicit prices reduced fund-holder elective admission rates by 3.3%.

One interesting study that considered why changes took place is Whynes *et al.* (1996) who undertook an analysis of GPs' choice of referral destination and showed that price (assumed to be key to fund-holding practices) was not an important factor. The proximity of the hospital and clinical factors played a more important role than price. Glennerster *et al.* (1994) make a similar point; loyalty, professional and personal links, and sympathy for hospital colleagues make GPs reluctant to change referral destination. This suggests that, although GPs may not be dependent on their local providers, they do not often exercise their choice of alternative agents.

Whynes *et al.* (1996) give a number of reasons why price was an unimportant factor in the choice of referral destination. First, GPs did not feel that their fund-holding budgets were binding. Second, concerns about the doctor-patient relationship and public image may have resulted in GPs being disinclined to tell the researchers that price was an important issue. Third, the real price of changing to a cheaper alternative was prohibitive. The real price of change included costs such as patient dissatisfaction and of establishing relationships with new providers. Robinson (1997) makes the same point (discussed in the section "Key elements of principal-agent theory" on page 21) when considering the effectiveness of contracts in relation to primary and secondary care physicians in the United States. A further reason why price was not important in the referral decision may be that the GPs who were asked to complete the questionnaire on which this research is based were not aware of the costs of their referrals and thus did not consider this in their decision-making. The

questionnaire was sent to senior partners; fund-holding lead GPs could have given very different answers. If it is the case that these GPs were not aware of price issues, this is important, given that one of the assumptions of fund-holding was that GPs would be able to make cost-effective referrals. For PCTs, where GPs' roles arguably change from being principals (with NHS Trust as their agents) to being agents themselves for their PCTs, this is worthy of note. If GPs are not aware of the costs of care and are not aware of incentive schemes then PCTs' control of GPs by these means will fail. The same applies to the influence of hospital doctors.

For fund-holding, there appears to have been a forgone conclusion that the contracting process was effective in instigating change. Fund-holders were assumed to have power over their hospital providers by virtue of holding a budget.

Although in the early days of fund-holding, practices were able to shift services between hospitals with little danger of destabilisation (Corney, 1994), when the scheme was expanded to cover more services and more practices, shifts of contracts were harder to achieve. Howie *et al.* (1993) and Wisely (1993) claimed that it was greater communication with consultants as a result of the contracting process that enabled GPs to achieve change, not shifting contracts elsewhere. In some areas, dialogue between fund-holders, consultants and managers was the only method of achieving change due to local monopolies (Howie *et al.*, 1993). No details are given in these papers about the process of negotiations or how agreements were eventually reached.

More recently, waiting times for elective surgery have been shown to be shorter for fund-holders' than non-fund-holders' patients (Dowling, 2000). The tool to achieve this change was being seen by providers as having the potential to refer patients to alternative providers for treatment, and hence to remove payments. Propper *et al.* (2002) agree that fund-holders' patients' waiting times were reduced. They found that where doctors could choose the hospital for referral but did not pay for the care, waiting times were rarely reduced. Both studies, therefore, suggest that it is the ability to remove payments that is the key to achieving such changes. If that is the case, then the ability of PCTs to provide financial incentives or sanctions to NHS Trusts and to shift services should be important tools.

b) Total purchasing pilots

The role of GPs in any form of multi-practice led purchasing is hard to define in terms of agency theory. In the strictest sense, when a GP is sitting on a TPP board, s/he is playing the role of principal, deciding on the TPP's objectives and form of contract and monitoring with both external and internal providers. When that same GP is treating patients and making decisions on their behalf, s/he is acting as an agent (both for the patient and for the TPP).

A collaboration led by the King's Fund undertook the national evaluation of first and second wave total purchasing pilots (see Mays *et al.*, 2001b). Four pioneer sites were subject to local evaluations, the most prominent of these being the evaluation of the Berkshire Integrated Purchasing Project (BIPP), undertaken by the Health Services Management Centre (HSMC) at the University of Birmingham (see Walsh *et al.*, 1999). Each evaluation explored a number of basic issues related to the structure, process and, to a limited degree, the outcomes of total purchasing.

Despite concentrating on the structure and process of the total purchasing system, the national evaluation did not explore in detail *how* the purchasers (principals) encouraged the providers (agents) to work in the purchasers' best interests. Many of the evaluation's reports describe structures and processes related to the internal organisation of the TPPs, to GPs' roles and to relationships between the GPs, TPPs and health authorities. These relationships, from a principal-agent perspective, are concentrating on principals only: how new principals develop their roles, and how the multiple stakeholders within principal groups work together. In the BIPP evaluation there is concentration on the division of labour between GPs within and between practices, but this division of labour is related to the purchasing (principal's) role rather than that of GPs as agents (Walsh *et al.*, 1997).

One reason for this concentration on principals may be that in many cases the TPPs' main objectives related to changes in primary not secondary care (Malbon *et al.*, 1998). As a result of this, relationships with secondary care agents were of less importance. Indeed, in the preparatory, first and second live years of purchasing, only 15% to 28% of total transaction costs were due to TPPs' NHS Trust related functions (Place *et al.*, 1998). The remaining costs were accounted for by internal and health authority related functions.

Research by Baxter *et al.* (2000) is an exception to the assumption that the role of the GP is to act as principal to NHS Trust agents. They attempt to explore the extent to which GPs as agents are encouraged to maintain activity and expenditure within budgetary limits. The research looked at how GPs were informed about the TPPs' aims, and to what extent GPs were managed and monitored by the TPP in order that the TPP achieved its aims. However, this paper does not give details of *how* GP agents were managed by their TPP principals. The research was based on a questionnaire survey and shows that although all GPs were made aware of expenditure and referral levels for the standard fund-holding element of purchasing, in over half the pilots, the lead GP (that is, the GP who was on the TPP board and hence played a role as principal) was the only GP to be given this type of monitoring information.

The BIPP first year report (Walsh *et al.*, 1997) also made some effort to explore the control by the TPP of GPs' referrals. They give the example of non-urgent extra-contractual referrals (ECRs). ECRs are usually referrals for rare and expensive conditions that need to be treated at a specialist hospital outside the local area, with which there is no predetermined contractual arrangement. In BIPP, the non-urgent ECRs were discussed at the TPP's Purchasing Forum, a monthly decision-making board. A GP representative from the practice wishing to make the referral led the discussion, with advice given by the public health representative from the health authority on efficacy of treatment. Consensus decisions were made on the grounds of clinical efficacy and costs.

Thus, there is limited evidence from TPPs about the ways in which TPP principals engaged their GP agents and monitored them to ensure that their objectives were achieved. The information that is available from the BIPP evaluation suggests that GPs are able to step in and out of their roles as agents and principals as necessary.

The majority of evidence relates to GPs as principals.

The national evaluation team (Mays *et al.*, 1997) asserted that it would be fascinating to see whether a "commissioning" or a "fund-holding" approach would be the most successful in bringing about change. A commissioning approach was considered to be one where the purchasers and providers worked together to achieve joint aims. From a principal-agent perspective, this requires principals and agents to work

together to agree a strategy, how this strategy should be met and to meet it. The alternative fund-holding approach was for the principal to decide upon its own aims and to impose these requirements on the agent through a contract, and to monitor that contract to ensure that the aims were met to a satisfactory standard.

Findings show that there was a lack of commissioning skills in TPPs and a resistance to change by NHS Trusts and health authorities (Mays *et al.*, 1998). It is likely that the TPPs were using their fund-holding expertise to attempt to bring about change, but that this method of purchasing was inappropriate for the range of services required. The implication of this is that the principals and agents were not good at working together, possibly due to inexperience and a poor understanding of each others' needs. Some TPPs did use a commissioning approach: "rather than merely negotiating a contract [they] participated with Trusts in service development or regular quality assurance meetings." (Place *et al.*, 1998: 19). In addition, one of the second wave TPPs instigated "tripartite meetings" where GPs, health authority managers and managers from the acute trust met once a month to discuss the TPP's strategic plans (Malbon *et al.*, 1998). Walsh *et al.* (1999: 77) found that although "BIPP was set up in the fund-holding mode", over time, GPs changed their input into the contracting process from one of squeezing out more activity for no more cost to one of looking jointly at how service change could be introduced.

Conversely, the BIPP first report (Walsh *et al.*, 1997) notes how this pioneer TPP was different to the majority of its first and second wave cousins in that, from the beginning, providers were included in the project's development. Members of the Project Board (an advisory group for BIPP strategy) included providers. GPs were keen to have provider representation on the Board as they had learnt through their fund-holding consortium that this was a way of influencing their relationships and thus securing service change. The purchaser-provider spilt in the BIPP model was "far less distinct than in the centralised health authority approach to purchasing" (Walsh *et al.*, 1997: 63). NHS Trusts as agents were therefore quite active in developing their principal's objectives. This model has similarities with that described by Coleman Selden *et al.* (1999), discussed earlier. They considered the involvement of city council managers in their elected councillors' priority setting decisions. Agents were categorised as being "active" or "passive". Active agents (those choosing to be involved in strategic decision-making) were more enthusiastic

and successful in implementing these strategies than their counterparts who chose to play a pure management role and have strategy decisions imposed upon them. This suggests that where NHS Trusts are active in the health community's decision-making, the implementation of agreements may be more successful.

Whilst the BIPP style of involving agents in decision-making may have helped to achieve some aims, it was not totally successful. Both principals and agents had problems changing their "mindsets" (Walsh *et al.*, 1997); some NHS Trusts found it hard to accept contracts based on activity where previously they had been block, and some requests from the GPs were considered unrealistic. Although initially it was felt that there was a common agenda, this partnership feeling did deteriorate and there were frustrations, as illustrated by the following quote from a GP who was

> *"...fed up with the [Trust] controlling the agenda...our needs seem to accommodate theirs...change will happen only if it suits..." (Walsh et al., 1997: 42)*

This suggests that without incentives or sanctions to ensure change was effected, NHS Trusts seemed to have the power to choose when and how to implement change.

One tool that might have helped TPPs to overcome any difficulties in engaging NHS Trusts and delivering change was the contracting process. In particular, the national evaluation team considered holding a budget and contracting independently from the health authority important in achieving change (Mays *et al.*, 1998). However, it is not clear which aspect of the contracting process delivered change. In fact, having the *ability* to contract, and being seen to have that ability, may have been more important than the actual contracting process. Mays *et al.* (1998) state that where TPPs held their own budgets (rather than handing these back to their health authorities) and so had the ability to contract (and therefore, in theory, to change services or providers), this led to better joint working between TPP and NHS Trust, and as a result, changes in service delivery. The contracting process can therefore be viewed as a catalyst for change, with the "carrot" being the chance to have closer working relations and the "stick" being the power (rarely used) to remove contracts (Mays *et al.*, 1998).

Sticks were used in a limited way by BIPP. Where information requirements were specified but not delivered, the NHS Trust was penalised (Walsh *et al.*, 1999). BIPP

also introduced a number of different contract currencies, including occupied bed-days and banded lengths of stay. Banded lengths of stay meant that the longer a patient stayed in the NHS Trust, the less BIPP paid. This payment method should have resulted in an incentive to the NHS Trust to discharge patients earlier. The evaluation team found no evidence that this happened to a greater extent than for other local purchasers. It was not clear why this was the case. Walsh *et al.* (1999) conclude that contracting had not been a very effective means of changing activity for BIPP.

In contrast, Robison *et al.* (1998) report for the national evaluation that the contracting process was seen as "very important" as a mechanism for change by 39% of TPPs with independent contracts in 1996/7. Independent contracts are defined as those negotiated separately from health authority contracts. This figure fell to 30% in the following year. The percentage of TPPs having problems in making agreements also fell from 82% to 41%. The reasons why the contracting process was considered very important initially were to do with communication and power; TPPs were given the opportunity to communicate with clinicians and to negotiate from a "position of strength with financial leverage over providers" (Robison *et al.*, 1998: 40). However, there was also a realisation that effective communication went beyond contracting. GPs in BIPP came to value clinician-to-clinician contacts inside the strategic forum as a way of moving forward clinical issues (Walsh *et al.*, 1999). One of the reasons given by Robison *et al.* for the decrease in percentage of TPPs considering the contracting process very important was that a greater degree of trust had developed between the TPPs and NHS Trusts, with a more collaborative and less confrontational approach. This emphasises the need for the principals and agents to communicate with each other, to have a good rapport and to build up trusting relationships over time (Goodwin *et al.*, 2001). TPP principals did not decide on their objectives alone, and then set a contract for an agent to deliver these objectives; the process was a joint one. NHS Trusts were active agents.

Some TPPs chose not to have independent contracts, but to contract jointly with their health authorities. In many cases, the TPPs were passive partners (Robison *et al.*, 1998). This method of contracting is in effect merging two principals (the TPP and the health authority). The reasons why these principals chose to work together are not clear, but one TPP stated that "changes in service configuration had made it too

complex to proceed independently" (Robison *et al.*, 1998: 47). This is an example of the principal being overwhelmed by the decision-making, and reverting to a more experienced (and possibly more powerful) principal rather than negotiating more fully with the agent.

In negotiating and achieving service change, it was not always the management level within an NHS Trust that reached agreements with the TPP management. In an NHS Trust that had a local monopoly, the Trust management were not willing to talk with the TPP about changes to service delivery unless other budgetary issues were agreed first (Robison *et al.*, 1998). The TPP therefore talked direct to the hospital clinicians, who did agree to certain service changes, outside the contracting process. It is not clear from the report whether it was the TPP managers or the TPP GPs who talked to the hospital clinicians. It is likely that these discussions entailed a mix of principal, agent, management and clinical agendas.

The monopoly position of many NHS Trusts may also influence the degree to which the principals are able to achieve their objectives through these agents. Goodwin *et al.* (2000: 55) report that "provider reluctance to release funds to TPPs has been widespread". Good working relationships may alleviate these problems. Gask *et al.* (1998) report on TPPs working with mental health providers. They show that where there is a history of joint working between the GPs and the managers of the mental health providers, there is a comparative advantage in developing contracts and agreeing service change over those TPPs where relationships are not well developed. BIPP also found difficulties in extracting finances from a local NHS Trust for a planned reconfiguration of health promotion services (Walsh *et al.*, 1997). This problem seems to have been overcome by dividing the finances into separate envelopes of funds for core activities and for BIPP project work.

The quality of routinely supplied information on services was poor (Walsh *et al.*, 1999) and in some cases hard to obtain (Goodwin *et al.*, 2001; Robison *et al.*, 1998). Poor activity and cost data hampered attempts by TPPs to make service changes (Mahon *et al.*, 1998). In addition, it meant that monitoring was hard to achieve. As a result, outpatient activity in BIPP was not well controlled (Walsh *et al.*, 1999). Outpatient services were provided from the fund-holding and not the total purchasing budget, but the principle of control is the same. Both the NHS Trust and the GPs claimed that they could not control throughput. The NHS Trust attempted to

pass the financial problems resulting from this over-activity back to its purchasers, with the effect that the health authority had to solve the problem because it was the only body with statutory responsibility to do so. This example shows the potential power of the agent over the principal. Where there is a combination of poor information which means that the principal is not able to monitor the agent adequately, where the principal has not set incentive contracts to encourage the agent to control its own activities, and where there are insufficiently strong lines of accountability, the agent can take advantage by extracting additional funds from the principal.

Some TPPs relied heavily on their project managers to build good personal relationships with NHS Trusts and health authorities (Mays *et al.*, 1998). In one case it was suggested that the health authority provided legitimacy by adding its approval to a proposed service change (Goodwin *et al.*, 2000). Legitimacy is an important point raised by Kiser (1999) who reviews agency theory from the perspective of economics, political science and sociology. The notion of legitimacy in agency relations arises from analyses of the relationships between rulers and their administrative staff. Kiser gives legitimacy as one of the main differences between economic and sociological approaches to agency. Officials are more likely to comply with a ruler's directives if they see that that ruler has a right to give orders and that they, the officials, have a duty to obey. Simon (1991) makes a similar point. He argues that, within principal-agent relations between an employer and employee, there is a "zone of acceptance" within which the employee is expected to obey orders. An incomplete contract contains implicit and explicit limitations that set the boundaries of the "zone of acceptance". This may be important for PCTs as principals. The legitimacy of the principal in the eyes of the agent is usually provided by the choice by the agent to act as an agent for that principal. In the NHS, there is no market in which this choice is exercised. PCTs are taking on a new role. They are taking over from health authorities as the main principal commissioning care from NHS Trust agents. It is doubtful that NHS Trusts will be quick to accept the legitimacy of these commissioning groups.

In summary, over the lifetime of total purchasing pilots, the style of purchasing began to change from one of activity-based contracts to joint discussions between clinicians and managers from the TPPs and NHS Trusts. Information was often

poor, making monitoring difficult. TPPs relied quite strongly on their health authorities to provide experience and legitimacy.

c) Primary care groups and trusts

PCG/Ts are similar to TPPs in their principal-agent relationships. PCG/T Boards and Executives can be seen as principals with two sets of agents: GP practices and NHS Trusts.

Two national evaluations of PCG/Ts have taken place. One (the Tracker Survey) was co-ordinated from Manchester (Wilkin *et al.*, 2000; Wilkin *et al.*, 2001; Wilkin *et al.*, 2002) and the other from the University of Birmingham's Health Services Management Centre (Regen *et al.*, 1999; Regen *et al.*, 2001; Smith *et al.*, 2000). The Tracker Survey was based on interviews and postal questionnaires with Chief Officers, Chairs and health authority leads from 72 nationally representative PCGs and PCTs. Dusheiko *et al.* (2000) report in more detail on budgets and incentives in these 72 PCG/Ts. The HSMC study evaluated twelve PCGs. The evaluation began in 1998 and was based originally on a larger study of 40 GP commissioning group pilots. PCGs in this study should therefore have been commissioning (or planning to commission) secondary care services since April 1998.

In addition, the Audit Commission (2000) undertook an early survey of 12% of PCG Chief Executives between July and September 1999 and interviewed PCG board members. It provides descriptions and recommendations for future action, rather than evaluation of progress.

Each of these reports offers a description of PCG/Ts and their many functions. The aims of the reports were to identify lessons to be learned (Regen *et al.*, 2001), to provide "a baseline against which progress in future years can be judged" (Dusheiko *et al.*, 2000: 30) and to describe how core functions were tackled and to identify features associated with success (Wilkin *et al.*, 2002). The reports vary in the depth of their analysis of why or how achievements are being made. In general, PCGs and PCTs were seen to have made slow progress in terms of commissioning secondary care services (Audit Commission, 2000; Regen *et al.*, 2001; Smith *et al.*, 2000; Wilkin *et al.*, 2002).

As with the evaluations of TPPs, the findings can be categorised into those concerned with GPs as agents and those concerned with NHS Trusts as agents.

In relation to GPs as agents for the PCG/Ts, the Audit Commission (2000) report found that there was a lack of involvement by GPs and that some refused to share data between practices. They recommend increasing the degree of ownership by practices by devolving some planning and decision-making to clusters of practices. Such a policy would in fact introduce an additional layer of agency. Fifty three percent (32/60) of PCGs planned to introduce practice-level indicative budgets for HCHS (Dusheiko *et al.*, 2000).

Some GPs, particularly single-handed ones, saw clinical governance as the start of a take-over by PCG/Ts (Smith *et al.*, 2000). This may be a serious issue for PCG/T boards to overcome. If GPs are to be effective agents, they must first accept that their principals have a legitimate right to devise and demand compliance with contracts. GPs are independent contractors and are accustomed to managing their own small businesses. As such "PCGs cannot direct; only (in partnership with other bodies) advise, educate, and apply peer pressure" (Audit Commission, 2000: 38). Management by collaborative boards comprised of lay people and other health professionals may not be accepted easily.

There is a varying commitment to board work by GPs and also a significant gap in understanding and engagement with PCG priorities between board member GPs and other GPs (Smith *et al.*, 2000). Fifty percent of GPs who responded to Smith *et al.*'s questionnaire had never attended a PCG sub-group meeting. This begs the question of why non-board GPs are not involved. It may be that board members have a defined role (as principals) whereas other GPs are unsure of their roles. In effect, they are agents for the PCG/T boards. This may open debates about the power relations between groups of GPs and the legitimacy of control (as referred to above).

There are few details with regard to the methods of control of GP agents. Most PCG/T Chairs reported that, for primary care development, they favoured rewarding improved performance and investing in poor performing practices rather than withdrawing funds (Wilkin *et al.*, 2000). If this is the case for controlling GP agents, it may be the case also for other agents, that is, NHS Trusts. Baxter *et al.* (2001, and see Appendix 1 for summary of study) showed that, in relation to commissioned

services, financial incentive schemes for practices were not widespread. Peer pressure, informal feedback on practice and GP activity, and written feedback on practice activity were the most common methods of influence. Few PCG/Ts supplied information to their practices or GPs on the cost of activity in secondary care.

Recently, the Health Service Journal has reported that eight or nine PCTs at the forefront of developments have begun to manage their GPs' referrals to hospital and hospital waiting lists (Davies, 2003). Their aims are to eliminate waiting lists and to divert patients to care in a more appropriate setting than hospital. The same article cites an Audit Commission report that found 23% of PCTs in 2002 were attempting to manage their referrals to secondary care.

In summary, research to date suggests that there is little realisation by PCG/Ts or by GPs that GPs are agents for their PCG/Ts in relation to commissioning, and methods of control are not well developed.

With regard to commissioning secondary care, progress by PCGs had been limited by insufficient management support, inadequate information and a perceived "lack of financial clout" (Regen *et al.*, 2001: 17).

Few PCG/Ts have member practices with experience of "collaborative commissioning", most have the different styles and skills needed for single practice GP fund-holding (Audit Commission, 2000; Wilkin *et al.*, 2000). The Audit Commission report suggests specifically that the "commissioning experience of former fund-holding practices ... is of less direct relevance" than that of collaborative commissioning such as through GP commissioning group pilots (Audit Commission, 2000: 16). In their study, more than a third of PCGs contained no general practices with experience of collaborative commissioning. With regard to viewing PCTs as principals and NHS Trusts as agents, the implication is that the relationships between the two should become more co-operative.

Co-operation *between* principals will be tested by lead commissioning arrangements. Where PCTs are working together, NHS Trust agents will face fewer principals. This may make it easier for the agent to provide services, but could bring problems to the principals in terms of group collaboration and decision-making.

Collaboration between PCG/Ts for commissioning was common, particularly for specialist services (Regen *et al.*, 2001; Wilkin *et al.*, 2002). A third of PCG/Ts in the Tracker Survey operated joint commissioning groups with other PCG/Ts and the majority of those in the HSMC evaluation participated in collaborative commissioning arrangements. Whether or not PCG/Ts commissioned services alone was related only loosely to the size of the PCG/Ts (Wilkin *et al.*, 2002). The HSMC evaluation showed that collaborative commissioning arrangements usually involved one PCG/T taking the lead role with certain providers on behalf of other PCG/Ts.

Most PCG/Ts participated also in health authority-wide commissioning groups that included representatives from PCG/Ts, the health authority and local providers (Regen *et al.*, 2001). In 1999/2000, all the PCG/Ts for which there were data had a main Service Level Agreement that covered more than just their own PCG/T. By 2000/1, two out of twelve had Service Level Agreements that were limited to their own groups. There were examples also of SLAs becoming more consistent with PCG/Ts' wishes.

Working together with other PCG/Ts was seen to increase the leverage of the PCG/Ts over the NHS Trusts (Wilkin *et al.*, 2002). This advantage was perceived as very important as a lever, second only to issues around economies of scale and expertise. For those PCG/Ts in the HSMC study, collaborative working was seen as a method of reducing financial risk (Regen *et al.*, 2001).

Financial incentives were not used routinely in SLAs for commissioned services (Wilkin *et al.*, 2002). Only 12% of PCG/Ts used financial incentives in 2001/2, whereas in the previous year 17% had done so. Where incentives were used, they were non-recurring bonuses to reward the meeting of waiting time targets. It may be that PCOs felt that they did not have sufficient funds available to offer rewards for achievements, or that withholding funds from NHS Trusts if they did not achieve may damage their ability to function. It may also be that the quality of information was not sufficient to allow PCG/Ts to monitor whether or not rewards should be paid.

Whilst almost a quarter of PCG/Ts felt that they had substantial leverage over their providers, almost half perceived they had little leverage (Wilkin *et al.*, 2002). There was no difference in these perceptions between PCGs and PCTs, that is, PCTs were

not consistently more or less powerful *vis-à-vis* their providers. "Financial clout" was also a major problem for some PCGs (Regen *et al.*, 2001). Many believed that transferring to PCT status would improve this. Some felt that as providers of community services, PCTs would be brought closer to secondary care providers with the potential for increased integration and communication.

From 1999/2000 to 2000/1 PCG Chief Executives became more aware of the need to manage a budget for commissioning (Regen *et al.*, 2001). Two strategies were adopted to manage risk: the use of block contracts with providers and the sharing of risk with other PCGs (Regen *et al.*, 2001). However, two thirds of PCG/Ts did not plan to make any shifts in expenditure between different elements of the unified budget; the other third planned to expand their spending on GMS by reducing HCHS or prescribing expenditure (Dusheiko *et al.*, 2000).

Not all PCGs had a delegated budget and, for those that did, the average amount delegated was 67% (Smith *et al.*, 2000). All of the PCGs studied by the HSMC team "acted collectively" in commissioning their main service agreement. It is not clear from the report whether the health authority commissioned these service agreements on behalf of the PCGs, or whether the PCGs themselves played an active role. The Tracker Survey (Wilkin *et al.*, 2000) gives similar results; 89% of PCG/Ts were involved in some sort of collaboration in the commissioning of community health services, 99% for hospital services. The evidence for total purchasing pilots suggested that contracting independently from the health authority was one of the key factors in achieving service change, although it is not clear why this was the case. If part of the success related to individual TPPs being small enough to negotiate change without destabilising providers, then this advantage may be lost through collaborative purchasing. The advantages of contracting as a catalyst to improve communication may also be lost if relationships become more remote as the size of the purchaser increases.

Some PCG/Ts in the HSMC study felt that their health authorities were attempting to "hang on to commissioning" by deliberately failing to provide the support and information needed (Regen *et al.*, 2001). In a survey of PCG/Ts in 2001, Baxter *et al.* (2002) found that about a third of PCG/Ts were still relying on their health authorities to commission services. In addition, some NHS Trusts had not accepted PCGs as their commissioners and were perceived to be likely to go "running back"

to the health authority if they did not like something about the PCGs' commissioning (Regen *et al.*, 2001: 55).

In fund-holding, the option of exit, that is, to change providers, has been shown to be a tool for achieving change in the form of lower waiting times (Dowling, 2000). For PCG/Ts, there was little evidence of attempts to improve services by changing providers (Wilkin *et al.*, 2002). One PCT had changed providers for orthopaedic services; there were no other examples. For the major acute specialties, most PCG/Ts had a choice of main provider, but did not activate this choice.

In most PCG/Ts, PCG/T and health authority managers rather than clinicians led the commissioning process (Regen *et al.*, 2001). Hospital managers were not considered to be influential in commissioning decisions, but hospital clinicians were (Wilkin *et al.*, 2002). This is interesting given the general desire to increase clinicians' involvement, in particular, clinician-to-clinician discussions about service priorities and developments. Where these discussions had taken place, they were seen to have increased the levels of trust between the organisations and fostered better relationships (Regen *et al.*, 2001).

In summary, the knowledge to date about NHS Trusts as agents suggests that financial levers as methods of influence by PCG/Ts are limited and that PCG/T managers are only beginning to come to terms with their role as commissioners. Collaboration between commissioners is common and a commissioning rather than purchasing approach considered most appropriate.

6) Summary

This review has outlined the economic theory of agency and shown how closely it parallels current policy with regard to commissioning. It has illustrated also the ubiquitous nature of principal-agent relationships in health care in hierarchical and network, as well as quasi-market, structures. The principal-agent framework has been used as a lens for investigating a variety of relationships in health care and other settings. Other frameworks, above all new institutional economics, have shed light on different aspects of commissioning, in particular, contracts and transaction costs.

To date, research relating to PCG/Ts and their commissioning has been predominantly large scale, providing insights into the pace and scope of progress. PCTs' relationships with both NHS Trusts and GPs are immature. The findings of this review suggest that PCT/NHS Trust commissioning relationships are developing more quickly than PCT/GP relationships with respect to commissioned services. Within PCTs, internal systems and levers are not well developed, to the extent that research to evaluate both internal and external methods of control by PCTs would not be productive at this stage.

With regard to the commissioning by PCTs of secondary care, the main findings to date beget further questions. For example, there is limited evidence on how organisations relate to each other. How are commissioning agreements reached? Do PCTs consider themselves principals and NHS Trusts consider themselves agents? Evidence shows that incomplete contracts are the norm. So are PCTs setting contracts designed to influence NHS Trusts' behaviour? If not, then how are PCTs trying to influence NHS Trust behaviour? Whilst joint planning and collaborative commissioning are becoming more common, research demonstrates that overlapping principal-agent relations may cause conflicts in objectives. This begs the question of how distinct the different organisations' roles are, and how multiple PCTs work collaboratively. Information has been shown to be of poor quality and as a result there is a concern that the transaction costs of managing long-term contracts may be high. The question then arises of how either PCTs or NHS Trusts can act in accordance with their commissioning requirements whilst informed by a possibly inadequate information base. Reliance up to now on health authorities to aid or even lead the commissioning process has been high. It remains to be seen whether PCTs are powerful enough or have the appropriate experience and legitimacy to commission services independently. The closeness of PCTs to their main providers should mean that they are in a better position than health authorities to set and monitor contracts. However, problems in measuring or specifying multiple outcomes, or both parties possessing very similar objectives, may mean that contracts are not considered critical. Indeed, the use of financial levers thus far appears to be minimal. If these levers are not being used, what methods of influence, if any, are they being replaced with? If PCTs and NHS Trusts do not consider themselves principals and agents, or do not act as if they are, then the effectiveness

and indeed purpose of a policy based on contractual relations, and the methods of reaching agreements within such a policy, are not immediately obvious.

Commissioning relationships between PCTs and NHS Trusts are new. Despite earlier forms of commissioning and purchasing, commissioning by PCTs is the first time that such large groups of general practices have been convened in a non-voluntary manner to commission secondary care. As such, they pose an interesting and new area for study. As Wilkin *et al.* (2001) assert, little is known about the extent and nature of commissioning activity. The remainder of this thesis fills part of this gap in knowledge by providing an in-depth analysis of the nature of these commissioning relationships.

The next chapter states the aims and objectives of this research and gives details of the methods employed to answer these questions.

Chapter Three: Aims, Objectives and Methods

Chapter two reviewed the use of principal-agent theory in health care research and the current level of knowledge about commissioning by primary care organisations. This revealed important factors, including the complex but ill-defined nature of PCOs' relationships with both NHS Trusts and GPs. Both sets of relationships were shown to be embryonic and the use of incentives not well developed. The role of GPs, in particular, as agents for PCOs is very immature. What is missing from the available body of research is an in-depth understanding of how and why PCTs manage their relationships with respect to the commissioning of secondary care services from NHS Trusts.

This chapter gives the aims and objectives of the research, followed by a statement of its originality. Sections three to six give the research strategy, the selection, recruitment and characteristics of the three case studies. Sections seven to nine detail the methods of data collection, coding and data analysis.

1) The aims and objectives of the research

The aim of the research is to provide an in-depth analysis of primary care trusts as commissioners of secondary care services using the underlying assumptions of principal-agent theory as a lens for investigation. The specific objectives are as follows:

1. To show the extent to which PCTs and NHS Trusts act as principals and agents respectively, and how they enact these roles.
2. To investigate the importance of objectives, information asymmetry and risk to the commissioning process.
3. To show if and how Service Level Agreements and incentives are used to manage relations between PCTs and NHS Trusts.
4. To demonstrate how commissioning negotiations are used to align NHS Trusts' objectives with PCTs'.
5. To illustrate the impact on commissioning styles of external and contextual factors such as multiple principals and vertical tiers of principals and agents.

2) The originality of the research

Silverman (1993) maintains that theories are neither true nor false, but provide sets of explanatory concepts that offer alternative views of the world. As shown in chapter two, a principal-agent view of the world of relationships between health care organisations can offer useful insights. To date, the principal-agent framework has not been used to evaluate primary care trusts as commissioners of secondary care services. A significant amount of research has focused on one aspect of commissioning relationships: contracts. In particular, the focus has been on whether or not contracts are complete and on the measurement of transaction costs associated with contracting. In addition, large-scale surveys have been used to study the overall impact and development of recent reforms in the NHS. Although valuable, they cannot offer an in-depth understanding of commissioning by PCTs.

This study fills a gap in current research knowledge. It considers the wider issues of how PCTs and NHS Trusts play their roles of principals and agents within the complex web of such relationships in the English NHS. The key elements and assumptions of the principal-agent framework are used as a basis for the analysis of relationships between PCTs and their secondary care agents. It may be that some aspects of the framework illuminate characteristics of these relationships not previously considered in detail. Others may not be realistic or relevant in this context.

Formal modelling in agency theory pays attention to important issues for public policy, such as multiple dimensions and multiple principals, and this is giving useful insights into reality (Dixit, 2002; Levaggi, 1999). Dixit (2002) suggests that empirical research on principal-agent theory in the public sector should not seek sweeping universal findings of success and failure of performance-based incentives. Instead, he suggests researchers should try to relate successes and failures to specific characteristics such as multiple dimensions and principals, and observability of outputs and inputs.

My own research relates characteristics such as multiple dimensions, multiple principals, and the observability of outputs and inputs to the process of agreeing commissioned activity and of controlling agents. My research will therefore use agency theory to offer a new perspective on devolved budget holding in the NHS. It

demonstrates to PCTs and NHS Trusts, in detail, the ways in which their counterparts in three case studies relate to each other with respect to commissioning secondary care services. It draws out the common factors that affect the attitudes towards and processes of commissioning. PCTs, NHS Trusts and other organisations that take part in commissioning processes will be able to use the findings of this research to develop their own commissioning styles in an informed manner.

3) Research strategy

This section outlines the broad plan of the research and explains its appropriateness to the research question. The strategy brings together case study research, qualitative methods and "realistic evaluation" (Pawson & Tilley, 1997).

Yin (1994) defines a case study as an empirical enquiry that investigates a contemporary phenomenon in context, where the boundaries between the phenomenon and context are not clearly evident and in which multiple sources of data are used. Case studies can be used to answer particular types of research questions, specifically, where a "'how' or 'why' question is being asked about a contemporary set of events, over which the investigator has little or no control" (Yin, 1994: 20).

Qualitative research is often termed interpretative research and can be defined as an attempt to interpret phenomena such as interactions or behaviours, in terms of the meanings people bring to them (Denzin & Lincoln, 1994; Pope & Mays, 2000). Qualitative research is concerned with taxonomies and classifications, seeking to ask "what is X, how does it vary in different circumstances, and why?". Quantitative research, in contrast, seeks to measure "how many Xs are there, and is X associated with Z" (Pope & Mays, 2000). Other distinguishing and key features of qualitative research are that it studies people in their natural settings and can use a number of different methods. These different methods include watching people in their own territories (observation), talking with people (interviews or focus groups) and reading what people have written (analysis of documents). Qualitative research may be used entirely independently, or in conjunction with quantitative research to illuminate or explain statistical findings (Ritchie & Spencer, 1994).

Qualitative research methods have long been used in the social sciences (Pope & Mays, 2000) and their use is growing in health economics and the study of health care organisations (see Coast, 1999; Coast, 2001; Goddard *et al.*, 2000; Griffiths & Hughes, 2000; O'Hanlon *et al.*, 1994; Peck *et al.*, 2002; Robinson *et al.*, 1997). A feature of much qualitative research is that there is no specific hypothesis at the outset; often hypotheses are produced through the research (Silverman, 1993). The aims of qualitative research are numerous, and include in-depth exploration of an issue, understanding processes, explaining why and showing how phenomena occur, and the generation of new ideas. When used as stand-alone research, qualitative research can uncover social processes or access areas of life that are not amenable to quantitative research (Pope & Mays, 2000).

In applied policy research, qualitative methods are used to meet a number of different objectives, often categorised into four groups: contextual, diagnostic, evaluative and strategic (Ritchie & Spencer, 1994). These are not mutually exclusive. Contextual objectives include identifying the form and nature of what exists. Questions to be addressed are those such as "What is the nature of people's experiences?" and "What elements operate within a system?". Diagnostic objectives examine the reasons for, or causes of, what exists. Areas to be considered could include "Why are decisions or actions taken (or not)?". Evaluative objectives appraise the effectiveness of what exists. For example, "How are objectives achieved?" and "What affects the successful delivery of programmes?". Strategic objectives identify new theories, policies or actions. Questions to be addressed could include "What actions are needed to make programmes more effective?" or "What strategies are required to overcome newly defined problems?".

The purpose of qualitative research is to seek explanations. Qualitative research does not make predictions about what will happen, but attempts to explain the reasoning behind the occurrence of certain events. Cicourel (1964) (in Silverman 1993) draws attention to how purely mathematical logic may neglect the common sense reasoning used by participants; following logical formulae to arrive at results may give correct results (given certain assumptions), but will not help to explain how or why those results came about. Woo (1986: 104) agrees: "...the laws of nature, and for that matter, the laws of human or social reality, cannot be formulated

as an axiomatic, deductive, formal and unambiguous system which is also complete."

Pawson and Tilley (1997: 220) characterise "realistic evaluation" as investigating how programme outcomes are generated by specific mechanisms and contexts in order to identify what works for whom in specific contexts. They consider the relationship between phenomenon and context by encouraging evaluators to search beneath the visible inputs and outputs of a programme. They stress the importance for research of remembering that a range of macro and micro social forces generate outcomes and that the balance of power and resources of actors limits their capacity for making choices.

Both case study and qualitative research gain their validity from analytic or theoretical generalisability rather than from sample to population generalisability (Miles & Huberman, 1994; Yin, 1994). The purpose of case study research is to generalise a particular set of results to some broader theory through replication (Yin, 1994), not to generalise to populations or universes. Likewise, qualitative research aims to reflect the diversity within a given population, rather than reflect statistical generalisability (Barbour, 2001). Qualitative research aims to improve the understanding of complex human issues (Marshall, 1996) and be analytically generalisable to existing or new theories (Miles & Huberman, 1994).

The generalisability of case studies occurs at what Yin (1994) refers to as Level One not Level Two. He defines Level Two generalisation as that obtained from statistical inferences about a population that can be made from a sample of that population. In case study investigations, Level One generalisability comes from using a previously developed theory as a template with which to compare the empirical results of the case study.

Where more than one case study exists within the same research investigation, each should be treated as a separate investigation rather than, for example, as an additional respondent to a survey. The similarities and differences between the dimensions of chosen case studies allows the testing of ideas in a conceptual framework and general statements about core processes and dynamics (Miles & Huberman, 1994). Pawson and Tilley (1997) agree that, instead of replicating interventions in anticipation of the same results, subsequent evaluations should be

seen as an opportunity for focusing on the fine-tuning of programmes to adapt them to local circumstances. Whilst Yin claims that where more than one case study supports a theory (particularly if neither support a rival theory) "replication may be claimed" (1994: 38), Pawson and Tilley (1997: 217) believe that researchers should use the accumulation of evidence to generalise about programmes to create "middle range theories" to interpret similarities and differences between programmes. Qualitative research's external validity is often referred to as transferability or fittingness (Miles & Huberman, 1994). The generalising process is perceived as more of a bringing together of data through the translation, refutation and synthesis of two or more studies, rather than merely "adding up" their results.

In addition to the choice between a single or multiple case studies, the choice should also be made between single or multiple units of analysis (Yin, 1994). This choice refers to the level at which analysis will take place, for example, in an investigation of an organisation, will data from different departments within that organisation be treated together or separately? This relates closely to the mechanisms and contexts discussed by Pawson and Tilley. To understand fully how a programme works it is necessary to understand "for whom and in what circumstances" a programme works and through what mechanisms (Pawson & Tilley, 1997: 216).

I chose to explore by in-depth study of three case studies, using multiple levels of analysis (main PCTs, other PCTs, NHS Trusts, managers and clinicians) the commissioning relationships between primary care trusts and NHS Trusts. I used multiple sources of data (observations, interviews and documents) that were analysed using qualitative techniques to give insights into theory and policy.

4) Selecting the case studies

The sample of case studies for observation and interview was selected purposively to generate pertinent data (Mason, 2002). Purposive sampling requires prior knowledge of the research population and the subject of study. My research population comprised all PCTs and NHS Trusts. My subject of study was the relationships associated with the commissioning of secondary care by primary care trusts and the lens through which I was viewing these relationships was principal-

agent theory. My prior knowledge of the research population was gained from recent literature and my own work (see Baxter *et al.*, 2001; Baxter *et al.*, 2002).

The main assumptions of principal-agent theory are that there is information asymmetry between principal and agent (the agent is better informed) and that principal and agent have different objectives (both aim to maximise their own self-interest). In this respect, agents are in a position of power relative to the principal because they can use this information asymmetry to their own advantage. The challenge was to select case studies that differed in aspects that could affect information asymmetry, objectives and relative power.

I selected case studies with different characteristics to each other but that mapped the characteristics of the wider population of all PCT/NHS Trust commissioning relationships. These case studies do not represent all possible models of commissioning, but do include particular circumstances that affect commissioning and are likely to be found in other examples of such relationships. The mixture of dimensions affecting how the case studies worked was unique to each. The dimensions that are shared or contrasted, however, enable the testing of ideas and allow general statements to be made about the core processes at work (Miles & Huberman, 1994). For example, there may be a small number of NHS Trusts working within severe financial constraints and with a large number of PCT commissioners, but many NHS Trusts have severe financial constraints and many have a large number of PCT commissioners. Findings about how these factors affect the commissioning relationships are therefore of interest to many other organisations.

I chose a two stage sampling procedure. First I selected the case studies, each comprising an NHS Trust and at least one PCT. After detailed observations of commissioning meetings, I selected interviewees from within and outside those meetings. This method provided me with an in-depth understanding of how these organisations worked together and was preferable therefore to a random sample of managers and clinicians from a greater number of organisations.

a) The sampling frame

A sampling frame was developed and case studies selected in July 2001. A sampling frame is a resource from which a sample can be selected (Mason, 2002). The nature

of data required for the sampling frame was informed in part by a survey of PCGs and PCTs undertaken in February 2001 (see Baxter *et al.*, 2001; Baxter *et al.*, 2002).

The sampling frame consisted of the following data:

- size of PCO - the number of practices, GPs and patients
- the percentage of patients classified as rural
- distance from target financial allocation
- number of potential providers per PCO
- number of PCOs per provider.

The National Database for Primary Care Groups and Trusts (Wagner & Baker, http://www.primary-care-db.org.uk/) provided data for PCOs in 1999/2000 for the first three items listed. The latter two were estimated from information given on PCOs' web sites; this information was taken into account only for those PCOs considered in the final selection process.

Each of these factors and the reasons why they are important from a principal-agent perspective is explained below.

- The size of the PCT. Size can be measured as the number of practices, GPs or patients. Size was considered important for a number of reasons. First, a large PCT may be considered more powerful than a smaller one due to its larger share of an NHS Trust's services. An NHS Trust is more dependent upon a single large commissioner than each of a number of smaller ones. Second, a small PCT may be considered more powerful than a larger one due to its flexibility in terms of shifting contracts to alternative providers. Third, a large PCT may be less able than a small PCT to represent the needs of all its member practices and offer a coherent policy to external organisations.

  It was therefore important to choose at least one large and one small case study. Size was defined as the number of practices in a PCO. The number of patients is reported also for the chosen case studies.

- The urban/rural mix of each case study was considered important. A geographically compact urban PCT would have different population needs compared to a sparsely populated rural PCT, for example in terms of

community services. As such, the secondary care objectives of a rural PCT may differ more from its NHS Trust than those of an urban PCT, for example in the type and location of care.

It was therefore important to have a predominantly rural and a predominantly urban PCT in the sample.

- The distance of the PCO's financial allocation from their target fair share. A national funding formula is used to calculate the equitable level of funds that each health authority and PCO should receive. This target allocation is compared with current allocations. The difference between the current and target allocation is known as the distance from target (DFT). PCOs can be over or under their target allocation. Over time, it is planned that the annual funding for each PCO will move towards the target level, either through the awarding of additional growth money for those under funded or through a reduction in growth money for those currently over funded.

  If the principal's budget is low, they will in turn have to pass on lower payments to their agents. This is likely to lead to conflicts where an agent's objective may be to maximise financial gain, and a principal's is to minimise expenditure. Where the budget is low, the PCT may have to use strong financial incentives to control the NHS Trust's spending, but at the same time feel unable to do so because insufficient funds are available for incentive payments. In addition, if a PCT is under target, it is likely that the health community in the past has been under target and the NHS Trust may have financial problems.

  The PCTs were chosen to reflect different levels from their "target allocations": one under, one over, and one approximately on target.

- The number of potential NHS Trust providers per PCO. The standard assumption is that principals and agents operate within a contestable market; principals can "shop around" for the agent of their choice. With regard to hidden-action, a higher number of agents with which the principal has contracts suggests that it would be more difficult for the principal to observe each agent closely enough to determine their effort. For example, if a PCO has SLAs with four or five hospitals, the PCO's ability to observe each

hospitals' effort in achieving the PCO's aims may be lower than if a single SLA were held with just one hospital. There is more likely to be a greater range of exogenous factors (both positive and negative) with a greater number of agents. Again, the greater the occurrence of exogenous factors, the less able will be the principal to observe them all. With regard to agent type, a principal with a large number of agents will be less likely to know each well enough to determine their type.

The market contestability of each NHS Trust was therefore important. The factor chosen to reflect this was the availability of other NHS Trusts within a 30-minute travel time[a]. At least one case study should have competitors and at least one should not.

- The number of PCOs per provider. In 2001/2, 45% of PCOs with a sub-group for commissioning operated this sub-group jointly with other PCOs (Wilkin *et al.*, 2002). A third of PCOs in the southwest region delegated commissioning responsibility to neighbouring PCOs in 2000/1 (Baxter *et al.*, 2002). A hospital that is contracted to work for a number of PCOs is likely to find that each principal's requirements differ in terms of effort, and that each principal monitors effort to different degrees. An agent acting on behalf of a number of principals may find that one principal's request affects the agent's ability to meet another principal's requirements.

  It was therefore important to choose a case study in which the NHS Trust had one main commissioner and also one in which the NHS Trust had a number of commissioners.

[a] Propper (1996) found that less than 10% of hospitals had no competitor within a 30-minute travel time.

The sampling quota is given in Table 2.

Table 2 Sampling quota

Factor	**Requirement**
Size	One large, one small PCT
Urban/rural mix	One urban, one rural PCT
Distance from target allocation	One above, one below target
Number of providers per PCT	One PCT with a choice of providers, one with no choice
Number of PCTs per provider	One NHS Trust with many commissioners, one with a single main commissioner

The PCOs were ranked according to size, DFT and urban/rural mix. The average size of a PCO at the time was 19 (range 5 to 68). Many of the PCGs had merged since the database had been compiled and so in reality the sizes of PCTs were larger. In 2000/1 the average size was 22 (range 5 to 85).

The number of NHS Trusts with which PCOs could contract and the number of PCOs contracting with an individual NHS Trust were considered only for those PCOs that seemed most appropriate in the other categories.

Deprivation was not considered to be an important issue per se in terms of differences in principal-agent relationships in commissioning. However, given the range of deprivation levels in the country, it seemed appropriate to mirror that with at least one deprived area. This was also a secondary consideration, taken into account after the PCTs had been chosen according to the other main factors.

It was not practical to select case studies according to the type of contract used; this information was not readily available. In addition, a questionnaire survey of PCOs in the southwest had shown that half of all PCOs used simple block contracts as Service Level Agreements (Baxter *et al.*, 2001). Furthermore, the focus of the thesis was to evaluate relationships and decision-making, not contract types.

5) Recruiting the case studies

An invitation to take part in the research was sent to the Chief Executive of the main PCT in each potential case study. The research was described as a study of commissioning, specifically, how primary care organisations work with NHS Trusts to achieve their goals of securing patient services from secondary care.

Three PCOs were approached to take part in August 2001. One was small (13 practices), one average (19 practices) and one larger than average (27 practices). The larger than average PCT agreed in September to take part in the research. This was PCT C. The other two declined.

One PCG (19 practices) declined to take part in the research because it was in the process of merging with another PCG and felt that the research would be too much for them to take on at the time. Although small at the time of recruitment, this PCG would have become larger than average sized after the merger. An average sized PCT (23 practices) was approached as a replacement. This PCT (PCT A) agreed in September to take part.

The small PCT (13 practices) that was approached agreed to take part but two neighbouring PCTs that commissioned jointly for services at the same NHS Trust were not happy for meetings to be observed. They had two concerns. First, the commissioning process was too sensitive because of its infancy and their main priority was to ensure the system was working appropriately. Second, the number of attendees at commissioning meetings was small and they were concerned that the presence of an observer would change the dynamics of the meetings. The small PCT therefore withdrew from the study.

By this stage (October 2001), two PCTs (PCT A and PCT C) had agreed to take part in the research; one was average sized (23 practices) and one larger than average (27 practices). Due to the apparent difficulties in recruiting a small PCT and the national tendencies towards mergers, the decision was made to approach a very large PCT instead. The first large PCT that was approached agreed in December 2001 to take part. This was PCT B with over 35 practices.

As a result of these refusals, none of the case studies includes a very small PCO as the main commissioner. However, some of the PCTs commissioning jointly with the

main study PCTs were small (between 14 and 18 practices). The possible effects of this are considered in the section on study limitations in the discussion chapter.

Each PCT that did agree to take part responded by directing me to a series of meetings that they considered most appropriate for gaining an understanding of the current commissioning processes. These meetings are described fully below, in the section on data collection.

Specific details of the recruitment in each case study are given below.

a) Case study A

The PCT Chief Executive agreed in principal to take part in the research but stated that the Health Authority (HA) took the lead role in commissioning. I was directed therefore to the Health Authority Director of Finance for further discussions. The Health Authority Director of Finance gave permission for the research to go ahead and became the main contact for the research. He contacted the Chief Executive of the NHS Trust to gain his agreement to take part.

I was invited to visit a number of key people at the health authority in order to understand the history and context of that health authority and its commissioning systems. I had meetings with the Director of Finance, the Director of Primary Care Performance, a Specialist Commissioning Manager and a Capacity Planning Manager. I also visited the PCT and had discussions with the Chief Executive and the Director of Finance. I attended one of the public board meetings of the PCT where I was able to meet the Chair and some of the GP members of the PCT. These preliminary meetings took place in October and November 2001.

To observe the commissioning process in practice, the Health Authority Director of Finance suggested I attend the Planning and Performance Review Meetings between the health authority and each of its PCTs and NHS Trusts. Initially, I attended three meetings between the health authority and organisations that were not part of the case study. These enabled me to understand the format and content of the meetings prior to observing three case study meetings.

b) Case study B

In case study B, the Chief Executive of the PCT agreed to participate in the research. This agreement was reached in December 2001. She discussed the research with me at length over the telephone and suggested I contact the PCT Director of Commissioning for details of commissioning meetings.

The PCT Director of Commissioning explained that the commissioning process for 2002/3 had just begun with a meeting between PCT and NHS Trust clinicians at which clinical priorities for 2002/3 had been discussed. This meeting had been held in the first week of December 2001. I was invited to attend part two of this meeting the following week. Part two was a continuation of discussions for which there had not been time in part one. This meeting was followed the next day with the first of a series of monthly meetings at which the Service and Financial Framework (SaFF) 2002/3 would be discussed. I attended this and a further four of these meetings.

PCT B was approached to take part in the research later in the year than PCT A or PCT C. This was because another PCO had been approached first but after initial agreement, declined to take part (see above for details). As a result of this late approach, I was not able to carry out any preliminary visits to case study B before the research began. The first meetings that I attended took place less than a week after the final agreement to participate had been given.

c) Case study C

In PCT C, the Director of Intermediate Care and Commissioning responded to the letter to the Chief Executive and agreed on behalf of the PCT to take part in the research. She suggested that I discuss the research with the newly appointed Project Manager for Recovery for the health community. At the time, the Project Manager was based in the PCT, but moved later to the NHS Trust to become Director of Operations.

I visited the Project Manager in October 2001 and she outlined the commissioning procedures used in the area and the plans for changes in the future. I also discussed the commissioning process with the PCT Deputy Director of Commissioning and attended one of the public board meetings of the PCT. The health community had used a "collegiate system" whereby most of the local community's NHS

organisations met to agree ways forward. Although this system was to continue, the structure and role of the sub-committees was to change and there was to be less emphasis on the term "commissioning" and more on "service redesign". I attended the first meeting of the new Operational Group that had as its main responsibility commissioning. I attended a further four of these meetings.

6) Characteristics of the sample

The characteristics of the case studies in the final selection are given below.

a) Case study A

PCT A became a level 4 PCT in April 2001. It is of average size, with 23 practices, 91 GPs and 132 000 patients. A fifth of its patients (19.6%) were classed as rural. Geographically, the PCT was quite large and covered two sizable towns. It was classed as "over resourced", with a distance from target allocation (DFT) in 2000/1 of 5.57%. Its host health authority was 2% over target.

There was one main acute trust that the majority of patients attended for secondary care services. A neighbouring PCT also used this hospital but the two PCTs did not work together. Another NHS Trust was situated approximately 15 miles away but was rarely used by PCT A.

b) Case study B

PCT B went live in April 2001. It was the largest PCT in its region and one of the biggest 5% in the country, with more than 35 practices, over 100 GPs and over 200 000 patients. It was an urban PCT, with only 1.8% of its patients classed as rural. Geographically, it covered a large city, but very little of the surrounding area. It was classed as slightly "over resourced", with a DFT in 2000/1 of 1.03%. Its host health authority was 2% over target.

There was one main acute trust that provided secondary care and also tertiary care. Another PCT from the same health authority and a PCG from a neighbouring health authority also used this hospital.

c) Case study C

PCT C became a level 4 PCT in April 2001. They were a slightly larger than average group with 27 practices, over 100 GPs and 184 000 patients. It was predominantly an urban PCT, with only 8.6% of its patients classed as rural. Geographically it was quite compact. Almost half the PCT patients lived in a city of approximately 80 000 people; the remainder lived in four smaller towns about ten miles from the main city. The PCT at the time was classified as "under resourced", with a DFT in 2000/1 of –4.52%. This was one of the most under target PCTs in its region, with only two others similarly under-resourced. The host health authority received approximately 1% under its target budget.

The PCT had one main NHS provider for secondary care services; this NHS Trust also provided some tertiary services. PCTs from three health authorities used the NHS Trust. A sizeable minority of patients used a neighbouring NHS Trust approximately 10 miles away.

Table 3 summarises these characteristics.

Table 3 Characteristics of the case study sites

Name of case study	Case study A	Case Study B	Case Study C
Number of practices in main PCT	23	>35	27
Distance from target allocation (%)	>5% over	1% over	>4% under
Rural patients (%)	19.6%	1.8%	8.6%
Potential alternative NHS providers	Yes	No	Yes
Number of PCTs using main NHS Trust	2	3	4
Size of NHS Trust deficit	Small	Medium	Large

7) Data collection

Data were collected from three different sources. These sources were observations of meetings, interviews with managers and clinicians, and documentary evidence including copies of SaFFs and SLAs. This method of "triangulation" (Barbour,

2001; Mays & Pope, 1995) was used in order to capture as wide as possible a view of the commissioning process and to increase the validity of the findings through comparison of the different sources of data (Yin, 1994).

a) Observations of meetings

For each of the case studies, I attended a series of meetings. The meetings I attended were in all cases the main meetings (as defined by the case study members themselves) for agreeing the SaFF for 2002/3. They were also the forums for reviewing performance in 2001/2. These were the meetings that the PCT and health authority contacts suggested I attend to gain an understanding of how commissioning was carried out. I did not ask specifically to attend the SaFF meetings, but to observe the commissioning process. I attended three meetings in case study A and five each in B and C. The meetings took place between November 2001 and March 2002. Other meetings that were related to the SaFF process took place in addition to these meetings, for example to prepare for the main meetings. It was neither possible nor necessary to follow the whole process by attending all the meetings in each case study.

The purpose of attending the meetings was to obtain insights into the commissioning processes, not to follow the entire process for each case study. I wished to gain a general understanding of the commissioning process, to witness specific discussions, to learn about the methods of reaching agreements between the organisations and to select participants for interview. I was able also to use my knowledge from the meetings to help develop the topic guide (see page 117) for the interviews and to use the notes made during the observed meetings as an additional source of data. Moreover, my attendance at the meetings allowed the potential interviewees to become accustomed to my presence (Mays & Pope, 1995).

The dates and general content of the meetings are outlined below for each case study, followed by a series of tables that compare across case studies the types of managers and clinicians attending these meetings.

i) Case study A

I attended three meetings in case study A. Each meeting was called a "Planning and Performance Review" meeting. One was between the Health Authority and NHS Trust A; the other two were between the Health Authority and PCT A. The meetings

between the Health Authority and PCT A were concerned primarily with the PCT's own provision of services, not with commissioned services. Details of the meetings I attended are given in

Table 4 below.

Table 4 Dates and purpose of observed meetings in case study A

Date	Title and Purpose
November 2001	Planning and Performance Review Meeting between HA A and NHS Trust A. The purpose of this meeting was to review the performance of the NHS Trust in 2001/02, to consider plans for 2002/3 and to ensure that the targets set out in The NHS Plan were achieved.
November 2001	Planning and Performance Review Meeting between HA A and PCT A. The purpose of this meeting was to review the performance of the PCT in 2001/2, to consider plans for 2002/3 and to ensure that the targets set out in The NHS Plan were achieved.
January 2002 (not observed)	Service and Financial Framework Meeting between HA A and NHS Trust A. I was not permitted to attend the second meeting between the HA and the NHS Trust. The HA considered that tensions between the participants were too high and that the attendance of an observer may alter the dynamics of an already difficult meeting.
January 2002	Service and Financial Framework Meeting between HA A and PCT A. The purpose of this meeting was to finalise the agreement of the SaFF for 2002/3, building on the agreements reached in the previous meeting.

ii) Case study B

I attended five meetings in case study B. Each of the main meetings was a "Recovery and Modernisation" meeting attended by NHS Trust B, PCT B,

neighbouring PCTs that commissioned services from NHS Trust B, and on occasions the local ambulance NHS Trust and the host health authority. Details of these meetings are given below in Table 5.

Table 5 Dates and purpose of observed meetings in case study B

Date	Title and purpose
December 2002	Primary and Secondary Care Clinical Review and SaFF Priorities Meeting. The purpose of this meeting was to discuss clinical priorities in the current and future year. Clinicians and managers from three PCOs and NHS Trust B attended.
December 2002	Recovery and Modernisation Group Meeting. This was an ongoing monthly meeting to discuss current and future provision of services and finances, and to agree the SaFF for 2002/3. Many of the same people attended that had attended the previous night's Clinical Review Meeting.
January 2002	Recovery and Modernisation Group Away Day. The purpose of this meeting was to agree the first cut SaFF. The usual monthly meeting was also held in January but I was not able to attend. That meeting discussed the first cut SaFF and how to move forward with discussions on the second cut SaFF.
February 2002	Recovery and Modernisation Group Meeting. The purpose of this meeting was to discuss the second cut SaFF.
March 2002	Recovery and Modernisation Group Meeting. The purpose of this meeting was to agree the final SaFF.

In addition to the commissioning related meetings detailed above, I observed one meeting between PCT B and three other PCTs from the same health authority. The purpose of this meeting was to discuss joint commissioning issues. The majority of the meeting was spent discussing issues to do with allocation of resources between the PCTs.

iii) Case study C

I observed five meetings in case study C. The majority of meetings were planned to be of the Operational Group consisting of commissioning managers from PCT C and three other local PCTs and the operations manager from NHS Trust C. On a number of occasions the Finance and Information Group joined the Operational Group. The Finance and Information Group consisted of Directors of Finance from the PCTs and NHS Trust. Table 6 gives details of these meetings.

Table 6 Dates and purpose of observed meetings in case study C

Date	Title and purpose
November 2001	Health Community Operational Group Meeting. This was the first meeting of this new group. The purpose was to agree terms of reference and plan future meetings and actions. The meeting was attended by PCT C's commissioning lead, three other PCTs' commissioning leads, the Project Manager for Recovery and a planning manager from NHS Trust C. Future meetings were to be held monthly.
Mid-January 2002	Joint meeting between the Operational Group and the Finance and Information Group. The purpose of this meeting was to discuss the investment framework and the SaFF process. At the November meeting, a decision had been made to keep the service development issues (discussed by the Operational Group) and the finance issues (discussed by the Finance and Information Group) separate. Many of the meetings were, however, joint.
Late-January 2002	Joint meeting between the Operational Group and the Finance and Information Group. The purpose of this meeting was to discuss the investment framework and the SaFF process.
February 2002	Operational Group Meeting. I was told that the purpose of this meeting was to finalise the draft SaFF for inclusion in

	the franchise plan for the new Strategic Health Authority. The meeting was chaotic. Three people arrived at 2.30, two arrived at 3.20 (they had been delayed in a previous meeting) and one arrived at 3.30. There was no agenda and no consensus as to the purpose of the meeting. At least two meetings had been held since the late-January meeting that I observed.
March 2002	Operational Group Meeting. This was another chaotic meeting. The usual members of the Operational Group were present but the meeting was referred to as a capacity-planning meeting. The meeting began 45 minutes late due to late arrivals from other meetings. A member of one of the neighbouring PCTs attended this meeting even though she was not part of the Operational Group. She was due to travel back to the PCT with a colleague who was in this meeting, so decided to attend the meeting as well. There was no agenda. The first half hour of the meeting was spent discussing the purpose of the different groups and meetings. The remainder was spent discussing the SaFF. The meeting ended after two hours (6.15pm) when half the people had drifted away.

The SaFF was due to be submitted two days after the March meeting. A further two meetings were scheduled provisionally for the following week but, at the time the March meeting ended, it was not clear which groups would be meeting or what they would be discussing. Some of the main participants of the meetings had planned leave over the following weeks and would definitely not be attending any meetings. My attendance at five meetings had given me insights into how the case study organisations functioned with regard to commissioning. As a result of this knowledge, the submission of the SaFF document, and the confusion about the purpose of future meetings, I felt that my attendance at any future meetings would be unlikely to provide me with any new insights and I chose therefore not to attend any more meetings.

iv) Attendance at the SaFF meetings

The style of the meetings differed across the case study sites in terms of the number and type of people and the organisations attending.

Table 7 shows which health authority members attended the meetings. It is notable that in case study C, no member of the host health authority attended any of these meetings.

Table 7 Health Authority members that attended the SaFF meetings

	Case Study A	**Case Study B**	**Case Study C**
Number of meetings	**3**	**5**	**5**
Chief Executive	November PCT meeting	February meeting	None
Director of Finance	All meetings	December, January & February meetings	None
Director of Primary Care Performance	All meetings	None	None
Specialist Commissioning Manager	November NHS Trust meeting	None	None
Performance & Development Manager	None	All meetings	None

Table 8 shows the PCT members attending the observed meetings. The Director of Finance and Director of Commissioning were common to all case study meetings. The Chief Executive attended meetings in case studies A and B but not C. In fact, the Chief Executive of PCT C made an appearance for about 20 minutes at one meeting to explain an issue around a particular service development. Only case study B had a GP present at all meetings. The Director of Operations in PCT A was in charge of internal PCT operations and attended a meeting that discussed PCT provision of services rather than commissioned services.

Table 8 PCT members that attended the SaFF meetings

	Case Study A	Case Study B	Case Study C
Number of meetings	**3**	**5**	**5**
Chief Executive	All meetings	All meetings	None
Director of Finance	All meetings*	All meetings	All meetings
Director of Commissioning	All meetings*	All meetings	All meetings
Director of Operations	November meeting	None	None
Head of Planning & Performance	January meeting		
General Practitioner	January meeting	All meetings	None

** In case study A, the Director of Finance was also Director of Commissioning*

Table 9 gives details of the NHS Trust members attending meetings. In case study C, the Chief Executive did not attend any meetings. In each case study, the Director of Finance attended at least some meetings. Case study B was the only one to have a clinician present at any meetings.

Table 9 NHS Trust members that attended the SaFF meetings

	Case Study A	Case Study B	Case Study C
Number of meetings	**3**	**5**	**5**
Chief Executive	All meetings	All meetings	None
Director of Finance	All meetings	All meetings	January meetings
Director of Operations	None	All meetings	All meetings*
Clinician	None	December & February meetings	None

**This NHS Trust Director of Operations was initially the Director of Recovery for the health community (see Table 10 below)*

Table 10 shows which other people attended the SaFF meetings. The Director of Recovery in case study B attended meetings late in the SaFF process, but his role was primarily to discuss long-term modernisation issues rather than the more immediate commissioning issues. The Director of Recovery in case study C was appointed Director of Operations at NHS Trust C part way through the study period. A new Director of Recovery was appointed after completion of the observations. In case study C, a Performance Manager from the regional office attended the final three meetings observed. Her role was to ensure the SaFF process was completed. In case studies B and C, Chief Executives, Directors of Finance and Directors of Commissioning from neighbouring PCTs or PCGs that commissioned services from the main NHS Trust also attended the meetings. This was not the case in case study A. The health authority there met with these organisations separately. A member of a neighbouring PCT's health authority attended and chaired one meeting in case study C. In case study B, members of the ambulance trust attended two meetings and in case study C a member of a community trust from a neighbouring health authority attended one meeting.

Table 10 Other attendees at the SaFF meetings

	Case Study A	Case Study B	Case Study C
Number of meetings	**3**	**5**	**5**
Director of Recovery	N/A	Two meetings	All meetings*
Performance Manager, Regional Office	None	None	Three meetings
Neighbouring PCT Chief Executive	None	All meetings	One meeting
Neighbouring PCT Director of Finance	None	All meetings	All meetings
Neighbouring PCT Director of Commissioning	None	All meetings	All meetings
Neighbouring PCG representative	None	All meetings	All meetings
Neighbouring HA representative	None	None	One meeting
Neighbouring provider	None	Two meetings	One meeting

**This Director of Recovery was later appointed as NHS Trust Director of Operations (see Table 9 above)*

b) Interviews with managers and clinicians

One purpose of observing these meetings was to select key players in the commissioning process for in-depth interview. In addition to the managers involved directly in the commissioning process, I interviewed two GPs and two consultants from each case study.

i) Selecting the interviewees

The purpose of the interviews was to elicit a wide range of views about the commissioning process. As one of the central themes of the research was to consider

the actions and beliefs of principals and agents, I needed to sample from a range of organisations. The main organisations of interest were the case study PCTs and NHS Trusts, but also neighbouring PCTs and health authorities. Within these organisations, potential interviewees were either managers or clinicians.

I chose to sample as fully as possible from the case study populations. The people attending the SaFF meetings provided the initial population from which the sample of interviewees was chosen. The roles that interviewees played in the commissioning process were at least as important as their job titles. I began by interviewing the same types of players from each case study (for example, Directors of Finance) and followed these with interviews with other key players individual to each case study (for example, the Director of Recovery in case study C). In addition to key members that participated in the meetings, I chose to interview members that were noticeably absent, for example the Chief Executives in case study C. Despite the fact that the number of interviewees was in effect selected in advance and the maximum number possible was fixed according to who was involved in the commissioning process, saturation point in the data (Marshall, 1996) was reached.

Those key players that attended the majority of commissioning meetings in each case study were almost exclusively managers. Clinicians did not play a significant role in the SaFF process in these case studies but are key to the delivery of services. It was considered likely that the clinical training and patient focus of clinicians would result in them having systematically different views on commissioning from those of management. As such, clinicians could provide important negative (or "deviant") views, and new factors not considered important by management, to help strengthen my interpretations (Barbour, 2001; Mason, 2002). Clinicians can also be considered agents for management and thus encompass a further set of principal-agent relations for both PCTs and NHS Trusts. To exclude clinical views would have been to exclude an important element of the commissioning process. To aid my understanding of commissioning relationships, I decided therefore to interview both GPs and surgeons. Further details of these interviewees and their selection are given in the section "characteristics of the clinical interviewees".

ii) Characteristics of the management interviewees

Table 11 gives the job titles of the managers interviewed. All except the Chief Executive of PCT C attended the SaFF meetings. A new Chief Executive of NHS Trust C was appointed during the research period. He did not attend any of the meetings and was not available for interview. Table 12 to Table 14 give details of the management interviewees in case studies A to C respectively.

In case study A, five managers were interviewed between April and June 2002. One was from the Health Authority, two from the PCT and two from the NHS Trust. No one refused to be interviewed. All interviewees were male. The Chief Executives of the PCT and the NHS Trust had both followed the NHS Management Training Scheme and worked in a variety of, predominantly acute, posts across the country. The NHS Trust Chief Executive had an exclusively acute background whereas the PCT Chief Executive had experience in other organisations as well. The HA and both NHS Trust interviewees had worked in their current posts for over a decade. Both PCT interviewees had been in post for less then 18 months and were appointed from outside the local area.

The Health Authority Director of Finance was chosen for interview because he played the main role in commissioning services from NHS Trust A. I observed a single meeting between the HA A and NHS Trust A. Two other HA members attended this meeting, but played minor support roles to the Director of Finance. In the two meetings I observed between the HA and PCT A, the Director of Finance also played the lead role for the HA. The Chief Executive of the HA was not interviewed. He attended one meeting between the HA and the PCT, and voiced some strong opinions, but the chair of the meeting and the main player was the Director of Finance.

Neither the Chief Executive nor the Director of Finance of PCT A attended the meeting between the HA and NHS Trust A. However, this was due to the style of commissioning chosen by the host HA. I considered it important to interview both the PCT Chief Executive and the Director of Finance for two reasons, first to consider their views about not being involved directly in discussions with NHS Trust A and second, for a degree of consistency across the case studies. Other members of the PCT attended the meeting between the HA and the PCT. They played a minor role, particularly in relation to the provision of secondary care services, and so were not interviewed.

The Chief Executive and Director of Finance of NHS Trust A both attended the commissioning meeting with the HA. No other member of the NHS Trust attended. The Chief Executive appeared to play the main role for the NHS Trust in the SaFF discussions, but the Director of Finance also played a major role.

Table 13 gives details of eight managers (five male and three female) interviewed in April and May 2002 in case study B. The Director of Finance of the NHS Trust declined the invitation to be interviewed. He was relatively new to the NHS Trust and although he had attended two of the SaFF meetings I had observed, he suggested I interview the previously Acting Director of Finance and the Senior Assistant Director of Finance instead. He considered they had been more involved in the process at the time. No one else refused to be interviewed. As in case study A, both Chief Executives had followed the NHS Management Training Scheme and held a variety of management posts previously. Again, similar to case study A, the Chief Executive of NHS Trust B had experience predominantly in the acute sector whereas the Chief Executive of the PCT had a more varied background, including acute hospital management. The Directors of Finance and Commissioning in the PCT both had acute hospital management experience. The NHS Trust finance managers both had HA as well as acute trust experience. Two directors began their careers as nurses: the Director of Commissioning in the PCT and the Director of Operations in the NHS Trust. The Director of Commissioning in the neighbouring PCT was the only interviewee to have a predominantly primary care sector background. The interviewees from the PCT had been in post for approximately 18 months. The Chief Executive was new to the area on appointment. The NHS Trust Chief Executive and Director of Operations were both new to their posts; the Director of Operations was also new to the local area.

The interviewees were chosen because they all played an active role in the meetings to agree the SaFF. The Director of Commissioning and Director of Finance in PCT B, and the Chief Executive and Director of Operations in NHS Trust B played the most active roles. The Chief Executive of PCT B played a supporting role to her directors. She chaired some of the meetings but occasionally stepped out of the Chair's role to put forward a view of behalf of primary care. The finance managers from NHS Trust B played a less active role and often commented on specific issues only.

I wanted to interview at least one member of a PCT that was not the main PCT in the case study to gain an alternative view of the SaFF process. There were members of two other PCOs present at the meetings. One was a PCT from which the Chief Executive, Director of Finance and Director of Commissioning attended. The Director of Commissioning was the most active member and so he was selected for interview. The other PCO was a PCG from which two managers attended. No one from this PCG was approached for interview because they considered themselves present as observers only and rarely made any contribution to the debate.

The Performance and Development Manager from the local HA attended all the meetings, the Director of Finance attended three, and the Chief Executive one. A member of the regional office attended two meetings. With the exception of the Chief Executive of the HA, the involvement of these individuals in the meetings was predominantly to support discussions relating to the recovery and modernisation of the health community, not the agreement of the SaFF for 2002/3. The Chief Executive of the HA attended the meeting on the day the second draft SaFF had to be submitted. He chaired the meeting but did not put forward his views on specific issues. None of the HA staff were interviewed. Throughout all the meetings, it was the NHS Trust and PCT staff that steered the discussions.

Table 14 gives details of interviewees from case study C. Eight managers were interviewed between May and September 2002. Three were from the main case study PCT, two from the NHS Trust, one from the regional office and two from neighbouring PCTs involved in the SaFF meetings. All except the Acting Director of Finance at the NHS Trust were female. No one refused to be interviewed. Unlike the other case studies, none of the interviewees were graduates of the NHS Management Training Scheme, although both Directors of Finance had trained as accountants through the NHS. The Chief Executive of the PCT had a financial management background but had latterly become involved in project management. The Director of Operations in the NHS Trust also had a recent history of project management but had originally trained in nursing. Both NHS Trust interviewees had spent a number of years in the private health care sector. The commissioning managers from the neighbouring PCTs were relatively new to the NHS, although one had some experience of fund-holding management. The interviewees from PCT C, the regional office and a neighbouring PCT had worked for many years in the

immediate local area. Both NHS Trust interviewees had worked for less than a year in the local area.

The interviewees were chosen partly because they attended all the SaFF meetings that I observed, and partly for consistency across the case studies. The Chief Executive of PCT C did not attend the whole of any of the meetings that I attended. On one occasion, she summarised an agreement reached in another meeting that had just finished, but left immediately after this. Despite this, she was interviewed, primarily to understand why she did not feel the need to attend the SaFF meetings. The Director of Commissioning appeared to take the lead role in the SaFF meetings for PCT C. On occasions when the commissioning and the finance teams met jointly, the Director of Finance also played a dominant role. Both were interviewed. The Director of Operations played the lead role in the SaFF process for the NHS Trust, sometimes accompanied by the Acting Director of Finance. Both were interviewed.

To gain a view of the SaFF process from individuals not from PCT C, I interviewed the commissioning managers from two neighbouring PCOs. One was a PCT, the other a PCG. The commissioning manager from the PCG, however, on occasions represented another PCT as well. She was therefore an active member of the group, although in practice contributed little.

The Performance Manager from the regional office was selected for interview some time after the other respondents had been approached. She began to attend the SaFF meetings part way through the process with a remit to ensure that an agreement was reached. Respondents later termed this action as a "hijacking" of the process. I considered it important therefore to elicit her views of the process and her role in it.

Table 11 Management interviewees

Case Study A	Case Study B	Case Study C
PCT Chief Executive	PCT Chief Executive	PCT Chief Executive
PCT Director of Finance	PCT Director of Finance	PCT Director of Finance
	PCT Director of Commissioning	PCT Director of Commissioning
NHS Trust Chief Executive	NHS Trust Chief Executive	
NHS Trust Director of Finance	NHS Trust Senior Assistant Director of Finance	NHS Trust Director of Finance
	NHS Trust Head of Finance	
	NHS Trust Director of Operations	NHS Trust Director of Operations
HA Director of Finance		Regional Office Performance Manager
	Neighbouring PCT Director of Commissioning	Neighbouring PCG Commissioning Manager
		Neighbouring PCT Waiting List Manager

Table 12 Characteristics of interviewees in case study A

Organisation	**Job Title**	**Date of interview**	**Setting**	**Gender**	**Background**
Health Authority	Director of Finance and Performance	May 2002	Interviewee's office	Male	Accountant. Worked in the same HA in NHS for 16 years. Previously worked in private manufacturing business.
PCT	Chief Executive	June 2002	Interviewee's office	Male	National Management Training Scheme. Predominantly acute sector experience (General Manager in DGH, HA Purchasing Director, HA Chief Executive, Regional Office purchasing) before joining the PCT.
PCT	Director of Finance and Commissioning	May 2002	Interviewee's office	Male	Worked for 10 years in the NHS in finance posts in various locations, initially in HAs, recently in PCTs. Commissioning role is relatively new.
NHS Trust	Chief Executive	April 2002	Interviewee's office	Male	National Management Training Scheme. Exclusively acute sector background (various management and administration posts then General Manager in DGH). Current post for approximately 10 years.
NHS Trust	Director of Finance	April 2002	Interviewee's	Male	Background in acute sector and HAs. Current post for 11

			office		years.

Table 13 Characteristics of interviewees in case study B

Organisation	**Job Title**	**Date of interview**	**Setting**	**Gender**	**Background**
PCT	Chief Executive	May 2002	Interviewee's office	Female	National Management Training Scheme. Mixed background includes Deputy Manager of DGH, Regional Office purchasing, Deputy Director of Commissioning in HA, Mental Health & Community Trust Director posts. Previous appointment was outside the local area.
PCT	Director of Finance	April 2002	Interviewee's office	Female	NHS posts for 10 years. Previous posts include NHS Trust Deputy Director of Finance & Ambulance Service Director of Finance. Area of previous post not known.
PCT	Director of Commissioning	April 2002	Common room	Male	Worked previously as a nurse, then moved into management in an acute trust, followed by HA management posts. Previous post was in the local area.
NHS Trust	Chief Executive	May 2002	Interviewee's office	Male	National Management Training Scheme. Recently 3 years as Chief Executive of Community Trust but mainly acute sector management. In current post for approximately 18 months. Previous post was in the local area.

NHS Trust	Senior Assistant Director of Finance	April 2002	Meeting room	Male	Accountant. Private practice then NHS for last 10 years. Finance & commissioning posts in local HA, 3 years in current post.
NHS Trust	Head of Finance	April 2002	Meeting room	Male	Previously Director of Finance in an HA, was Acting Director of Finance in NHS Trust B during SaFF process. 5 years in current post.
NHS Trust	Director of Operations	April 2002	Interviewee's office	Female	Worked previously as a nurse, then moved into management. Masters & PhD level management studies. Director level posts in acute trusts for 10 years. 1 year in current post. Previous post was outside the local area.
Neighbour PCT	Director of Commissioning	May 2002	Meeting room	Male	10 years in the NHS. Predominantly primary care. Began in FHSAs then Regional Office fund-holding management. Recently managed a locality-commissioning pilot. Previous post was in the local area.

Table 14 Characteristics of interviewees in case study C

Organisation	Job Title	Date of interview	Setting	Gender	Background
PCT	Chief Executive	July 2002	Interviewee's office	Female	Predominantly Director of Finance roles at Regional Office & HA. Other HA roles as Programme Director for Mental Health, Patch Director then Project Manager for current PCT area.
PCT	Director of Finance	May 2002	Interviewee's office	Female	Accountant trained through NHS. Worked in all types of NHS organisation. Managed fund-holding consortium in local area for 5 years, then HA finance role before current post.
PCT	Director of Commissioning	May 2002	Interviewee's office	Female	Posts in publishing company before joining NHS. Trainee manager & business manager in local acute trusts, commissioning posts in 2 local HAs, then Chief Officer of PCG (now PCT).
NHS Trust	Acting Director of Finance	May 2002	Shared office	Male	Accountant trained through NHS. Mainly NHS posts (Director of Finance at RO, HAs & acute trusts), 2 years in private sector, now financial consultant. Acting Director posts at all types of NHS organisation. Previous post outside current area.
NHS Trust	Director of Operations	July 2002	Interviewee's office	Female	Worked previously as a nurse, 8 years for BUPA, became Director of Nursing, returned to NHS 10 years ago to general management.

					Exclusively acute background, Deputy Chief Executive of acute trust, project management posts of acute & community trust mergers. Seconded as Project Manager for Recovery for health community, transferred to NHS Trust C, currently acting as lead for Performance Management and for Planning as well as Operations. Previous post outside immediate area but within the same region.
Regional Office	Performance Manager	Sept 2002	Empty office	Female	No information on previous roles. At time of interview was based in SHA, soon to move to local PCTs as shared Director of Capacity and Modernisation.
Neighbour PCT	Commissioning Manager	May 2002	University office	Female	4 years in NHS. Previous posts in a HA as Audit Facilitator for primary care and Specialist Commissioner. New to area.
Neighbour PCT	Waiting List Manager	May 2002	Interviewee's office	Female	MBA graduate, worked in private sector before becoming fund-holding manager for group of practices in local area. Current role includes commissioning; as a small PCT they do not have Director of Commissioning.

iii) Characteristics of the clinical interviewees

Table 15 gives the job titles of the clinicians who were interviewed. Interviewees were selected to provide views from clinicians not involved in the commissioning process as well as those who were involved. In all cases, the relevant Chief Executives, Directors of Operations or Directors of Commissioning were asked for the names of Clinical Directors of Surgery, GP Professional Executive Committee Chairs, and orthopaedic consultants and GPs not involved directly in commissioning. Chief Executives or Directors of Operation gave permission for these clinicians to be approached for interview. The Clinical Directors, after their interviews, were asked also to suggest consultant orthopaedic surgeons not involved directly in commissioning who they considered would be appropriate for interview.

For each PCT, the Chair of the Professional Executive Committee and a GP involved in PCT issues but not involved directly with commissioning was approached for interview. The existence of the Commissioning Lead in case study B was discovered after the other two interviews had been arranged and so this GP was interviewed also. None of the Chairs refused to be interviewed. Three other GPs declined interview; one was too busy (PCT C) and two felt that they did not have enough knowledge of the commissioning process to have any views about it (PCT B).

For the NHS Trusts, the choice was made to interview surgeons rather than medical doctors. This choice was made primarily because, in the majority of NHS Trusts, despite pressures to meet access targets in surgical specialties, long waiting times remain. Surgical waiting times were a priority area in SaFF discussions in these case studies. Consultant surgeons that were not involved in commissioning discussions would still have been aware of, and be able to provide views about, the pressures to meet targets. Clinical Directors of Surgery were approached because they were most likely to be involved in the commissioning process or the internal management processes associated with commissioning decisions. To explore the views of those not involved directly in the commissioning process, orthopaedic surgeons were chosen. Orthopaedics is one of the specialties that have notoriously long waiting times in many NHS hospitals and all of the case study NHS Trusts had discussed in the SaFF meetings or in the interviews the problems they had in reducing their access times for orthopaedics.

Table 15 Clinical interviewees

	Case Study A	Case Study B	Case Study C
GP	Chair of Professional Executive Committee	Chair of Professional Executive Committee	Chair of Professional Executive Committee
GP	Ex-Chair of Professional Executive Committee	Clinical Governance Lead	Professional Executive Committee member
GP		Commissioning Lead	
Consultant Surgeon	Clinical Director of Surgery	Clinical Director of Surgery	Clinical Director of Surgery
Consultant Surgeon	Consultant Orthopaedic Surgeon	Consultant Orthopaedic Surgeon	Consultant Orthopaedic Surgeon

Table 16 to Table 18 give details of the characteristics of the clinicians who were interviewed in case studies A to C respectively.

In case study A, two GPs and two consultant surgeons were interviewed between August 2002 and January 2003. All interviewees were male. Both GPs had been in non-fund-holding practices in HA A. HA A had used a locality-commissioning model. The NHS Trust Director of Surgery had been in his post at the NHS Trust for 12 years. The orthopaedic surgeon was in his first consultant post and was new to the NHS Trust. He had experience of public and private sector hospitals abroad. Neither consultant felt that they played a role in commissioning.

The Chair of the Professional Executive Committee was chosen for interview partly because he was the Chair and partly because he was the only clinician to attend any of the SaFF meetings with the HA. The other GP interviewee was chosen because he was the previous Co-Chair of the Professional Executive Committee and remained on the Committee in a more general role.

The Clinical Director of Surgery was chosen because his job title meant that he was most likely to be involved in commissioning. Two orthopaedic consultants declined

interview. The third agreed; he was described by the Director of Finance as new and enthusiastic, willing to discuss ideas and likely to agree to interview.

In case study B, three GPs and two consultant surgeons were interviewed between May and November 2002. One GP interviewee was female. One GP was from a previously community fund-holding practice, the other two were from non-fund-holding practices. None had any management training; two were involved directly in commissioning. One surgeon was involved in the commissioning process; the other was not. One was a surgeon for the armed forces; the other had a busy private practice.

The Chair of the Professional Executive Committee was chosen for interview in part for consistency across the case studies, but also because he attended all the SaFF meetings. The commissioning lead GP attended one SaFF meeting and the clinical priorities meeting. The clinical governance lead was chosen because she was the chair of one of three geographical sub-groups of the PCT. The other two chairs of these sub-groups had declined the interview request.

The Clinical Director of Surgery was approached and agreed to the interview. He and the Director of Operations at the NHS Trust suggested two orthopaedic surgeons who might speak to me. I approached the consultant most likely to agree, and he did.

In case study C, I spoke to two GPs and two surgeons between October and December 2002. One of each was male, one female. None considered that they had any direct involvement in commissioning. Both GPs were involved in other aspects of service development within the PCT. The Director of Surgery had been a consultant at NHS Trust C for nine years but was quite new to the Director's post. The orthopaedic surgeon was a newly appointed consultant and new to NHS Trust C. She had undertaken a management course elsewhere.

Again, the Chair of the Professional Executive Committee and the Director of Surgery were chosen because of their job titles. Neither attended any SaFF related meetings. Both agreed to be interviewed. A second GP agreed to be interviewed but was not able to agree a date within the research deadlines. Another GP was approached and was subsequently interviewed.

The NHS Trust Director of Operations provided names and gave permission to contact two orthopaedic consultants. One refused to be interviewed. The other agreed to be interviewed but was unable to commit to an interview date (three were cancelled). He supplied the names of a further three orthopaedic consultants who could be contacted. Two refused to be interviewed. One agreed and was subsequently interviewed. Those refusing to be interviewed had no interest in commissioning and no available time.

Table 16 Characteristics of clinical interviewees in case study A

Organisation	**Job Title**	**Date of interview**	**Setting**	**Gender**	**Background**
PCT	Chair of Professional Executive Committee	August 2002	Meeting room in PCT	Male	GP for 15 years. Large non-fund-holding practice. Involved in locality commissioning model covering area that became PCG.
PCT	Ex-Chair of Professional Executive Committee	August 2002	Board room in PCT	Male	GP. Chair of PCG. Non-fund-holding practice. Involved in locality commissioning model covering area that became PCG.
NHS Trust	Clinical Director of Surgery	October 2002	Meeting room	Male	General Surgeon. 12 years in current post. No direct involvement in commissioning.
NHS Trust	Consultant Surgeon	January 2003	Meeting room	Male	Orthopaedic Surgeon. 1 year as consultant. Worked in public and private sectors abroad. No direct involvement in commissioning.

Table 17 Characteristics of clinical interviewees in case study B

Organisation	Job Title	Date of interview	Setting	Gender	Background
PCT	Chair of Professional Executive Committee	May 2002	Interviewee's office in PCT	Male	GP from small practice. Became a community fund-holding practice as soon as size rules allowed it. Was Chair of PCG.
PCT	Clinical Governance Lead	September 2002	Meeting room in PCT	Female	GP. Chair of Local Care Group (a geographical sub-division of PCT). Previously mental health lead. Member of Professional Executive Committee. No direct involvement in commissioning.
PCT	Commissioning Lead	September 2002	Meeting room in practice	Male	Previously a GP in armed forces. Joined NHS 5 years ago. Interest in PCG issues led to commissioning role. No previous commissioning experience & no management training.
NHS Trust	Clinical Director of Surgery	September 2002	Meeting room	Male	General Surgeon. Employed by armed forces. Honorary post with NHS Trust B for 7 years. Involved in management, commissioning and SaFF issues.
NHS Trust	Consultant Surgeon	November	Interviewee's	Male	Orthopaedic Surgeon. Clinical Director of Orthopaedics.

		2002	office in outpatient area		Involved in planning for new Diagnostic & Treatment Centre. Busy private practice. Chairman of private hospital Medical Advisory Committee. No direct involvement in commissioning.

Table 18 Characteristics of clinical interviewees in case study C

Organisation	Job Title	Date of interview	Setting	Gender	Background
PCT	Chair of Professional Executive Committee	October 2002	Interviewee's office in PCT	Male	GP. Involved in Service Development Groups that discuss clinical aspects of services. No direct involvement in commissioning.
PCT	Professional Executive Committee member	October 2002	Interviewee's office in practice	Female	GP. Ex-PCG Board member. Chair of city based Clinical Governance meetings. Involved in various service development working groups. No direct involvement in commissioning.
NHS Trust	Clinical Director of Surgery	December 2002	Interviewee's office	Male	General & Vascular Surgeon. 9 years with NHS Trust C, 18 months as Director of Surgery. No direct involvement in commissioning.
NHS Trust	Consultant Surgeon	December 2002	Shared office	Female	Orthopaedic Surgeon. 6 months as consultant. Previous training posts and a management course. No direct involvement in commissioning.

iv) Topic guides

A topic guide is a prompt sheet for the interviewer to use in interviews. It covers all the main areas of interest that the interviewer wishes to be discussed during the interview. It is not a list of questions, but a list of relevant topic areas. The purpose of the case study interviews was to allow the respondents to give their perceptions of the commissioning process, placing emphasis on the issues they considered most important. Although the main areas of interest in the topic guides were developed from principal-agent theory, the aim was to allow respondent rather than interviewer-led experiences to be elicited. For these reasons, topic guides were chosen in preference to more restrictive semi-structured interviews. All the interviews were based on topic guides. There were some small differences in the topic guides used for principals and agents and for managers and clinicians. An example of a topic guide is provided in Appendix 2.

The topic guides covered five areas of interest. The areas were based on principal-agent theory and my knowledge from the meetings I had observed. The first area of interest was general background about the respondent, for example, the length of time they had been in their current post and their career history.

The second section asked about the objectives of the organisations; each respondent was asked about their own organisations' objectives as well as their perceptions of the other organisations' objectives. It is assumed in principal-agent theory that the agent has objectives that are different to the principal. The purpose of this section was to determine how, if at all, the objectives of the PCTs and NHS Trusts differed and how any differences were reconciled. For example, respondents were asked how they tried to ensure their own objectives were met and their responses were probed further to draw out views about the relative strength of objectives and the risk sharing associated with not meeting objectives.

The third section asked about information for commissioning. The general aim of the section was to determine the extent to which respondents felt that information and decisions were shared between organisations, and their attitudes to unshared information. Principal-agent theory assumes that the agent has information not readily available to the principal and the agent will hide this information in order to gain advantages. Among other things, NHS Trust respondents were asked to give

the circumstances where they might be tempted to hold information back from the PCTs (and vice versa), and where relevant, respondents were asked about incidents that had been discussed during the observed meetings, such as the unilateral initiation or discontinuation of services.

The fourth section asked about the roles that the different organisations perceived themselves as playing, how they felt about these roles and any changes they would like to see in the system. Many of these prompts arose from the political science and sociological concepts of agency. For example, PCT interviewees were asked how they felt about discussing NHS Trusts' provision of services and finances whilst NHS Trust interviewees were asked how it felt from their position being monitored and scrutinised by PCTs. This was an attempt to discover how legitimate the respondents felt their organisations' roles were without prompting them directly to discuss power relations or legitimacy.

The final section asked about monitoring and external influences on commissioning. Agency theory assumes that the principal is indifferent to the agent's choice of action as long as it is diligent and efficient; the principal is concerned only with outcome. However, where incentives are not in place and outcomes not easily measured, the principal may monitor the agent's actions more closely. This section asked respondents to describe, for example, the extent and ease of monitoring commissioning agreements. Responses were probed further to extract perceptions about how it felt as PCTs to be monitoring NHS Trusts, and how it felt as an NHS Trusts to be monitored by PCTs.

The content of the topic guides was not followed in strict order. The respondents moved between sections and discussed issues that they felt were most important as they arose. However, all topics on the guide were covered in all interviews.

Most interviews lasted between 45 minutes and an hour. The shortest lasted for 30 minutes. This was planned and the main areas of interest were covered in sufficient detail; the interview was with a surgeon who was due back in clinic. The longest interview lasted for an hour and fifteen minutes. This was with a PCT Chief Executive.

In one case the tape recording failed. I made extended notes on the interview immediately after its completion. In two cases the tape recording was at times of

poor quality. Again, I made detailed notes on some of the missing information as soon as the interviews were completed. For the remaining thirty-one interviews, the tape recordings were of excellent sound quality.

I transcribed both tapes that were of poor sound quality plus another four tapes. University administrative staff transcribed the remainder. I listened to all the tapes after they had been transcribed to correct any mistakes and to fill in any gaps. Finally I read each transcript and marked all names and words that could be used to identify the case studies or respondents. These were replaced in the transcripts with confidential codes known only by myself. The transcripts were then formatted for use with a qualitative data management software package.

c) Documentation

Copies of the Service and Financial Framework and the Service Level Agreements were obtained from each case study. Some respondents provided other documentary evidence not requested specifically. These were used for background information.

8) Data coding

This section details the method I used to apply codes to the transcripts of meetings and interviews.

Qualitative data management software called Atlas.ti (www.atlasti.de) was used. This package allows the researcher to annotate, code and search the transcripts and to draw diagrams that relate quotations and codes to each other. Summaries of the main features of the package are given below.

Codes – Codes are labels applied to quotations in order to be able to retrieve those pieces of text with similar meanings or referring to similar events. They are equivalent to keywords or indexes. Codes are created as a result of reading the text.

Free codes – Free codes are codes that are created in abstract from the text. They may refer to issues that the researcher expects to find within the text.

Super codes and queries – A query is a search using Boolean operators for quotations labelled with a combination of codes. A query can be saved for future

use. A saved query is known as a super code. For example, a super code W could refer to all quotations labelled with code X and code Y but not code Z.

Free quotations – A free quotation is a piece of text that is considered important enough to be noted but does not fit into any pre-existing code and where the researcher does not consider it appropriate to create a new code. Free quotations can be labelled with a new or existing code at a later stage.

Memos – Memos are a form of electronic notebook. They allow the researcher to makes notes throughout the coding and analysis. Memos can refer to any aspect of the research, for example, the past or planned analysis strategy, emerging theories or unexpected insights. These memos can be linked to codes, quotes or other memos, but can also stand alone.

Links – Codes, super codes, quotations and memos can be linked to each other. There is no limit on the number of links that can be made. The links can be observed visually in diagrams called *networks*. For example, a memo that comments on a particular code can be linked to that code; symbols for both the memo and the code can then be seen in a network, linked by a line.

The principal-agent framework guided my research questions and the selection of the case studies. Consistent with this approach, I developed codes for the data in a number of stages. I created "free codes" prior to my analysis. These codes covered the main elements of principal-agent theory. I expected that these issues would arise in the course of the observations and interviews. Whilst reading and re-reading the texts, I created codes appropriate to those texts. Some codes were created in-vivo, that is, using terminology used by the interviewees; others I devised myself. I created memos during the analysis. Some memos related to analysis plans, others to my thoughts about associations between codes and others to how issues related to the principal-agent framework. Observations and interviews were coded and analysed together so that the same coding frame was applied to each set of data. Some of the codes were purely factual, labelling examples of events; others were subjective, labelling interviewees' beliefs and my interpretations of their beliefs. Some codes fulfilled both roles.

a) Free codes created prior to analysis

The creation of these initial codes was based on principal-agent theory. The codes created were as follows.

Objectives – Principal-agent theory assumes that the agent has different objectives to the principal. Separate codes were created for the objectives of the PCT(s) (that is, the principal), the NHS Trust as agent, and the Health Authority (as a principal higher up the principal-agent chain). These were descriptive codes attached to quotations that stated what the perceived objectives of the organisations were. Later in the analysis, codes for the objectives of the government and of clinicians were added. The final set of codes relating to objectives were *objectives – PCT*, *objectives – NHS Trust*, *objectives – HA*, *objectives – government/must do's*, *objectives – clinicians*.

Information asymmetry - Principal-agent theory assumes that the agent has access to information additional to that which the principal can access. Initially, two codes were created: *information asymmetry* and *information asymmetry - uncertainty/state of the world*. Later, *information asymmetry* was divided into codes for *hidden action/effort* and *hidden information/knowledge*. These codes were sub-divided again to become the final codes of *behaviour – shared information*, *behaviour – unshared information*, *behaviour – shared decisions* and *behaviour – unshared decisions*. Two further codes (*information asymmetry – agent type/adverse selection* and *information asymmetry – agent effort*) were introduced for the quotations that did not fit within the *behaviour* codes.

Incentives - Principal-agent theory assumes that the principal aligns the agent's objectives with its own through the use of incentives. Initially, the code was simply *incentives*. Later this was revised into two codes: *incentives – incentives/levers/sanctions* (used to show financial or other incentives) and *incentives – threats from above* (used to show verbal pressure in particular as an influence). These codes were used to show examples of incentives used as well as interviewees' general views about incentives and perceptions of their effectiveness.

Power – Although the principal in principal-agent relationships controls the agent through a contract, the agent is generally considered to be the most powerful because of its potential gains from information asymmetry. Initially, two codes were created:

power – agent and *power – principal. Power – professional* and *power – other* were added later. Again, these codes referred to examples of one party showing its power over the other as well as interviewees' perceptions of their own or other organisations' power.

Contracts – Principal-agent theory assumes the principal sets a contract for the agent. Initially, codes of *output* and *activity levels* were created. These were later merged to become *behaviour - output relevant/process irrelevant.* This code related both to actions taken in meetings and interviewees' perceptions of appropriate behaviour in monitoring agents. Two further codes relating to beliefs about the importance of contracts were added later: *contracts do matter* and *contracts don't matter.*

Agent involvement and agent action – Principal-agent theory assumes that agents are passive takers of contracts. They choose to accept or reject contracts but are not involved in their development. Two codes (*agent – active* and *agent – passive*) were created to show examples of agents' involvement in contract design. It became apparent during the analysis that contracts were not as important as expected so *agent – active* was used to illustrate active involvement by agents in any aspect of the commissioning decisions. *Agent – passive* was harder to apply. It was intended to show examples of the agent playing a passive role in accepting decisions imposed by the principal. In fact, unless the agent explicitly stated that this was the case, this code was hard to apply. Agent action was denoted using the codes *effort* and *effort/outcome relationship.*

Risk - The payment schedules devised by the principal should share risk between the principal and agent with the most risk averse being subject to a smaller risk level. Too little risk to the agent introduces moral hazard; too much risk means the agent refuses the contract. A single code *risk* was created to denote any discussion of risk sharing or any examples of shared risk.

Other issues that appeared important in the literature were the impact of pressure groups on decisions, the reliance of principal and agent on each other in monopoly situations and the rights of the principal to play that role. The following codes were therefore created: *external/third parties, dependency, multiple principals, multiple/choice of agents* and *legitimacy.*

b) Codes created during analysis

As the coding frame was refined, additional codes were created. Most of these were categorised eventually into the following general areas: *agendas*, *attitudes*, *behaviours*, *conflicts*, *context*, *definitions*, *feelings*, *finances*, *information*, *people*, *responsibilities*, *system* and *targets*.

The codes were used to mark text that was either subjective or objective in nature. For example, *finances – funding constraints* contained quotations showing perceptions of the effects of funding constraints...

> *... it doesn't change the problem, because there is no more money. So we all understand much better how we are and where we are but it doesn't stop the problem and therefore it doesn't solve the tension...*

...as well as examples from the observed meetings of particular constraints...

> *A PCT Chief Executive asked if the modern matrons were new posts or renamed positions already in post. An NHS Trust representative responded that they were not new posts, but new roles. It was "not affordable" to have new posts.*

Other codes related solely to the transcripts of meetings and denoted factual details such as who was leading a debate or what the debate was about, for example *meeting – manager agent* and *meeting – outpatients*.

Codes that did not fit in the general areas given above included *barriers to sharing, catalysts to sharing, immature organisations, managing expectations, organisational sophistication, principal-agent role reversal, PCT's own services/agents, private sector* and *status/hierarchy*.

This list of codes is not exhaustive. For a full list, see Appendix 3.

c) Super codes

Queries and super codes were used to group codes together.

For example, a super code *methods of influence* grouped together quotations coded with the following codes: *incentives - incentives/levers/sanctions, incentives - threats from above, contracts do matter, objectives - government/must do's, behaviour – monitoring, behaviour - micro-management, private sector* and *multiple/choice of agents*.

Super codes were developed in part by making obvious connections between the codes (for example, *incentives - incentives/levers/sanctions* is an obvious part of the super code *methods of influence*) and in part by searching for codes that had been applied to the same or overlapping pieces of text.

d) Free quotations

Free quotations were used initially to label quotations that did not appear to fit an existing code or to justify the creation of a new code. I revisited free quotations regularly and where groups of meanings became apparent, a new code was created to which the free quotations were assigned. By using this method, I minimised the chance of "losing" important quotations. At the end of the coding stage, all remaining free quotations were very short quotes comprising phrases that used descriptive language, such as "ostrich management", "straight jacket", "hijacked" and "P45 issues".

e) Memos

I created memos to build up my own interpretation of the data as I was coding the texts. In the main, these memos comprised thoughts, insights and questions relating to the data. These memos were altered, added to and merged throughout the coding and analysis process. They became the high level themes that emerged from the data.

An example of a memo is "multiple principals". This memo noted that interactions between the PCTs in case studies B and C were different, it questioned why there appeared to be a power vacuum in C and why the PCTs in B managed to collaborate more effectively, as well as speculating that the difficulty in ring-fencing services for particular PCTs' patients might add to the problem, and that it might be useful to explore relationships between the codes *multiple principals* and *dependency*.

9) Data analysis

The SLA documents for each case study were scrutinised for use of incentives or other methods of influencing the agent. A summary of the main sections of the

documents, the finances available and the activity expected is given in the results section.

The data management software allows each transcript to be searched on its own, with all other transcripts or with a sub-set of transcripts. I labelled each transcript type as (1) interview or (2) meeting and as (1) case study A, (2) case study B or (3) case study C. For interview transcripts only I gave the following additional labels: (1) clinician or (2) management interviewee and (1) principal or (2) agent. Using these combinations I was able to search different sub-sets of transcripts, for example, all manager interviewees from the agent organisation in case study B. This allowed me to undertake the multi-level analysis (Yin, 1994) described earlier.

Although my coding had been led initially by the expectations of principal-agent theory, my analysis was led also by the main themes that had arisen from the data and that I had noted in the memos. These were issues around "multiple principals", "tiers of principals and agents", "engagement and disillusionment" and "micro-management". I followed the same format for searching the transcripts for each topic area of interest. This format consisted of speculating about associations between memos and codes, creating queries and super codes to test for the existence of these associations and searching for any contrasting or unexpected associations.

For example, during the coding, I had created a memo for multiple principals and linked a number of related codes to this memo. This memo contained a series of notes about the ways that the PCTs in case studies B and C worked together and questions about why they were different to each other. Principal-agent theory predicts that where there are multiple principals, they will collude if they have the same objectives and equal access to information about their shared agent. My search for data followed a series of questions related initially to the predictions of principal-agent theory, for example, do the PCTs have the same access to information about the NHS Trust? To determine the answer, I searched the data for quotations labelled by the factual codes *information – good, information – poor,* and *information – use of* and the subjective codes *information – desired, information overload* and *information vacuum*. This search strategy was carried out for meeting transcripts, then management interviews and finally clinician interviews. For example, I searched for relevant quotations from case study B meetings, then PCT B managers

followed by NHS Trust B managers, then PCT B clinicians followed by NHS Trust B clinicians and so on.

For the example given, I searched next using codes related to objectives, power, partnerships, boundaries, responsibilities and sharing/not sharing. The resulting quotations for each case study were considered separately to produce a picture of events and attitudes. In this way, I ensured that the searches followed a consistent pattern and any negative cases (for example, clinical viewpoints) were included in the analysis.

In addition, during the coding phase, some quotations had been linked with others that either supported or contradicted them. Where these quotations arose in the search and analysis phase, the links were investigated and contradictory or supportive quotations presented where appropriate.

The next chapter presents the results. Contrary to convention, I have labelled each quote with a respondent type label and a code number but, to retain anonymity, I have not linked these labels or code numbers to individual interviewees. For example, the respondent type is given as Manager PCT A rather than Director of Finance PCT A. This is because there is only one Director of Finance at PCT A and labelling them as such would make their comments identifiable within that case study. Similarly, the code number refers to the quotation's reference number in the data analysis package, and so can be traced, but does not identify the respondent to the reader.

Where the respondent is from a PCT that is not the main case study PCT, a lower case "n" is used to denote that they are from a neighbouring PCT (for example "nPCT A"). Within quotes, names of individuals, organisations and places have been removed to retain anonymity. Place and organisation names have been replaced with "n" for a neighbouring organisation and N, S, E or W to indicate the direction from the main case study area, for example, "nHA to E" indicates a neighbouring health authority to the east of the case study area. The health authority in case study A played a prominent role and is referred to throughout as the "Health Authority". All other references to health authorities use small case letters.

Where sections of text within quotes have been removed for the purposes of clarity and brevity, they have been replaced with three full stops (...). The meaning conveyed by the quote remains the same.

Chapter Four:

Principal-agent relationships in practice

This chapter describes the main areas of interest that arose from the analysis of documents, observations and interview data from the three case studies. The results are presented as four themes. Issues pertinent to each theme are described in relation to each case study and compared with relevant aspects of the other case studies (Yin, 1994).

I consider first a basic assumption of agency theory, that principals are active in attempting to align agent's objectives to their own through incentive contracts. I consider this assumption as two separate issues, first that a principal sets a detailed incentive-based contract for its agent, second, that a principal is active in attempting to align its agent's objectives with its own. This separation allows an exploration of methods other than formal incentive contracts used by the principal to align the agent's objectives with its own. I then describe and discuss evidence around the case of multiple principals and a common agent, and of tiers of principals and agents and, in each case, how these affect commissioning.

The remainder of the chapter therefore considers the following:

1. Did principals set incentive-based contracts for their agents?
2. Were principals active in aligning agents' objectives to their own?
3. What was the effect on commissioning of multiple principals and a common agent?
4. What was the effect on commissioning of tiers of principals and agents?

In each sub-section, descriptive data are presented. In sub-sections (3) and (4) these descriptions are followed by an exploration of why there are differences between the case studies. A fuller discussion of these issues in the context of the wider literature and policy requirements is presented in the discussion chapter.

1) Did principals set incentive-based contracts for their agents?

In this section I present details of the Service Level Agreements between PCTs and NHS Trusts, and explore, using views expressed by respondents in interview, whether or not these are incentive-based contracts. If SLAs were being developed as incentive contracts, one would expect respondents to comment on the use of incentives, the alignment of objectives through incentives, monitoring of agreements and the sharing of financial risk.

a) Case study A

In case study A, a three way Service Level Agreement for 2002/3 between NHS Trust A, PCT A and the Health Authority was signed in April 2002. The SLA set out the "*agreed financial framework and principal delivery targets for 2002/3 for [NHS Trust A]*". It was stated in the preface that the SLA would inform the preparation of the business plan for NHS Trust A and the performance framework being developed by the Health Authority. The SLA was set out in two main sections. One detailed the allocation of funds and the other the targets required to be met.

A table listed the amount of funds available on a recurring and non-recurring basis. In addition, funds were split into a "baseline allocation" and "additions". The baseline allocation comprised 92% of the total. Of the additions, 4% was provided on a recurring basis to fund mandatory cost pressures, 2% was recurring to fund service developments and 2% was to fund mandatory cost pressures but on a non-recurring basis. The 2% for service developments was to be released in April 2002, the start of the financial year. An additional sum of money (equivalent in size to another 2.5%) was to be released for previously approved developments once their timetables and programmes for implementation had been approved. This was the only sum of money that was to be withheld at the beginning of the financial year.

The section of the SLA labelled delivery targets re-iterated many of the targets given in the NHS Plan, National Service Frameworks (NSFs), other national and local documents. An appendix stated the maximum expected waiting times, numbers of

patients waiting and cancelled operations, and the minimum inpatient activity numbers.

The meeting of these activity requirements was not linked directly to the release of finances. No incentives for achieving any of these requirements were included in the SLA. However, one of the targets to be met was to achieve a 2% cost improvement programme out of which all "*unavoidable non-mandatory cost pressures*" should be met. A further target, under the heading of performance management, was to "*review and develop incentive arrangements to promote high levels of performance*". No other details were given.

This SLA was not an incentive-based contract of the form assumed to be set in principal-agent theory. From discussing SLAs in the interviews, it transpired that none of the respondents considered incentives to play a large role, and in fact, many considered that negotiated agreements no longer existed.

The SLA was seen as more of a "direct accountability agreement" than an incentive-based contract.

> *The Service Level Agreement is then a more detailed expression of that agreement [the SaFF], in terms of a direct accountability agreement between one organisation and another, so it would basically put the requirements of what that organisation is expected to deliver. (Manager HA A 23/4)*

As already shown, the SLA gave no details about how agreed activity was to be delivered or paid for.

> *Respondent: But, you know, to me, if you've got a target and the NHS plan says that orthopaedic operations should be done to 6 months by the 31st March so and so, you know, that writes the Service Level Agreement for you. The only big issue for discussion is well, how do you do it? But the Service Level Agreement is very clear.*
> *Interviewer: Do those "how do you do it" things go into the SLA?*
> *Respondent: No, no. (Manager HA A 23/53)*

Commissioning was considered essentially as a joint process of planning. Performance management played an important role, perhaps replacing incentives, ensuring that people "*do what they say they will do*".

> *...there are a variety of ways in which the SAFF process can work . . . [it] is about forecasting your costs, matching those or otherwise to funding streams and determining from that what you're able to achieve.... (Manager NHS Trust A 22/1)*

> *...what we've got to actually do is ensure that we are delivering services on behalf of all our population. ...is [NHS Trust A] actually delivering in terms of the acute services and is [neighbouring PCT] delivering in terms of mental health. (Manager PCT A 24/1)*

> *I would define commissioning now as a process where the community agrees a plan, the community then allocates responsibility for delivering it and then the community then has a performance system in place to make sure people do what they say they will do - to me that's commissioning. (Manager HA A 23/80)*

Another view (predominantly from clinicians) was that PCTs could have an important level of control over the NHS Trust, but hospital clinicians had not yet realised this.

> *... the surgeons do not appreciate what potentially is the importance of Primary Care Trusts to their own work, the commissioning of their work. It hasn't sunk in at all.*
> *Interviewee: Importance in terms of?*
> *Respondent: Well, what I would call control, influence, those sorts of things. A driver, you know, we want this done. It's control and influence are the probably the two aspects to call it. (Clinician NHS Trust A 84/5)*

Clinicians' views appeared divided over the importance of SLAs. One view was that their importance was "*huge*". This consultant was the only respondent of any kind to mention a relationship between activity and funding.

> *Huge, because activity is our biggest thing and a lot of our money depends on us achieving our activity targets, which is fine, as long as it's achievable. (Clinician NHS Trust A 84/6)*

The other view of SLAs was that they had no teeth.

> *... I've been through so many years with these kind of agreements and quite a lot of the time they're not worth the paper that they are written on, so in other words, if an agreement is not adhered to what happens? The tradition has been that there has been very little under that to pin it down.*
> *(Clinician PCT A 35/56)*

This view was perhaps aligned more with those that performance management was the key, not incentive contracts. This was summed up by a Health Authority manager who considered that commissioning no longer existed.

> *I mean in my view there is no such thing as commissioning, because basically what we're all here to do now is to deliver the NHS Plan. Commissioning implies some sort of negotiation and local interpretation. (Manager HA A 23/93)*

The inference here is that the NHS as perceived in this case study was a top down hierarchy; the NHS Plan drove all NHS organisations towards the same objectives with little room for local manoeuvre.

In summary, the SLA was being used as part of the performance management framework with little significance in terms of providing incentives for activity. The Health Authority in case study A appeared to be the principal.

b) Case study B

At the time of writing (July 2003), the Service Level Agreement for 2002/3 between NHS Trust B and PCT B was available in draft form only. The document covered services provided by NHS Trust B to PCT B, but in fact it included also services provided to two neighbouring PCTs for which PCT B took the lead commissioning role. Importantly, these neighbouring PCTs were not those that attended the SaFF meetings; they were more distant PCTs that used NHS Trust B to provide only a minimal level of services. PCT B did not share a contract with the PCTs that did attend the SaFF meetings. The SLA consisted of seven pages labelled "General Agreement" followed by nine annexes that gave detailed spreadsheets covering finances, and activity and monitoring information.

The General Agreement had a number of short sections beginning with definitions of terms, and the aims and philosophy of the agreement. A large part of the philosophy was the commitment to joint working by the PCT and NHS Trust B, including a statement that PCT B recognised the pressures faced by NHS Trust B and would work with them to resolve those pressures. A section on Service Specification explained Annexes 1-7. These detailed the assumptions (referrals, removals, activity and conversion rates) agreed by both parties, services not provided and services for which a specified volume had been agreed. The Financial Agreement section gave the total contract price and an additional sum for which brokerage had been requested (an additional 2.1% of the total contract price). Procedures for dealing with variations in the agreed contract then followed. There was little detail in the section on Information Exchange and Monitoring; this merely committed both parties to introducing an adequate monitoring system in the future. Similarly, a section on Quality and Governance committed both parties to developing a new scheme. The Risk Management Arrangements specified that neither party had reserve funds on which to draw, but stated some expected risks, for example, that waiting list targets may be breached due to clinical vacancies, high referral levels or excess emergency pressures. NHS Trust B had signed the SLA, but PCT B had not.

The spreadsheet showing the draft finances was arranged as follows. The 2001/2 contract price was given. Recurrent variations agreed for that year were then added; these amounted to 0.3% of the value. A further 5.4% of the value of the 2001/2 contract was then added; this covered agreed cost base changes (recurring funds such as excess pay awards and cancer drugs) (5.8%), earmarked funding (1%, recurring), further recognised pressures (1.1%, mainly non-recurring), and technical and slippage adjustments (-2.6%, a mix of non-recurring and recurring). The 5.4% of funds that made up these adjustments were the SaFF funds for 2002/3. Other technical and inflation adjustments raised the value of the 2002/3 contract to 106.6% of the 2001/2 contract value. However, this level was then reduced to 105% of the previous year's contract as a result of a "non-recurring income gap" that the PCT must "find in year".

There were no details in the contract of incentives such as funds withheld at the beginning of the year or additional funds given if targets were reached. As stated,

neither party had any reserves. The annex detailing limited volume procedures gave the specialty, procedure, contract currency (although not price) and agreed volume.

From interviews with respondents, the general view appeared to be that the SLA was a detailed "contract specification" or a "mechanism of agreement". Again, none of the respondents mentioned the role of incentives in SLAs or links between funding and activity. Some did, however, mention monitoring.

> *It's all about exclusions and terms and conditions and monitoring requirements... (Manager PCT B 33/107)*

> *The SLA then puts the flesh on those bones [of the SaFF] and just sews up what you are actually getting for the investment and how it will be monitored. (Manager PCT B 26/5)*

> *The Service Level Agreement is normally a speciality or client group specific and it is a contract specification which says this is what we will do for this amount of money to this quality standard with these governance issues, with these access targets met etc, so that is very precise and much more as a contractual arrangement. (Manager NHS Trust B 31/5)*

> *They're mechanisms of agreement, they're mechanisms to say well this is what you agreed to do. (Manager NHS Trust B 83/2)*

The cost of monitoring SLAs was raised specifically by one GP who was interviewed after the publication of *Reforming NHS Financial Flows* (Department of Health, 2002c). She described a recent meeting at which the PCT Director of Finance had outlined the new system.

> *...she was saying that [the new payment system] could potentially be a big problem in that you are going to have all these invoices, and people ticking off number of hips done and putting a whole layer of clerical staff in there that you're going to have to pay for whereas now we just hand the money over and say get on and do the job. (GP PCT B 88/11)*

As far as the GP was concerned, the system was "*going back to fund-holding*". There was perceived to be a choice between two systems: the current and the new. The current system involved handing over a fixed level of funding and relying on

discussions with the NHS Trust to ensure that appropriate care was delivered as agreed; this system was seen to have low administration costs. The new system was seen to involve setting complex contracts with incentives and sanctions. The belief was that this alternative should ensure that the PCT's objectives would be met, but there was the assumption that to make the system work, the PCT would be expected to provide additional funds to enable the NHS Trust to monitor and report on their activity. Administration costs would therefore be higher. As far as this GP understood it, the Director of Finance would rather follow the current system of relying on informal agreement with the NHS Trust to meet requirements than potentially creating a "*big problem*" through relying on incentives and monitoring.

Another GP described SLAs in their current state as not helpful, very short and not detailed (PCT B Clinician 29/35) and a PCT manager compared the value of an SLA to that of a job description.

> *A good job description you actually get out of the drawer to see what are you meant to be doing. I think a Service Level Agreement should be like that and I don't think they are.*
> *(Manager nPCT B 34/108)*

Having SLAs at all was not viewed as essential (a view perhaps confirmed by the fact that the SLA had not been agreed even after the end of the financial year). The value of the SLA was not seen necessarily as the end product, but as the discussions and solutions that arose out of debates about the agreement. Both of the following respondents could see the benefits of a good agreement but were concerned that in their current state, SLAs were a remnant from the internal market. The fact that the organisations developed SLAs even though they described them as remnants and felt they were just "*going through the motions*" suggests that the importance of being seen to be following policy requirements was greater than the actual value of the documents.

> *I suppose at the end of the day they could not sign it. They could sign it and not do the thing that they don't like. ... I mean, that was- let's face it, that was part of the problem with the internal market. All these blinking quasi contracts when at the end of the day they were meaningless because you can't go to law on it and let somebody else thrash it for you. You've got to keep going until you get the issues resolved. (Manager PCT B 26/47)*

I'm not totally convinced that that is distilling out the absolutely, the really important things. Are we just slightly going through the motions? ... I suppose it serves some function but I'm slightly doubtful, I can't really energise myself to take it that seriously unless we can turn it into something different which really works for us and that people look at because it's helpful. (Manager nPCT B 34/110)

Unusually, the NHS Trust took the lead in developing the SLA. One reason for this was that it was used as an internal NHS Trust performance management document. Again, respondents used the term performance management, not incentives or contract.

... most of what constitutes the Service Level Agreements at the moment are actually our performance management plans ... which are developed by our performance management development department here. (Manager NHS Trust A 83/4)

I think in the past [NHS Trust B] has led because then that's their sort of internal agreement with each of their directorates and we sign it off with them. (Manager PCT B 33/107)

Although, as shown above, both NHS Trust and PCT could see the logic of the NHS Trust developing the SLA, some respondents from both organisations found the fact that the NHS Trust took the lead a little strange.

It's unusual as I understand it for provider Trusts to be drafting service agreements. (Manager NHS Trust B 28/48)

... [it] is mainly written by the hospital, which sounds slightly odd to me. Shouldn't it be mainly written by commissioners? I don't know! (Manager nPCT B 34/109)

The development of an SLA as an internal performance management document for the NHS Trust may have been a pragmatic response to a policy requirement in which few people saw value. By using an SLA in this way, the organisations could be seen to be complying with policy at the same time as gaining some value themselves.

In summary, both organisations saw the SLA as an agreement pertaining to the activity, finance and quality of services to be delivered. Its usefulness as a contract between the PCT and NHS Trust was uncertain but the NHS Trust used the SLA

instead as an internal performance management document. The SLA contained no incentives but the supply of some services was limited in volume. There were concerns expressed about the future use of incentives and monitoring and their associated costs.

c) Case study C

PCT C did not develop a Service Level Agreement with NHS Trust C for 2002/3. They decided instead to use their SaFF as an SLA. The attitude was perhaps similar to case study A; the HA manager there suggested that "*if you've got a target and the NHS Plan... that writes the Service Level Agreement for you*".

The document as supplied to me as the SLA was labelled "Service and Financial Framework 2002-2003" and included a general background to discussions, an Investment Plan (comprising four annexes), a Summary of Developments (including one annex), Areas Not Addressed, Risks and Next Steps. All of these sections described discussions and agreements between NHS Trust C, PCT C and other PCTs that used the services of NHS Trust C.

Two versions of the SaFF were presented. One gave a position of financial balance but failure to meet many national targets; the other presented the costs of achieving all targets but at the expense of significantly increasing the community's deficit. A main table showed the income and expenditure for NHS Trust C, and PCT C's share of that. (The PCT had to provide slightly less than half the required funding for NHS Trust C; the remainder was provided by neighbouring PCTs.) The "recurring baseline" was shown as 95% of the total funds available, the remaining 5% was provided for Category 1 (that is, unavoidable) cost pressures such as inflation. There was no funding for Category 2 cost pressures, given as, for example, external audit fees. These figures allowed for financial balance but failure to achieve many national targets. An extension to the table showed the cost of proposed service changes in order to meet national targets. These costs were the equivalent of 11% on top of the total funds available. There were negligible resources shown as available for funding these service developments. The tables were supported by a verbal description of "key priority areas" and a summary of key targets that would not be achieved within the existing plans.

There was no mention in the SaFF/SLA of any incentive arrangements. The document was purely a plan of action and costs.

In the interviews with both managers and clinicians, there was confusion about the purpose of an SLA, and whether or not the SLA and SaFF were different documents.

> *There must be a distinction! SLAs and SAFFs can be terms that are used interchangeably, but the SAFF is the Service and Financial Framework and I guess, maybe you can correct me if I'm wrong, is there a right or wrong answer? ... I don't know. ... I don't know. You might have an SLA with a small organisation which isn't necessarily included... I don't know, I don't know. Sorry. (Manager nPCT C 38/3)*

This confusion was justified given that in this case study the documents were the same. However, there is also the implication here that the value of an SLA is limited. Perhaps, as in the other case studies, the organisations were just "*going through the motions*" in developing a document called an SLA.

> *... they're just a document. They're pieces of paper. ... I'm not quite clear what the purpose of a Service Level Agreement is anymore. It was all- it's a hangover from the days of contracting. (Manager PCT C 32/50)*

> *I have to say, as regional office we asked for Service Level Agreements and nobody anywhere ever provided them for us, it's not just a [case study C] thing. So I've never seen one... I don't entirely believe that they exist... (Manager Regional Office C 80/63)*

An NHS Trust respondent was certain that an SLA did not exist.

> *... we have no agreement on the funding... we have no Service Level Agreements in place with our commissioners. I don't think we've probably ever really put together proper Service Level Agreements which have been monitored. (Manager NHS Trust C 39/16)*

In contrast, there were some quite specific ideas about what SLAs ought to include, although it was notable that no one expected incentives to be included in the agreements.

> *The Service Level Agreements should be an expression of the Service and Financial Framework on a specific organisation basis. (Manager PCT C 36/2)*

A Service Level Agreement to me is their contracting arrangements between- so it's everything historically plus whatever was agreed in this year's SAFF round becomes a Service Level Agreement. (Manager Regional Office C 80/63)

The latter quote serves as a reminder that the majority of service delivery by an NHS Trust is dependent upon historical activity. Annual negotiations are around marginal changes only.

In summary, respondents were not sure whether or not an SLA existed, but if it did, considered it as an expression of the SaFF rather than a means to influence behaviour. The SLA in this case study was, in fact, the SaFF.

This section has shown that incentives were not being used in SLAs. There was little consideration of incentives by either principals or agents and few discussed the direct relationship between funding and commissioned activity. SLAs tended to be used as performance management and monitoring agreements, either between principals and agents or as internal documents for agents. SLAs did not include any specific statements pertaining to the sharing of financial risk.

2) Were principals active in aligning agents' objectives to their own?

Theory suggests that alignment of objectives is achieved through incentive contracts. The previous section showed that incentives were not used in contracts. Service Level Agreements were merely expressions of what organisations had agreed they should deliver. So how were these agreements reached?

I consider here if and how principals attempted to align agents' objectives with their own. I do this through describing the commissioning related meetings that I attended at each case study. Chapter three gave details of the meetings attended. I consider also whether agents were passive or active in this process, and indeed, whether roles were reversed and the agents attempted to align the principals' objectives with theirs. This would be possible if the agents were more powerful or able to hide information from the principal.

a) Case study A

It was the Health Authority (rather than the PCT) in this case study that played the role of principal. There were few examples of NHS Trust A being active in its meetings with the Health Authority. The following illustrates where individuals from the Health Authority or NHS Trust were active in attempting to steer discussion to meet their own interests. The Director of Finance from the Health Authority acted as chair. The Health Authority had set the agenda and the meeting was held in the Board Room of the Health Authority.

i) The principal led the discussions

From the very beginning of the meeting, the HA Director of Finance demonstrated his position of relative power and his expectation that the NHS Trust would meet the HA's requirements. He opened the meeting in a formal manner and summarised the agenda items, in particular the areas he wanted to discuss in detail. The Director of Finance from the NHS Trust attempted to question an issue about revenue, but was stopped and told by HA Director of Finance that this issue would be picked up later.

A few minutes later, the Chief Executive of the NHS Trust was asked to give an "*honest assessment*" of the NHS Trust's position in relation to meeting activity targets for that month. The Trust Chief Executive spoke in some detail and for some time (10 minutes) about the difficulties of managing waiting lists and times. The HA members appeared to be listening intently, but as soon as the Trust Chief Executive finished, the HA Director of Finance re-iterated his original question. This pattern, of allowing the Trust members to put forward their views but returning to the original questions to ensure that the answers supplied the information the HA wished for, was repeated throughout the meeting. (This style was also prevalent in meetings that I attended at this HA with other NHS Trusts, not reported on here.)

ii) The agent depended on the principal for leadership

At a point almost half way through the two hour meeting, the NHS Trust members appeared to be unsure whether they were still discussing the current year's performance, or if they were planning the following year's requirements. The Trust Director of Finance relied on the HA Director of Finance to clarify the position. The NHS Trust members seemed to be playing a subordinate role, accepting that the HA

was in the driving seat, steering the meeting in the direction desired by the HA, whilst the NHS Trust merely supplied the appropriate information as required. There did not appear to be any attempt by the NHS Trust to change the emphasis of the meeting or to negotiate on any of the issues raised.

iii) The principal was not prepared to negotiate

The second half of the meeting concentrated on commissioning for the following year. The HA Director of Finance continued in the leading role by explaining to the NHS Trust the financial framework within which they were expected to work. There did not appear to be any expectation (by either party) that the NHS Trust would negotiate about the financial framework. Indeed, in introducing the issue, the HA Director of Finance stated that in the previous year, a two year financial framework had been agreed with the other NHS Trusts in the area, but not with NHS Trust A. As a result, the HA had assumed two year costs for NHS Trust A, and they now wished to agree on the remaining year. The HA Director of Finance took 10 minutes to explain the details of the financial framework, and did so on a flip chart at the front of the room. Throughout the process, both the Director of Finance and Chief Executive of the Trust made notes. On numerous occasions the HA Director of Finance signalled quite explicitly to the NHS Trust how they were expected to act: "*We really need you to...*" and "*I think there's two things...*". The HA seemed to have decided in advance what they required of the NHS Trust and were using this forum as a means to convey those requirements. One concession was a statement by the HA Director of Finance that they were not being *"precise"* about how the money was spent as long as the targets were met. This links back to the previous section on SLAs which showed that there were no incentives, merely an expectation that agreements would be delivered.

A debate ensued that was essentially an NHS Trust wish list of new developments. As earlier in the meeting, the HA Director of Finance appeared always to be in control of the debate, and summed up at the end of the meeting by explaining again what he expected the NHS Trust to be doing and the finances it would have to achieve these things. At all times, the NHS Trust remained inactive, seeming to accept the legitimacy of the HA's requirements.

A follow up meeting was arranged for February 2002. I was not permitted to attend this meeting as it was felt by the HA that the discussions would be too sensitive, in terms of personalities and behaviours rather than the topic areas discussed. I attended instead two meetings between the HA and PCT A.

iv) The "higher" principal dominated the "lower" principal

The first of these meeting was exactly the same format as the meeting described with NHS Trust A: a review of performance to date and plans for the following year. The HA Chief Executive attended this meeting, along with three other HA members and three PCT members. It was held in the HA Board Room. Again, the HA Director of Finance chaired the meeting and, as with the NHS Trust, the PCT appeared to accept a subordinate role. The issues being discussed were the PCT's performance and the plans for the PCT's provision of services the following year. There was little mention of the services the NHS Trust was providing.

The second meeting, to finalise plans for the PCT's provision of services in 2002/3, was held in the PCT Board Room. Three HA members and four PCT members attended. The HA Chief Executive did not attend. The HA Director of Finance once more acted as Chair. Although the HA Director of Finance was again quite dominant, the dynamics of this meeting seemed a little different. The PCT Chief Executive and in particular the PCT Director of Finance appeared to take the leading roles more so than in the first meeting, with the HA Director of Finance adjusting his strategy to what the PCT members had to say.

v) The "higher" principal protected the "lower" principal

In the second meeting, the HA Director of Finance appeared to be trying to protect the PCT from the possibility of strategic moves by a local mental health trust. The HA Director of Finance delved a little deeper for details in a discussion about management costs. The situation was that the local mental health trust had been trying to initiate discussions with the PCT about additional funding. The HA Director of Finance explained that, at the time, the HA was the sole funding body for the mental health trust and as such the mental health trust should not be coming through the *"back door"* for funding from the PCT. The PCT should ensure that the mental health trust was directed back to the HA for any funding discussions. This

event illustrates the hierarchical structure within this HA, the dominant role of the HA and the legitimacy the HA appears to have in playing this role.

In summary, the discussions and format of these meetings illustrate a number of important issues. First, the HA did not allow the PCT to work directly with its agent. The agent in the last example (albeit a different agent to NHS Trust A) was acting in a strategic manner, relating to the PCT as if it were principal, and the HA was refusing to allow this to take place. Second, the HA was acting as principal to NHS Trust A, rather than acting via PCT A. Third, the HA's objectives appeared to dominate; it was assumed without question that the NHS Trust would meet the objectives of the HA.

b) Case study B

The Chief Executive of PCT B chaired the first two meetings that I attended (plus an evening priority setting meeting). The Chief Executive and the Performance Manager of Health Authority B respectively chaired the final two meetings I attended. Eighteen or nineteen people from up to seven NHS organisations usually attended these meetings.

Perhaps because of the monthly nature of these meetings, there was less definition than in case study A about what the outcome of each meeting should be. Many of the agenda items were ongoing debates, appearing on the agenda for each meeting. I describe here some of the key debates that illustrate the ways in which the PCT attempted to align the NHS Trust's objectives to their own, and how the NHS Trust was active in putting forward its own interests.

i) The agent refused to agree with the principal

On many occasions, the PCTs put forward their plans for service delivery only to have the NHS Trust refuse to agree to it.

For example, a framework for restructuring services was discussed in the December meeting. The community's Director of Recovery, not the PCT, had produced the framework. The framework showed where the same services could be supplied for less money, and where more services could be supplied for the same money. It applied to both primary and secondary care services. Members of NHS Trust B refused to agree to the framework, stating that it would be "*stupid to agree*" when

they didn't know if they could achieve what was proposed. They refused to sign up to the framework before getting internal NHS Trust agreement. The result was that the framework was left without agreement and was not discussed again at any of the meetings I attended.

On another occasion (January 2002), there was an absolute refusal by NHS Trust B to discuss any issues to do with a particular pot of funding (over £0.5m). The general debate was about agreeing service priorities for 2002/3.

The history behind the funding problem (as explained by PCT B) was that in the previous year, the NHS Trust had been given non-recurrent funds to help reduce waiting times in one specialty. NHS Trust B had spent these funds in part on reducing waits, but in part on other priorities. NHS Trust B claimed that the funds were recurrent, and that they could spend these funds as they wished in 2002/3. In fact, they had already planned the use of these funds and had assumed that they were an addition to their funding envelope. No one appeared to be entirely clear about whether these funds were recurrent or not. According to the PCT, even if they were, the NHS Trust should have assumed they were part of the overall recurrent funding, not an add on. As a result of the NHS Trust's assumption that they were additional funds, their deficit would have to increase by over £0.5m. A heated debate ensued, but, throughout, the NHS Trust member present (Director of Operations) refused to discuss the issue. As far as the NHS Trust was concerned, there was nothing to discuss.

The end result was an acceptance that the situation was "*virtually impossible*" and the funds in question would be added to the whole community's deficit. Later in the same meeting, the PCT suggested that in return for allowing the NHS Trust to treat the funding as additional and recurrent, they should ensure that they met their 21-week and 1-year waiting time targets. Again, the NHS Trust refused to agree before undertaking the modelling to show this could be done. On this occasion, the NHS Trust's refusal to co-operate had achieved a result in the NHS Trust's favour.

ii) The agent was resigned to the principal's wishes

In contrast, there were occasions when the NHS Trust agreed to the PCT's wishes without discussion as they considered any discussion fruitless. Part of the meeting in January 2002 concentrated on agreeing how funds would be spent in 2002/3. Each

organisation had been allocated a funding envelope within which it must work. Each funding envelope would allow approximately a third of each organisation's wish list to be funded. The general idea was to begin with the total wish list and remove or cut down services until the funding required met that available. (It is important to remember that the funds being discussed in all these meetings were growth funds; the bulk of annual funding was allocated on a historical basis, without further discussion.) A member of the Health Authority and a member of PCT B chaired this part of the meeting jointly. There were a further five PCT members and just one NHS Trust member present. All other participants at this monthly meeting had chosen to break off to discuss long-term financial recovery rather than commissioned services for 2002/3.

Within minutes of being asked to make suggestions, the single member of NHS Trust B present appeared to be in despair, asking *"what's the point?"* given that achieving their access targets alone would cost more than their allocated funds. The PCT members made suggestions for reductions. They also corrected what they saw as an error in the NHS Trust's calculations. The NHS Trust had included £150k as essential costs for a new cataract theatre. The PCTs claimed that the funding had been given for that particular development in the previous year and as a result they cut £150k off the NHS Trust's estimated costs. The NHS Trust accepted this but insisted the PCT take responsibility for providing the additional funds if it transpired that they had not in fact been given previously.

A further 35 minutes of debate followed when each item on the wish list was discussed in turn. One of the PCTs realised part way through the debate that in fact the size of the funding envelopes had been calculated incorrectly and that the NHS Trust would be given even less than originally planned. The NHS Trust member appeared somewhat demoralised nearing the end of the debate, not really considering the implications of the decisions being made – *"just put fifty [thousand pounds] into peads and fifty into nursing"* and *"just cut what you like"*. The result was that the agent agreed to a series of decisions about service delivery with what appeared to be little serious thought about how these promises were to be delivered or the impact on service quality and targets of making such reductions. This was in marked contrast to debates in previous meetings where the NHS Trust had refused to make hasty agreements.

iii) The agent threatened the principal with increased costs

During the same debate in January on how to pare down the wish list, a new cataract theatre was discussed. NHS Trust B stated that some of the funds they were requesting were to set up a new theatre that, although expensive in the short term, would in the longer-term reduce waiting times. This was backed up with a warning that if the new theatre was not funded, patients would have to be sent from the NHS Trust to a private provider in order to meet the waiting time targets, and that would end up costing even more. The PCT did not agree to fund the new theatre (they claimed it had been funded previously – see discussion above). A final decision was made to allocate the NHS Trust only the amount that had been ring-fenced nationally for cataract surgery.

The agent in this case had threatened the principal with higher costs in the future. It was able to do this in part because the financial deficits were shared across the community and also because the NHS Trust (not the PCT) had responsibility for commissioning private care. Any increases in costs incurred by the NHS Trust would impact therefore on the whole community. There would be no way of the PCTs knowing whether the private care was essential or could have been avoided. The PCT did not succumb to this pressure.

iv) The agent ensured the principal's actions benefited the agent

In both the January and February meetings, the NHS Trust made efforts to ensure that planned changes to services provided by the PCT would be in the NHS Trust's favour.

In the January meeting to decide on priorities, not only did the NHS Trust have to pare down planned services, but the PCTs had to do so as well. One of the areas of discussion was the number of community physician supervisors employed. The PCT wanted to increase the number of supervisors in order to meet the requirements of the National Service Framework for Older People and to have an adequate community care service. Without the increase, they claimed, more people would have to stay as inpatients at the NHS Trust. The NHS Trust member wanted to know exactly how many additional patients the NHS Trust would be able to discharge as a result of the extra community physicians. The PCT was not able to give any figures, but justified the plans by quoting them as one of the most popular proposals agreed

at the December evening clinical priorities meetings. The NHS Trust again questioned the PCT, wanting them to guarantee that their investment in community physicians would mean no "corridor waits" for the NHS Trust, and wanting to know how many physicians would be appointed and the result in terms of quicker discharges. The PCT was not able to answer these questions and would give no guarantees. Eventually, the PCT decided the number of appointees on the basis of the funds available, not the impact on the NHS Trust.

This example shows the principal appearing to justify to the agent some of the principal's own plans for service development. The reason this happens is that, unlike in standard principal-agent relationships, the actions of the principal affect the agent as well as vice versa. Because they serve the same population, they are dependant upon each other's actions. It is interesting also that the principal used the same tactics on the agent as the agent did on the principal. The tactic was threats of the form "if you do not allow us to have our way, it will impact adversely on you". The agent attempted to take advantage of this situation by obtaining guarantees from the principal about benefits to the agent. The principal, however, gave no such guarantees.

v) The agent made financial gains by refusing to change plans

On a number of occasions, the PCT and NHS Trust had misunderstandings about some financial issues that appeared more fundamental than any attempt to align service objectives. Two examples occurred in the February meeting. This was a long meeting (scheduled for three but lasting three and a half hours), chaired by the Chief Executive of the Health Authority. The aim was to agree a draft SaFF to be submitted to the regional office by the end of the day. PCT B was responsible for composing the SaFF. From early on, tensions were high, after the PCT revealed that the NHS Trust had presented them with a bill for private care to meet waiting time targets, a bill that had "*arrived on the table last night*". In addition, the NHS Trust had presented its figures showing a £2m deficit of which the PCT was not aware. The NHS Trust was asked about this deficit.

Part of the deficit was due to the Clinical Negligence Scheme for Trusts (CNST). The CNST works like an insurance scheme for negligence claims. NHS Trust B paid premiums of around a million pounds. A debate followed in which the NHS

Trust insisted that these payments were "*a category one cost pressure*" and as such should be included in the SaFF (and therefore the deficit) like all other category one pressures, pressures outside their control. The PCT and HA wanted to see a strategy to remove this cost. The NHS Trust insisted that it was "*not [their] strategy*" to remove these costs. The PCT Chief Executive reminded everyone that at the previous meeting they had agreed the finances and pared down their development plans in line with the financial agreement. It was not possible now to add to the agreed deficit or cut the planned developments. NHS Trust B insisted that this figure was not new - "*We're not adding to it!!*".

Later in the same meeting, the Director of Finance at PCT B suggested that the NHS Trust had "*double counted the slippage*". The issue here was that the PCT had presented in the SaFF table the cost of its developments over a full year, and then adjusted this figure for slippage, assuming that developments would not in fact begin until half way through the year. This meant that the expected costs would be only half the full year costs. NHS Trust B had calculated the cost of their developments over half a year, already allowing for slippage. The PCT had taken the NHS Trust's development costs as given, presented them in the table with their own full year costs, and applied 50% slippage. The result was that all of the NHS Trust's development costs had been reduced to allow for slippage twice.

In response to the accusation of double counting, the NHS Trust insisted that it was not them, but the PCT, that had made the mistake. The PCT was angry, the NHS Trust was in despair - "*Well that's a major problem for us*", but adamant it was the PCT that had got things wrong. The HA Chief Executive attempted to mediate and suggest it was sorted out at a later date. The PCT refused; they wanted it agreeing there and then. Another HA member suggested they go back to previous papers to check the slippage, and asks if everyone is clear about its impact. "*About as clear as mud*" was one response.

At the end of this meeting there was no clear decision about either of these issues: the clinical negligence payments nor the slippage.

Whether deliberate or accidental, the agent had succeeded in adding to the overall deficit of the health community (principals and agent) without reducing their own development plans. Despite efforts by the principal to force the agent to reconfigure

its services to allow for (what the principal saw as) the agent's mistake, the agent had again refused. The fact that the HA Chief Executive had chaired this meeting suggests that the PCTs did not have the legitimate power to achieve the required agreement.

vi) Principal and agent agreed joint responsibility

In addition to these conflicts, there were many occasions when the PCT and NHS Trust agreed joint responsibility for issues and showed a shared commitment to service delivery.

In the March meeting, there was a discussion about "in-year pressures", in particular, who had the responsibility for agreeing funding for additional high cost/low volume cases. The scenario presented was of a patient requiring treatment, but the patient was the twentieth that year, when funding had been agreed for only nineteen. The debate centred on the roles of a clinical group and a commissioning group that both fed into the current meeting. All parties agreed that the final say would come from themselves after discussion at these monthly meetings.

On an earlier occasion in January, the minutes of the meeting that I did not attend show that the PCT and NHS Trust had agreed to communicate jointly with GPs and others in telling them that some services had been stopped due to the funding position.

These examples illustrate a shared ethos between the organisations; despite the different roles they have been given to play, the main broad aim of all of them is to provide good patient care.

In summary, these meetings showed genuine debates between the principal and agent about services and finances. At all times the organisations had been attempting to agree a way forward. On many occasions, the agent played a powerful role. It is not clear whether, on the whole, the principal was trying to align the agent's objectives to its own, or vice versa, or if the many organisations within the health community were influencing each other equally. At times, the agent appeared to treat the principals as legitimate funding bodies, but at others it did not treat them with the respect that a legitimate body might expect.

c) Case study C

In case study C, I attended five meetings (see chapter three for details). The organisation of meetings deteriorated throughout the period of observation. Attendance at the meetings by neighbouring PCTs declined over time. Many of the meetings had little focus and consisted of discussions of what progress people had made in the previous week or two, usually related to improving the quality of information.

i) Neither principals' nor agent's objectives were explicit

In the majority of the meetings, attendees appeared to have few explicit objectives. The four PCTs did not have the same objectives (this is discussed in the section on multiple principals), and none made it absolutely clear to the NHS Trust what they expected. One of the possible reasons given for this was that the health authority was sending out conflicting messages.

In the first of the meetings of the Operational Group, held in November 2001, there was a discussion about which targets the organisations could meet in 2002/3. An NHS Trust manager asked the PCTs which targets they expected the health community to reach successfully. The Director of Commissioning at PCT C responded that the organisations should have a common set of targets, but that PCT C would only be able to reach those it was currently reaching or could reach through service reconfiguration at no additional cost. They did not have the finances to achieve any more. She continued that she believed the health authority was sending out separate messages to the NHS Trust and the PCTs. They were telling the NHS Trust that they must hit their targets whilst they were telling the PCTs to reach financial balance. She believed that the health authority was "*working in silence*" and did not know it was sending out these conflicting messages.

It may have been that the principals and agent were reliant on a higher level principal (the HA), and if they did not receive clear messages they could not give clear messages themselves.

ii) The principal and agent worked as one

The Director of Commissioning from PCT C played a prominent role, although second to the NHS Trust Director of Operations in the earlier meetings. The Trust

Director of Operations and PCT Director of Commissioning appeared to have discussed in advance of the meetings a lot of the issues covered. For example, in the first meeting, the Trust Director of Operations explained the history of the commissioning group, then referred to the PCT Director of Commissioning to add to that. The PCT Director of Commissioning explained the complexities of four PCTs commissioning services from the NHS Trust and from each other, and the financial position of NHS Trust C. The Trust Director of Operations then resumed with the minutes of the last meeting, but again referred to the PCT Director of Commissioning to fill any gaps. This shared process was evident in all of the meetings.

These directors did not seem to be playing the roles of principal or agent. The degree of collaboration was as if they were working for the same organisation. In particular, in the March meeting, the NHS Trust Director of Operations made a comment "*with my [NHS Trust C] hat on, I suppose that's the only one I wear these days...*". The extent of collaboration between PCT C and NHS Trust C appeared to be greater than that between PCT C and the other PCTs present.

iii) The "higher" principal did not act as principal

Likewise, the higher principal (in this case, the regional office) did not play a strong principal role. The purpose of the March 2002 meeting was to agree a draft SaFF. A member of the regional office chaired the meeting. Unlike the HA in case study A, this regional office representative did not direct the other participants to achieve particular objectives. Her role was to ensure that each item within the SaFF was discussed and agreement on funds and subsequent achievement of targets was reached.

One of the first debates in this meeting was about how the target relating to a maximum wait of four hours in A&E could be achieved. The regional office representative stated that although this target was for 100% of patients and was not negotiable, NHS Trust C would be able to achieve only 75%. She stated that they should be "*upfront*" about this in the SaFF and "*see what happens to us*". It is interesting that the regional office, as a principal higher up the principal-agent ladder, referred to "*us*", the health community, as if the organisations were all equally responsible.

Later in the same meeting, the regional office representative made a similar comment in a debate about nurse consultants. The PCTs were not convinced that nurse consultant posts in NHS Trust C were a priority. The regional office representative commented that the health community may "*be told we have to*" introduce nurse consultant posts.

Throughout this meeting, the regional office representative reminded the other participants of priority areas and non-negotiable targets, but did not impose the region's own objectives. She was acting as a catalyst for agreement of the SaFF, not as a high-level principal imposing high-level objectives.

iv) The principal did not steer the agents

In the February meeting, it became clear that none of the organisations knew what the others were planning to invest in. A local community trust had been invited to attend the meeting to discuss its capacity modelling system and how this could help NHS Trust C. It transpired during the discussion that both the community trust and NHS Trust C were planning to invest in gastroscopy nursing staff. This overlap in intentions appeared to be discovered by chance. It was agreed that only one organisation should invest in the service improvements, although to my knowledge this issue was not discussed again. The SaFF/SLA document (discussed in the previous section) mentioned this issue briefly. It stated that NHS Trust C had submitted to the PCT a number of proposals that the NHS Trust considered top priority. One of these was additional capacity for gastroscopies. The only comment in the SaFF/SLA that related to this meeting's discussion was that *"discussion is required to consider whether this work could be undertaken in community hospital facilities"*.

Given that two agents had set funds aside to develop a similar service, and the decision had been made that only one would do so, one would expect that the principal would lead a debate about the alternative use of the released funds. This did not happen. This could mean that the principal did not have strong enough objectives to debate clear alternatives or that it did not feel such a debate was within its legitimate rights. Alternatively, it could mean that there was a high level of trust between the principal and agents; the principal may have trusted either agent to use the released funds in the best interests of the health community.

v) The agent did not take advantage of its dominance

In the initial meetings of this group, a member of staff from NHS Trust C organised the meetings, set the agenda and chaired the meetings. This was a similar role to that of the HA in case study A. This member of staff had been employed to begin with to work on behalf of the whole health community and was based in PCT C, but was seconded to and then became the Director of Operations at NHS Trust C. Later, a member of the regional office chaired these meetings.

At the first meeting in November 2001, the NHS Trust Director of Operations asked if everyone was happy for her to "*co-ordinate*" the meetings. Everybody was happy and the Trust Director of Operations continued to set the agenda throughout the SaFF process. As expected, the majority of items appeared to relate to NHS Trust C achieving its targets. All meeting attendees were able to add items to the agenda prior to the meetings. On more than one occasion, the Trust Director of Operations struck an item off the agenda at the start of the meeting, the reason being that the NHS Trust had not completed its preparation. On none of these occasions did the PCTs object.

In general, it appeared that the agent had the opportunity to control the meetings and to ensure the items discussed resulted in actions in their own favour, but did not always take advantage of this opportunity. Moreover, the principal did not make any attempt to impose its own agenda.

One debate shed some light on this issue. The debate took place in one of the January 2002 meetings. The specific issue under debate was the release back to the PCTs of funds from NHS Trust C as a result of the PCTs decreasing their level of service use. The underlying issue appeared to be the fairness with which NHS Trust C treated the different PCTs. There was a view that NHS Trust C was treating the different PCTs differently in relation to funding and service use. NHS Trust C responded they were not doing this; their systems were not sophisticated enough to do so.

It is interesting that the principals thought the agent might be using its knowledge to differentiate between the principals, but in fact the agent confessed to the principals that it was not capable of this. This suggests that although the agent may have

wished to pursue its own objectives, it was not able to do so in a way that was deliberately detrimental to individual principals.

vi) The principals felt that the agent was dominating the agenda

As illustrated above, the agent did not feel that it was able fully to exploit its potential dominance. However, the PCTs felt that it did dominate the SaFF agenda. In the March meeting in which the draft SaFF was finalised, PCT C complained that the draft SaFF was "*an [NHS Trust C] list*", not a health community list. NHS Trust C Director of Operations responded that it was not just a hospital list. The regional office representative commented that all the finances would go to NHS Trust C anyway so what they should concentrate on was how they were to achieve the community's priorities. The debate continued for another 20 minutes, with each item on the list being discussed in turn. Tempers rose after one of the newer members of the group asked where community investment decisions were made. The NHS Trust Director of Operations became defensive, complaining that it felt as if everyone was "*scrutinising*" NHS Trust C and yet not producing their own priorities. Two PCTs responded that they had "*zeroed community investment*". The Trust Director of Operations then questioned the level of funds NHS Trust was receiving compared to primary care; primary care was receiving a 10% increase whereas the average across the health community was just 5.6%. (This issue was raised again in the interviews). One PCT claimed that their SaFF and investment plans had always been available to NHS Trust C but that there was very little to look at, and that the 10% increase in funds was for prescribing only. The debate continued with a discussion about each item on the SaFF list but few further comments about whose priorities the list comprised. Members of one PCT left the meeting shortly after this exchange.

This exchange showed a lack of trust between the principals and agent; the principals felt that the agent was driving the agenda to its own advantage and the agent felt that the principal was favouring itself in the allocation of funds. The agent, however, appeared to believe that it had fallen to the agent to drive the agenda because the principals were not doing so.

vii) The principals refused to agree to the agent's objectives

In the March meeting, the participants debated the introduction in NHS Trust C of a Rapid Assessment Team (RAT) on admission, an Integrated Assessment Team (IAT) for discharge and a consultant nurse post in A&E. The Winter and Emergency Services Team (WEST) had identified the RAT and IAT teams as priority requirements.

The Trust Director of Operations justified these expenditures as being part of the WEST action plan. One of the PCTs twice stated that her PCT did not "*recognise*" these plans as something they had worked through. (The word "recognise" was used to mean acknowledge rather than be familiar with.) PCT C Director of Commissioning commented also that she did not believe a nurse consultant post in the NHS Trust was helpful when the community's plans were to treat more patients outside hospitals. After further debate, a third PCT expressed concern that if the nurse consultant post and the RAT/IAT proposals were agreed together, then priority 1 and priority 2 funding was being merged. This would mean that external pressures to fund priority 1 issues would advantage the agent by being linked automatically to an innovation of lesser priority. A decision was made by the PCTs that the priority 1 RAT/IAT proposals should be funded but the nurse consultant post would not.

This is one of the few examples in these meetings where the principals refused to agree with the agent. This meeting is also the only meeting that I attended where a Chief Executive of one of the PCTs (not PCT C) was present throughout. It may have been the presence of the Chief Executive or the pressure of the SaFF deadline that prompted more definition than previously in the roles of the organisations, that is, the PCTs acted in what they saw as the community's interest rather than the interest of the NHS Trust.

In summary, the principals and agent in this case study appeared to have less distinct roles than in the other case studies. The agent often spoke of a whole health community approach despite the SaFF agenda being dominated by the agent's issues. This domination may have been due more to the local context (this case study was the most under target of the three in terms of finances, NHS Trust C had a large deficit and it was struggling to meet many national targets) than to deliberate manipulation by the agent.

On the whole, the principals attempted to align the agents' objectives with their own through negotiation but were not always successful in doing so. NHS Trust A was the least active agent; it appeared willing to accept the objectives of its principal (the Health Authority) with little question. NHS Trusts B and C were more active and at times attempted and succeeded in forcing their own objectives on their principals. The agent was more powerful than the principals in case study C and at least as powerful in case study B. In case study A, the principal was more powerful. Although the agents may have been able to hide information about their costs, there was no evidence that they did so deliberately.

3) Multiple principals and a common agent

The previous two sections have shown that incentives were not used in contracts and that principals were sometimes but not always successful in aligning agents' objectives to their own in other ways. I turn now to the first of the main themes that arose from the data, the case of multiple principals and a common agent.

Agency theory offers two predictions for the case of multiple principals and a common agent. One is that the principals will collude if their objectives and access to information about the agent are the same; the other is that they will act independently if their objectives and access to information are different. If acting independently, principals may set competing incentive contracts that weaken each other.

A number of general questions arise: do the multiple principals in the case studies have the same objectives and access to information from their common agents; what factors encourage them to collude; and what are the results of any collusion? These factors have been considered separately for case studies B and C only. Case study A was selected specifically because PCT A was not involved in joint commissioning with other PCTs. It is therefore not appropriate to discuss case study A in this section. This section presents data labelled with the codes related to *multiple principals, objectives, agendas, information, partnerships, boundaries, responsibilities, sharing* and *power.*

My argument here is that the predictions are borne out to a certain extent, but not for the reasons expected. In case study B, principals collude and become more powerful *vis-à-vis* the agent. In case study C, principals do not collude as strongly (although they attempt to do so) and appear less powerful *vis-à-vis* their agent. This is as expected. The loss of power in C, however, is not due to principals setting contracts that weaken each other, but is due to an attempt to collude when in fact the principals have different and unclear objectives and a lack of trust in each other. The result is that the agent retains power.

a) Case study B

This section illustrates how the principals in case study B worked together. The evidence presented is based on my own perceptions of meetings that took place as well as interviewees' perceptions of the commissioning process.

The PCTs appeared to present a united front to the NHS Trust. Their broad objectives were similar and information for commissioning was available equally to all the PCTs. The NHS Trust provided this information. The PCTs supported each other in discussions and seemed to have a shared understanding in terms of attitudes and desires. Although the PCTs colluded in negotiations, they did not share a contract with the NHS Trust. The result of their collusion was seen by them and the NHS Trust to be a position of greater power. However, the PCTs felt that they could work together better and there were signs of tensions between the PCTs as they became aware of their different needs. Interestingly, the PCTs professed that they colluded in order to try to support the development of the NHS Trust and benefit the whole health community rather than to gain power over the NHS Trust.

i) Principals had broad objectives: *"to improve the health of the population"*

Two sets of broad objectives emerged for PCT B and the neighbouring PCT interviewed. One set related to internal objectives and the other to commissioned services. The PCTs' internal roles were to improve the health of their populations and be good employers.

> *...the PCT is here to improve the health of the population.*
> *(GP PCT B 29/4)*

...[a] whole lot of things like to be a very good employer. (Manager nPCT B 34/60)

... developing primary care, commissioning services, improving health and local inequalities and improving the workforce, the role of our staff within the organisation. (Manager PCT B 33/2)

The commissioning objectives were to meet the government's agenda.

...our priority's around meeting the national targets (Manager PCT B 33/75)

The first line has to be to meet the various Government directives. (Manager nPCT B 34/18)

The NHS Trust agreed with these general objectives of the PCTs.

One is to promote health and well-being in their environment, you know, for the catchment population they serve, if you like. Second is to provide good quality primary and community care services... (Manager NHS Trust B 83/15)

I think the PCT – you know, their objectives are, would be about increasing access for their population to some of the services that we offer. (Manager NHS Trust B 31/30)

These stated objectives were, however, very broad. It may be that the generality of these objectives helped the PCTs to maintain cross PCT agreement for commissioning issues. In the interviews, there was little mention of any measurable objectives that related to commissioned services. Some of the GPs did discuss specific issues (for example drug abuse services and prescribing) but these were associated mostly with primary not secondary care. As primary care issues they were related to individual PCTs, and so, in considering the issue of multiple principals and a common agent, are not relevant.

ii) Principals had equal access to information: *"It's shared information"*

Principal-agent theory suggests that principals should have similar objectives, but also shared information to make collusion beneficial.

There was no doubt that what information was available about NHS Trust B for commissioning purposes was available equally to all the PCTs. The access that the PCTs had to information about the performance of NHS Trust B was generally considered to be good.

> *Yes, it's shared, it's shared information so we all understand what's happening around GP referrals and how that's going to affect [NHS Trust B's] ability to perform (Manager PCT B 33/60)*

> *I would say we get very good information about the numbers of things that are done and how long people have to wait for them. (Manager nPCT B 34/67)*

The NHS Trust supplied the information to the PCTs. One interviewee at the NHS Trust provided me with a copy of their monthly performance report. As described below, this gave detailed information about activity and trends by practice and specialty. The perception was that this information was provided to the PCTs as a free service, rather than as an integral part of the NHS Trust's role as an agent.

> *We also supply information by practice and by PCT with trends, graph trends about additions to lists, by speciality etc. waiting times, benchmark data and we supply that for day cases, outpatients and emergencies, monthly to each PCT ... and we do that as a free service. (Manager NHS Trust B 31/35)*

> *...around activity and waiting list modelling, monitoring, planning, my team out here provide all the information for all the local community. (Manager NHS Trust B 28/95)*

> *... [the PCTs] should know about referral rates, should know about DNA rates at outpatients clinics, should know about waiting lists, should know about changes in waiting lists, should know about financial costs on a month to month basis and where the problems are, all these things are shared with the PCTs... (Surgeon NHS Trust B 89/69)*

There were areas of missing information, but there is no reason to believe that these were different for the different PCTs, and that is the important factor under consideration here. Despite the claim by the surgeon above that financial costs on a month-to-month basis were available to the PCTs, this PCT manager spoke about the desire to understand exactly what the hospital's costs were.

A real understanding of cost and capacity structure, probably largely by speciality, ... what the nature of their cost structure is like and where they are at any time on it, on their cost curve. (Manager PCT B 26/61)

Similarly, the neighbouring PCT manager wanted to see more information given about the services actually being provided and the quality of the care.

We ought to have information about the services, the range of services that is offered by [NHS Trust B] and that is not very good. ... I think that we need information about performance of the services ... We get almost no information at all about the quality or the outcome. Those are the two really major gaps. (Manager nPCT B 34/62)

Whether or not this information was appropriate or timely for the commissioning process is a different question. The important point here is that the PCTs perceived that on the whole they were receiving good information from the NHS Trust and that they were all receiving the same information.

This evidence suggests that the PCTs were in a good position to collude: they had similar (albeit broad) objectives and equal access to information. They therefore should have colluded, setting joint contracts to increase their power relative to the NHS Trust. However, this happened only to a degree. The PCTs worked together during negotiations but did not have a joint SLA. However, their separate SLAs were very similar.

I think it's very much the same, 98% the same, and there are bits on the back which show activity for our PCT and so on, a few numbers and things for us. And the [neighbouring NHS Trust] one is going to be the same. (Manager nPCT B 34/112)

iii) Principals had a shared understanding: *"they may not be quite seamless but it's pretty close"*

The PCTs had agreed when they were set up that each would represent the others in negotiations in certain clinical areas. As a result, PCT B led in discussions with NHS Trust B on surgical matters and the neighbouring PCT led on all issues to do with medical specialties.

...we've divided up the divisions at [NHS Trust B] so we lead on particular ones, so I do medicine division. (Manager nPCT B 34/92)

... they have made good inroads into developing a sort of collective approach to commissioning ... so if we have a conversation around something in surgery with [PCT B commissioning director] then I'm happy that he's either speaking on behalf of the other two or if he can't agree something, he says I'm going to have to go back and talk to him about this because I don't know what they think. (Manager NHS Trust B 28/58)

Despite this organised division of responsibilities, PCT B, as the largest, tended to be viewed as the lead PCT for all commissioning with NHS Trust B. PCT B certainly considered itself to be in the lead.

I think there is a hierarchy there. Between the PCTs I would see [PCT B] as being the top, simply because of our size and our capacity. So we do often take the lead on PCT issues, commissioning. (Manager PCT B 33/108)

...we've got a bigger budget and a bigger need to interface with [NHS Trust B]. I think our budget spend in [NHS Trust B] is what 50-60% of their budget so we actually are the major purchaser... (GP PCT B 82/95)

The was also a view from the NHS Trust that the smaller PCTs felt that it treated PCT B as the lead, although the NHS Trust was not sure that this was the case.

... I think there is a sense in the two smaller PCTs that we tend to jump more to [PCT B's] tune than theirs. I'm not sure we do particularly but I think there is a feeling amongst them that we do. (Manager NHS Trust B 28/61)

One of the most prominent examples of the PCTs sharing an understanding of the commissioning process and providing support to each other in meetings was the discussion about double counting the slippage (see previous section for details). The NHS Trust clearly had a different understanding to the PCTs. Each of the three PCTs involved had calculated their finances in the same way. One of the PCT managers made a comment during interview that may have been referring to this incident, and certainly makes the same point.

...all of the commissioners coming away with an understanding and [NHS Trust B] simply not having the same understanding and I don't know how that happens.
(Manager PCT B 33/87)

The NHS Trust shared the view that the PCTs worked well together.

I think with the services that involve us they work quite well, they may not be quite seamless but it's pretty close.
(Manager NHS Trust B 83/62)

The PCTs had supported each other against the NHS Trust during many debates in the SaFF meetings. The meeting when the NHS Trust refused to discuss the recurrent or non-recurrent nature of a half million pound pot of money is a prime example. The PCTs all agreed on the status of the funds; the NHS Trust didn't. On other occasions when the NHS Trust wanted guarantees about the impact on them of PCT activity, the PCTs were united in refusing to give any guarantees.

iv) Principals increased their power vis-à-vis the agent: *"We'd be out-voted"*

Theory suggests that principals increase their power in relation to their shared agent if they work as one.

There was a generally held view that the simple fact that the PCTs held the budgets made them powerful. Respondents commented on this power base in a general way and did not relate it specifically to the fact that the PCTs worked together. Clinicians and managers in the NHS Trust felt that the balance of power between them and primary care had changed already in favour of primary care.

...consultants are put in a kind of kneeling position and the GPs are the ones saying 'yes you can have that' and 'no you can't'. (Manager NHS Trust B 31/76)

I think the Primary Care Trust has very much been empowered by the fact that they hold the budgets nowadays and that has very powerfully changed the relationship between the Primary Care Trusts and the Hospital Trust, so now the Hospital Trust takes a lot more notice of what the PCTs are saying. (Surgeon NHS Trust B 90/11)

Primary care respondents, however, were less likely to believe that they had begun to use this new power, although they were aware that it existed and they would be able to use it in the future.

> *Increasingly PCTs, and [PCT B], is beginning to spread its wings and to think actually we have some real power in this system, ... because of what we can do with our commissioning budget and ... also the role we've been mandated to take on. ... Power is something that we don't ever like to talk about in relationships but I think we are in a more powerful position. (Manager PCT B 33/112)*

> *They see that we've got the muscles but we haven't shown any sign particularly of using them. I suspect that they are probably slightly wary of the time we do but perhaps slightly reassured that we haven't shown any inclination to do so, so far. (Manager nPCT B 34/41)*

There were a number of comments specific to the power gained by the PCTs through working together. Theory suggests that this power is achieved through the use of incentives set jointly; these data suggest that it is achieved by more simple means, through voting and the advantage of greater numbers in negotiations. The NHS Trust Chief Executive was seen as the most powerful individual in commissioning negotiations but his power was countered by the collaboration between the PCTs. Numbers carried more weight than personal power.

> *... at the end of the day we are one Acute Trust and there are three Primary Care Trusts so if it came to a vote, we'd be out-voted. (Manager NHS Trust B 30/12)*

> *... the most powerful individual is on one side of the fence but on the other side of the fence there are actually three other organisations ... it's two voices against six if you've got Directors of Finance and Chief Execs. so it doesn't really matter how good your Chief Exec. on the acute side is ... if you've got six people coming back at you and only two going that way it can actually be quite an unbalanced debate. (Manager NHS Trust 28/56)*

v) Principals felt they could collude better: *"Not enough, it's very sad"*

Despite appearing very organised to the outside world, within the PCTs there was a view that their level of collaboration was poor. There was a feeling that even within the PCTs, they were not communicating and agreeing as a single unit as effectively as they could. One of the problems was considered to be the difficulties in developing corporate objectives for an organisation that was made up out of a number of previously independent bodies, that is, PCTs that had developed out of a mix of PCGs and community trusts.

The view from a neighbouring PCT was that PCT B gave out confused messages to the other PCTs because it could not agree its internal objectives.

> *... they have quite different objectives and they haven't sorted out what their corporate objectives are. ... I can have a meeting with one fairly senior person and get one view and have another meeting with another fairly senior person and I get almost the opposite view. (Manager nPCT B 34/116)*

The PCTs had planned to meet regularly to discuss issues of concern to them in both their commissioning and providing roles. I attended the first one of these meetings in January 2002. Seven people attended; they were from four PCTs and were all finance managers. The majority of the discussion was a technical discussion about the levels of funds available to the PCTs to commission services. There was also a heated discussion about whether or not it was the responsibility of PCT B to ensure that NHS Trust B met its targets within the funds provided by the PCTs. There was no conclusion to the discussion at this meeting. These PCT only meetings faded out not long after they had begun. These types of meetings appeared to be missed by both managers and GPs. The following comments were made after being asked about how PCTs worked together.

> *Not enough! Not enough, it's very sad. We started having some meetings ... we thought well we ought to be getting together to agree our common front sometimes without [the NHS Trust], but we hardly ever meet. We were meant to have a meeting of that this week but when we had the main meeting everybody had to rush off and we never got round to it. (Manager nPCT B 34/25)*

...we used to have meetings, ... just being the GPs and GP managers sitting down before the combined meeting with secondary care, so what our goals, targets, aims were for that meeting and how we wished to move things forward. (GP PCT B 82/23)

There were also examples of a PCT making "*unilateral crunch decisions*" that affected the other PCTs adversely and show a breakdown in collaboration.

...[nPCT to east] has decided to commission, to purchase additional ultrasound activity and that has slightly destabilized the provision of ultrasound in [NHS Trust B], which means that [nPCT to west] and [PCT B] have a slightly diminished ultrasound service because one primary care organization has moved ahead without perhaps as much consultation as might have taken place. So in terms of working together we are not working together perhaps now as efficiently as we have in the past. (GP PCT B 82/25)

vi) Tensions between local needs and collusion: *"referral rates are different and that can have a big impact"*

At the same time as stressing the need to work together, there was an awareness that the different organisations had different local needs and agendas, and despite collaboration, these differences should not be forgotten.

...they all have their own agendas which are subtly different... (Surgeon NHS Trust B 89/81)

As one respondent commented, the original purpose of PCGs and PCTs was to have "*local care for local people*". There was a view that by working too closely together, important differences in population needs would be lost.

... half the idea of the PCGs was to have local care for local people and for us to work in a very unified way doesn't actually carry the philosophy of PCGs through ... we need to have different services because we've got different populations with different needs. (GP PCT B 82/26)

The management view tended to be that these differences were important, but should not obstruct collaboration between the PCTs. Although remaining aware of different needs, they appeared happy to look for shared broader issues rather than search out

differences. The manager from a rural PCT was aware of the different population needs of his PCT compared to urban PCT B, but could see similarities as well.

> *I think there is bound to be a difference just from the urban nature of the city. Although we may have some common objectives say with the deprived areas ... (Manager nPCT B 34/24)*

Different local care needs could manifest themselves in differences in quantity rather than type of service and so the solution to discrepancies was merely to remain aware of any changes in service use.

> *Where it does become an issue is if ... the referral rates are different and that can have a big impact on [NHS Trust B]. We have to sort of dis-aggregate the information to understand our own PCT's perspective and that's the dilemma when we're working as both health communities which would cover the 3 PCTs and as an organisation. The information that you get for a health community needs to be dis-aggregated so you can understand each individual PCT's position, so you do in fact have differential performance. (Manager PCT B 33/104)*

vii) Principals colluded to help the agent: *"Another layer of complexity"*

Whatever the extent of collusion, one would expect PCTs to collude in order to gain an advantage over the NHS Trust by increasing their relative power, or to prevent being disempowered by the actions of other PCTs. Neither of these reasons appeared to be the case. It appeared that the PCTs felt that they colluded to help the NHS Trust rather than themselves, and the NHS Trust allowed the PCTs to do so because it was advantageous to the Trust.

PCT B felt that the system for commissioning was complex enough and that it would be unfair for the NHS Trust if the different PCTs imposed different demands for service provision on them.

> *...there'd be nothing worse for [NHS Trust B] if we all wanted something slightly different, or yes they can do such and such with [PCT B] patients but no they couldn't for [neighbouring PCT], I mean that just adds another layer of complexity into the system which, you know, the system's got*

enough complexity as it is, so, yeah I think it's important we try and keep it as simple as possible. (Manager PCT B 27/27)

It was suggested also that the NHS Trust might prefer the PCTs to work together, that is, the agent may prefer collusion by the principals. Both the PCTs and the NHS Trust held this view.

I think a key objective of [NHS Trust B] is to have a consistency of approach from its commissioners, rather than being say a [PCT to west] approach, a [PCT B] approach and a [nPCT to east] approach, all of which are different. At their present state of development, I don't think they could cope with that. (Manager nPCT B 34/30)

...in the past with health authority [to the west] we almost had a completely separate discussion process with [them] and often ended up by doing quite different agreements... I think now [nPCT to west] will see themselves as part of [the main area] ... so that we can agree reasonably similar arrangements across the patch. I think that's actually an advantage to us. (Manager NHS Trust B 83/61)

Other respondents supported this view, but the desire for equity of access for PCTs' patients was also considered an important reason for collaboration between the PCTs.

I think there's an issue about making sure that we provide some continuity between the PCTs because we wouldn't want to develop differential access targets or differential types of service as you had in fund-holding days where acute units were having to have different, twenty five different agreements with different fund-holders. (Manager PCT B 33/103)

The implication of these views is that the NHS Trust could not cope with a diversity of approaches and demands, although there were contrasting voices from the NHS Trust. Compared to the era of fund-holding, being commissioned to provide services to three PCTs was not considered a problem.

Well, you know, when we had GP fund-holding we would have 50 practices to contract with, so 3 is fine. ... doesn't make a difference really. (Manager NHS Trust B 31/67)

In addition, and in contrast to the view from the PCTs that it was they who were collaborating to help the NHS Trust, there was a view from the NHS Trust that part of the success of the PCTs' collaboration was a result of the NHS Trust choosing not to take advantage by dividing and ruling. This suggests that the NHS Trust could choose to divide and rule if it suited.

> *... we do meet with all three of them, we don't sort of divide them and say we'll meet with [PCT B] and discuss [PCT B] and then we'll nip off ... then go back to [nPCT] and say come on. (Surgeon NHS Trust B 89/81)*

A lone GP voice suggested that the collaborative approach used by the PCTs might not have been permanent; the seemingly successful collusive system that these PCTs had developed may not have been planned as a strategic move, but instead was something they felt they had no choice in at the time and may alter in the future.

> *Things might change, places like [nPCT to west] have really said we don't want to spend any more money, stop. ... there are some slight changes in the philosophies between the primary care organizations, perhaps as they mature they want to do things slightly differently whilst when we started this PCG game to begin with none of us knew quite what we were doing and therefore we had to come together and work very closely. (GP PCT B 82/20)*

In summary, these PCTs did have shared access to information and shared broad objectives although their local objectives differed slightly. The PCTs were therefore in a position to collude, and did so in negotiations. They did not share contracts although their contracts were very similar. Although their collusion was motivated more as a way to keep commissioning simple than to gain any kind of advantage over their shared NHS Trust agent, the PCTs were empowered through voting together on contentious issues. This is an important finding as PCT B had no alternative NHS provider and as such NHS Trust B may have considered itself in a very powerful position and taken advantage of this.

b) Case study C

This section discusses how the principals in case study C worked together. The PCTs appeared to follow the motions of presenting a united front, but without any

underlying conviction. It did not appear as if the PCTs had planned a joint strategy or agreed which PCT would act as the lead. At times, there did not seem to be any obvious reason why the PCTs were meeting as a group with their shared NHS Trust. Although the quality of information provided was poor, it was available equally to all PCTs. The reasons why the PCTs tried to collude seemed to be the perceived pressures to use a collegiate commissioning system, a concern about taking responsibilities for commissioning decisions and a culture of sharing.

i) Principals' objectives were different or unclear: *"Different PCOs with different focuses"*

The high level objectives of the PCTs were understood well. These objectives are those set out in the NHS Plan and the National Service Frameworks.

> *... to secure services for the population, secure health services, improve health and provide services. The high level objectives are clear. (Manager PCT C 32/30)*

> *Achieving the key national access targets ... (Manager PCT C 36/12)*

> *...you're set objectives aren't you, your waiting time targets, cancer targets, CHD targets and other processes about trying secure the delivery of the targets. It isn't as simple as that but, that should be the intent. (Manager PCT C 91/7)*

Interestingly, each of these quotes is from a member of PCT C. The Chief Executive, Director of Finance and Director of Commissioning all spoke of the clarity and importance of the nationally set objectives. From the point of view of the other PCTs and the NHS Trust (both managers and clinicians), however, the objectives of the PCTs appeared at best different, at worst very confused and unclear.

> *...the priorities weren't clear around what people were deciding. (Manager nPCT C 41/10)*

> *...there isn't [a] common agenda ... (Manager Regional Office 80/6)*

> *Feels like there's four or five groups wanting something from us! (Surgeon NHS Trust C 95/27)*

I think part of the problem that we've got [is] the lack of one focus or at least one or two visions that we accept as the way forward, I think we've got different PCOs with different focuses that don't see the priorities in the same way as each other.(Manager NHS Trust C 39/32)

And later the same interviewee responds...

I think going back to my point – four PCTs, no-one taking the lead, everybody having different objectives is horrible! Let's have one way of doing it. That's what I feel like because I'm sitting in the middle of it all. (Manager NHS Trust C 39/82)

The other NHS Trust manager had no idea what the PCTs' objectives were and could not expand.

I've no idea. (pause) I've no idea. (Manager NHS Trust 37/22)

Despite shared and clear views about the high level objectives, PCT C did accept that, at a lower level, different objectives existed and the different PCTs perceived the best way to meet these objectives differently also.

...there can also be different service priorities in different areas ... The objectives are the same it's just that the mode of delivery might be, there might be a different perception about the mode of delivery. (Manager PCT C 91/17)

This is an important point. It shows an acceptance by the PCTs that although they may all be trying to get to the same point, they are trying to get there in different ways. Similarly, the timeframes over which the different PCTs wanted to plan were also different. PCT C focused more on the immediate needs of meeting targets (something that the NHS Trust considered realistic) whereas a neighbouring PCT was looking at how to improve health over the long-term.

I think [nPCT to east], for example, is focusing on health improvement and wanting a longer-term strategy for dealing with how we improve health so they don't need operations in the future. Whereas [PCT C] is more realistic I think, and says well how the hell are we going to get through to the end of this year and not to get 12 month waiters. (Manager NHS Trust C 39/34)

There were also feelings of jealousy and mistrust between the PCTs, although this first example is from a GP who accepted that he did not understand how the system worked.

> *The other thing that I personally feel quite miffed about ... is there are quite a few things that as a PCT we are funding and some of the other PCTs aren't paying their share ...*
> *(GP PCT C 93/51)*

However, one of the PCT managers shared this view. She expressed a concern that for PCT C (which is predominantly city based), the only option for development of services was with NHS Trust C. The other PCTs that also used NHS Trust C as a main provider had access to their own network of community hospitals and so could initiate developments in them that were accessible only to their own patients. Any development in NHS Trust C was accessible to all patients, not just those of PCT C. PCT C felt that it was footing the bill for developing new services that other PCTs were then using.

> *... if we, [PCT C], decide we want to develop a service at [NHS Trust C] the reality is you can't stop it being accessed by anybody else really. It's easy for the [nPCT to E] community hospitals because you are very self-contained ... anything developed at [NHS Trust C] will by default be available to the whole population. (Manager PCT C 91/21)*

Similarly to case study B, there was a general acceptance that each PCT was different and had different needs.

> *We've got a big provider arm here, which a lot of PCTs don't... Quite different. In fact, I suppose by default you can't be the same because you're all, you've all got different aspects to your own PCT then there isn't one size fits all really. (Manager PCT C 91/64)*

Here the NHS Trust manager confirms that it is the different agendas that make the collegiate style commissioning fail. The view is that the whole health community should agree a joint agenda, not just the PCTs. The agent here is in effect rejecting the principal-agent approach.

> *...the commissioning arrangements haven't worked because everybody's got a different agenda. We've never sat in a room and agreed as a health community our objectives are "x", our outputs will be "y" and this is how we are going to*

get from where we are today to doing that. We've never done that. (Manager NHS Trust C 39/35)

Others agreed that there had never been an attempt to focus on commissioning objectives. The main focus for each PCT was on community care and that meant that there was never a common commissioning agenda.

...there's a real lack of focus as to where we're supposed to be going and what our objectives are. It's very kind of partnership, community type side driven and the acute stuff seems to be kind of right we'll just go along with what the objectives of the host PCT are. (Manager nPCT C 41/8)

This respondent was the only one to mention the term "*host PCT*". The term host may have been used to indicate that NHS Trust C was situated within the geographical boundaries of PCT C. The respondent was also the only one to imply that the host PCT set objectives with which the other PCTs were happy.

ii) Principals had equal access to poor information: *"We're walking blind"*

None of the interviewees gave examples of good quality information available from NHS Trust C. One of the main concerns from the PCTs and the NHS Trust was the inadequacy of the information. There were, however, discrepancies about whether this was due to a system problem or a people problem.

...resolving the information systems is quite difficult and that's a people problem and it's a technical problem. It's about if you put rubbish in you get rubbish out but its also about the systems not being designed for modern day health care.... (Manager Regional Office 80/40)

The information systems in [NHS Trust C]... they have an adequate system but they don't know how to use it...
(Manager PCT C 32/68)

I mean we've produced pretty awful information. I think the whole health community feels that what comes out of [NHS Trust C] is not accurate in terms of information.
(Manager NHS Trust C 39/95)

...well the information systems are terrible, absolutely dreadful, and that's where there's a need for change.
(Surgeon NHS Trust C 95/35)

Whatever the reason, the result was little or no information being available to the commissioners or the provider.

> *[There's] just a complete information vacuum.*
> *(Manager nPCT C 38/42)*

> *We're walking blind. (Manager NHS Trust C 39/1)*

> *I just started to remember sitting in those rooms and everybody saying "we've got no information to work with, we need information"... (Manager Regional Office 80/36)*

Only one respondent commented on the lack of sharing of information, but she was referring to a commissioning process from a previous year. At the time of this study, it seemed that the NHS Trust was very open about its information.

> *[PCT C] in particular has been through the books in great detail and whilst they don't like what they see, they now understand and believe what they see... (Manager NHS Trust C 37/3)*

There was even a view that the NHS Trust was "*baring all*" whilst the PCTs just did their own thing behind closed doors. This raises the issue of whether or not the NHS Trust has a right to know what the PCTs are providing.

> *I always describe it that [NHS Trust C] has to, sort of, walk around naked in front of the PCTs and bare everything and the PCTs keep all their clothes on and I've no idea what they get up to. (Manager NHS Trust C 39/2)*

There was a view from a neighbouring PCT that they were provided with too much information from the NHS Trust, but not sufficient analysis of that information. Whether analysis is the responsibility of the NHS Trust or the PCT is another question.

> *...in terms of my limited time I probably feel, in a way, that I get too much information. I get lots of information and not much analysis in terms of what does that mean.*
> *(Manager nPCT C 38/37)*

Despite what appeared to be good sharing of information between the NHS Trust and the PCTs, each PCT seemed to be undertaking its own monitoring and information collection. This PCT manager described a process in a different health

authority in which she had worked previously. There, there was a process of pulling together performance-monitoring information on each specialty and each consultant, describing referrals, waits and activity. (This information appears to be similar to that provided by NHS Trust B to each of its PCTs.) The respondent found this very helpful for the commissioning process and would have liked to see something similar here.

> *[It] would be much better if we were working together, if our information teams were working as one, because what tends to happen is that we all, each PCT is doing their own little bit, [NHS Trust C] are doing their own little bit and actually we are probably all using a lot of resources to do broadly the same sorts of data searches, which if we worked, worked a bit smarter, it could actually get much better, true, really good performance information out of the system and monitoring information. (Manager PCT C 91/24)*

iii) Principals failed to work together: *"Nobody agrees"*

The PCTs appeared to go through the motions of trying to work together but did not follow this up with a conviction to make it work. The evidence presented in the previous section on aligning objectives showed that the PCTs had met to discuss issues, but they had done this with the NHS Trust present and to the extent that they could not face any more meetings.

> *We're meeting-ed out! ... the endless meetings with, it feels at times, dishearteningly little results. (Manager nPCT C 38/29)*

There was a feeling of frustration by some PCTs with their PCT partners. The host HA of one of the PCTs was based in what would become a different StHA to the others. The HAs worked to different timescales, with the StHA that encompassed NHS Trust C allowing service redevelopment proposals to be submitted later in the financial year than its neighbour. As a result, one PCT missed its own HA's deadlines for proposals for funding and was therefore unable to contribute to service redevelopment in NHS Trust C.

> *...they missed all the Programme Board deadlines, I didn't feel in a position to say 'don't be silly, let's just take a decision otherwise it's going to be February and we're going*

to be scrabbling around trying to implement these things at the eleventh hour'. (Manager nPCT C 38/24)

Perhaps as a response to the slow progress in agreeing service redevelopment objectives, another PCT began unilateral discussions with NHS Trust C, with no prior agreement to do this from the wider PCT community.

...we're hearing again, despite the fact we're meant to have this collegiate approach to commissioning, that [NHS Trust C] are having separate discussions outside of that process with the PCTs in [nHA] about developing specific services for that PCT. So we've heard that through the grapevine... (Manager PCT C 91/33)

The provider capacity of the PCTs was different also. A new model of elderly care at NHS Trust C had been under consideration for two to three years. One of the PCTs concerned had decided that it would rather invest in its own community hospitals' services than those at NHS Trust C. They had therefore stopped their investment in elderly care at NHS Trust C. Later, they had realised that a lot of elderly patients entered the system via emergency admissions and they could not stop their patients using the new facility at the NHS Trust. They therefore needed to re-invest in the service, but the money had already been spent on other priorities.

Whilst the PCTs were failing to agree objectives and work together, there was a tendency for NHS Trust C and PCT C to collaborate and take joint decisions. The example given shows how PCT C and NHS Trust C decided to make a joint appointment even though the other PCTs had been approached and decided against it.

...at the moment we have four PCTs all of which run their own performance management systems relating to [NHS Trust C] and [NHS Trust C] runs its own performance management independently. Now, it doesn't take a genius to say, why don't we have one system... [PCT C] and [NHS Trust C] have made a joint appointment, a single post, to do some work around that. Couldn't get any other PCT in yet, but I think they will come in. (Manager PCT C 36/55)

Despite these joint initiatives with NHS Trust C and the frustrations shown by each of the PCTs when others acted too quickly or too slowly for the group as a whole, the general view was still that the PCTs should work together.

I don't think we have sorted the messes very well really and they've ended up being antagonistic rather than, you know, we should be working together really. (long pause) The danger is that you don't get any service development do you, because nobody agrees. (Manager PCT C 91/21)

iv) The agent stepped into the power vacuum: *"We're going to send it to the PCTs and tell them"*

The result of these attempts at collusion was weak PCTs. The PCTs did not attempt to weaken each other deliberately by setting competing incentives for the NHS Trust (as predicted by principal-agent theory), but they did, according to the NHS Trust, seem weak.

I have not come across this degree of dis-functionality anywhere else. (Manager NHS Trust C 37/96)

So no real agreement on what the commissioners were commissioning, no Service Level Agreement on the levels of activity or the timescales that it was going to be delivered in ... So altogether no process in my view at all. (Manager NHS Trust C 39/19)

The NHS Trust felt that it was trying to create an appropriate level of dialogue with all of the relevant PCTs, but that not all of them were receptive. The Trust was particularly concerned about PCTs from a neighbouring HA. The NHS Trust provided a substantial amount of services to them, but the PCTs did not enter into a full dialogue with the Trust.

...we should have a better dialogue and understanding with the [nPCTs] than we do for the amount of activity and I think that's not for want of trying from our part. (Manager NHS Trust C 39/52)

The NHS Trust was incredibly frustrated at the current lack of agreement between the PCTs with regard to commissioning decisions and as a result one manager took matters into his own hands. He was developing a spending plan to present to the PCTs for agreement. The NHS Trust was forced into taking on a more powerful role in terms of leadership than it might otherwise have done.

...the longer the decisions are deferred, the longer we phaff around not being clear about what the position is, the more extreme the consequences will be. I find it extremely frustrating! I'm used to having agreement with people about what is expected of the organisation in the coming year. ... in frustration we're currently sort of setting out our understanding of the position and we're going to send it to the PCTs and tell them, these are the figures that we're working to, this is the money that we're going to spend.
(Manager NHS Trust C 37/18)

The view from NHS Trust C was that the PCTs had declined to negotiate with the NHS Trust.

...we'll end up making that decision I think without the support of PCTs because they've effectively declined the opportunities to discuss it with us. (Manager NHS Trust C 37/40)

This could have been a show of strength: the PCTs did not wish to give funds and were not prepared to debate issues any further. It could also have been a weakness: they were not able to agree. From comments by the PCTs, it appears that their lack of clear direction and co-ordination was a weakness that they acknowledged.

I'm sure that it's frustrating for [NHS Trust C] feeling that there's lack of clarity for them as to who it is they're supposed to ask for. No one's telling them what to do.
(Manager nPCT C 38/82)

This respondent went on to predict that the appointment to a co-ordinating role within the health community of a known strong leader from a local health authority would end this confusion. It implies that a strong leader is important, whether or not that leader is a principal or agent.

There was a single example of the PCTs appearing quite strong in relation to allocating funds to NHS Trust C. This manager felt that the PCTs were strong enough to choose not to give the Trust as much money as it felt it was entitled to. If the PCTs were weak, one would assume that the NHS Trust would be able to extract sufficient funds from them. This example shows also that the NHS Trust believed that the PCTs were favouring themselves in terms of funding allocations.

The extra money we've had this financial year is something of the order of 7.5% extra for the Trust. So something's

getting a higher priority than secondary care ... GPs are referring masses of extra patients to this hospital and we have to treat them more quickly than we've treated them before and we're not getting a fair slice of the money.
(Manager NHS Trust C 37/47)

The reality was that, despite the PCTs trying to work together, they were seen as un-coordinated and lacking in direction. This left a power vacuum. The NHS Trust appeared reluctantly to fill this vacuum.

v) Principals' roles were unclear: *"Who works where and who does what?"*

One of the reasons why the NHS Trust perceived the SaFF process with these PCTs as confusing may have been that the PCTs themselves were confused about their roles. There was confusion within the PCTs about who was the spokesperson for commissioning issues in neighbouring PCTs.

I just think there's lack of clarity as to what the process is and what it is that various people are supposed to be doing...
(Manager nPCT 38/78)

It varies between [three names given], and then we get [other name] who was one of them before. ... But I think [other name] works for [a different PCT]. We get confused about who works where and who does what. ... And we don't know whether she speaks for both or just for one. We think she actually speaks for both but then you get someone saying 'oh, we don't agree to that'... *(Manager PCT C 91/65)*

Although all the PCTs were involved directly in the commissioning process, they still did not understand their roles and did not perceive any one PCT as a leader.

I actually think that part of the problem has been lack of clarity on who is leading. *(Manager nPCT 38/75)*

The NHS Trust viewed the lack of a single lead PCT as one of the main problems.

Well as things are at the moment it's not working at all well. I think part of that is because we've haven't got a lead commissioner. *(Manager NHS Trust 39/62)*

PCT C tried to play the lead role in commissioning. It appeared that some viewed PCT C as the lead by default, purely because NHS Trust C was located

geographically within its boundaries. Some PCTs seemed happy with that arrangement, some not. Unlike in case study B where the commissioning responsibilities had been divided up between the PCTs, PCT C was trying to take the lead for all specialties.

One PCT implied they were at fault themselves for leaving everything to PCT C; they were too "*woolly*" about their own needs.

> *I think we need to be clearer as a PCT around our objectives and what our needs are for our population ... at the moment I just feel it's very woolly and we just go along and listen and say yes or no. (Manager nPCT C 41/30)*

A more detached view from the regional office was that the lack of clarity over roles had led to misunderstandings, with each PCT relying on another to carry out tasks. On a more worrying note, the NHS Trust perceived this as a lack of trust in each other rather than a simple lack of organisation.

> *I suspect it might have something to do with having four PCTs so the- they all thought the other one was doing it or something like that. (Manager Regional Office 80/61)*

> *...from my point of view [it] would be really helpful that we would have one dialogue with one organisation, but I don't think the other PCTs would trust them to be able to do that alone. (Manager NHS Trust C 39/92)*

Despite claims by the NHS Trust that they tried to negotiate with all of the PCTs, they did see PCT C as their main focus.

> *...our main focus ought to be with [PCT C] because we are their major provider. (Manager NHS Trust C 37/77)*

> *I think [PCT C] could potentially be our last ally if we're not careful ... they're much more heavily dependent on us ... (Manager NHS Trust C 39/58)*

This may have given PCT C a feeling of superiority that resulted in it not trying as hard as it otherwise might to align its objectives with the other PCTs. Certainly there was a very strong view from one PCT C manager that the PCTs and NHS Trust C should all sign up to PCT C's vision of shared decision-making and planning. The

concept referred to is one of having a clinical champion to lead service developments.

> *I have to say that I'm not sure that I've got everybody signed up to this concept yet, this is my concept, which the local PCTs are sharing, which we are promoting ... we've got to get everybody, and particularly [NHS Trust C]... the clinicians in [NHS Trust C], the managers in [NHS Trust C] have to believe that that's the way to make change happen as well. (Manager PCT C 32/113)*

None of the other PCTs mentioned this concept.

vi) Principals would not take responsibility: *"Ostrich management"*

Not only was it seen as too difficult to agree on decisions where PCTs had different objectives, but also there was a view that taking some important decisions was seen as too worrying by the PCTs. Both NHS Trust managers agreed that people were hiding from the difficult decisions that had to be made, hoping that they would go away because they could not bear any conflict. Everyone was perceived as hiding from these potential conflicts, but especially the PCTs.

> *I think there is a sort of ostrich management going on, put your head in the sand and hopefully it won't happen...*
> *(Manager NHS Trust C 37/14)*

> *I think we hide behind difficult decisions ... people just can't bear the conflict so don't talk about it and pretend it's not there and put it on the back burner. I'm absolutely sure of it.*
> *(Manager NHS Trust C 39/43)*

PCT C agreed.

> *...you try to avoid that situation of winners and losers and actually I think it's why we haven't done very well ... because we've skirted the issues actually rather than tackle them.*
> *(Manager PCT C 91/19)*

There was also an example given of one PCT worrying about an unexpected surplus of funds. The PCTs had on this occasion agreed a list of developments they could afford and had allocated the funds. They were surprised then to discover that they had funds remaining. The decision to allocate these funds to other developments had

to be postponed whilst the accuracy of the figures was investigated by one of the PCTs.

> *[Ch Exec of nPCT] felt that she wanted to look at it in more depth because she couldn't believe that it was that simple and thought that we must all have been missing something.*
> *(Manager nPCT C 38/23)*

In tandem with avoiding decisions, the NHS Trust saw the PCTs blaming it for the health community's problems.

> *...the PCTs had said it's all down to [NHS Trust C], crap management, don't know what they're doing, it's all your fault [NHS Trust C]. (Manager NHS Trust C 39/87)*

In contrast, the NHS Trust viewed the PCT management as failing to deliver difficult decisions because they were too afraid of accepting their mandated role.

> *There has been a lot of complaint from PCTs in the past that they're not involved in the decision taking process and they're now being fully involved in the decision taking process. ... I think it's coming hard. Well, OK, you want to be involved in decision taking process, you have to take decisions and some of the decisions are very difficult.*
> *(Manager NHS Trust C 37/43)*

> *...both [neighbouring PCTs] won't send representatives to meetings when you think they are going to when you are trying to make a decision, so you can't make a decision ... I sometimes wonder whether that's, I shouldn't say this really, but whether it's done on purpose so the decisions don't have to be made. (Manager NHS Trust C 39/44)*

Towards the final stages of the SaFF process, a member of the regional office and a member of a local health authority were drafted in to take charge of the process by arranging and chairing meetings. However badly the PCTs and NHS Trust had been managing alone, the NHS Trust did not consider this "hijacking" helpful. This is perhaps an illustration of the organisations higher up the NHS organisational hierarchy not trusting the lower organisations to perform their mandated roles satisfactorily.

> *We set up a process that was what I would call hijacked because of people's anxieties locally, in terms of would the PCTs and [NHS Trust C] manage to do it on their own.*
> *(Manager NHS Trust C 39/3)*

vii) Principals and agents rejected organisational boundaries: *"Does it really matter who leads?"*

A further reason why the collaboration between the PCTs did not appear to be successful was that there was a deep feeling that the whole health community should be working together; there should not be a split along organisational lines. PCT C (like PCT B) had a desire to work in collaboration with the other PCTs not for themselves but for the benefit of the NHS Trust. However, as discussed, this desire was not carried out in practice. The PCTs, and PCT C in particular, may have been so keen to work well with NHS Trust C that they neglected the process of working well with the other PCTs. As described earlier, the managers in NHS Trust C portrayed being in the middle of different commissioning systems from four PCTs as "*an absolute nightmare*".

It may be that some of the apparent weakness of the PCTs came about from a belief that it was not the role of the PCTs to be the leaders, that is, the PCTs were not necessarily legitimate principals. PCT C was very sure in its view that the most appropriate person should be the "*champion*" for a service, and that it did not matter to which organisation that champion belonged.

> *...if you think about the future and I think we're blurring the edges now of commissioning and providing. We're back to the old fashioned planning model. ... what we actually need is a champion. You need a clinical champion and you need a manager to work alongside them to deliver change. I don't really care whether the manager is an operational manager or a commissioner, all I care about is that they know how to champion service change. (Manager PCT C 32/27)*

In summary, the PCTs in case study C appeared to be acting independently from each other but at the same time trying to create an illusion of working together. PCT C seemed more dedicated to joint working and joint agendas. The managers from PCT C were keen to develop along whole health community lines and to take joint decisions. NHS Trust C appeared to have the same view. The other PCTs had their

own agendas and placed a lot of the blame for problems with the NHS Trust. The result was a chaotic process with weak PCTs.

c) Why were PCTs in B more successful in joint working than PCTs in C?

Both case studies B and C comprised a number of PCTs working with a single NHS Trust. In each case, the PCTs and the NHS Trust met collectively to discuss commissioning. However, the PCTs in case study B appeared to show a more united front and work as a team, whereas those in case study C seemed to be pulling in opposite directions. Both sets of interviewees claimed they were working in partnership across the whole health community (that is including PCTs and the NHS Trusts), yet tensions seemed to be higher in C than B.

There are two questions to be addressed here. First, why was the collusion between the PCTs in case study B more successful than in C? Second, why did the attempts at collusion in C weaken the PCTs relative to the NHS Trust?

i) Why was collusion more successful for PCTs in case study B?

The professed purpose of the PCTs working in partnership in both case studies was to keep things simple and to work for the benefit of the health community. However, the provision of services by an NHS Trust is complicated if its commissioners cannot agree on delivery but still attempt to work together. If success is defined as reaching a SaFF agreement after following a shared and consistent process, the PCTs in case study B were more successful than in case study C.

There are a number of reasons for this. They are discussed under the following headings: objectives, information, systems, personalities and leadership, and trust.

Objectives

The inability to agree objectives meant that the PCTs in case study C were pulling in different directions and therefore not able to work together. But were the objectives in case study B's PCTs more similar than those in C?

The answer is no. The objectives of case study B's PCTs were similar to those in C. Very broadly they appeared to be the same, but on a more local level they were quite different, partly due to the different urban and rural mix of the PCTs. PCT B and

PCT C served predominantly urban populations. In both case studies, the neighbouring PCTs served predominantly rural populations. Although many of the differences in the populations' needs were manifested at primary or community service level, respondents in both case studies discussed differential performance in secondary care.

The underlying issues were the same in both case studies; different levels of service infrastructure in both local communities impacted on demands for secondary care. For example, the neighbours of both PCT B and PCT C had access to community hospitals. This meant that the level of service they required from the NHS Trusts was different to the more urban PCTs with fewer community facilities. PCTs in C did not seem to be able to agree exactly what services they wanted NHS Trust C to deliver, or in what form the service should be delivered. PCTs in case study B were aware of their differences but had either resolved them or masked them. As reported, the PCTs in B had at one stage worked together to agree joint objectives. The PCTs in C had not done this and were not able to agree which objectives were priorities.

The PCTs in case study C held different beliefs about how commissioned secondary care services should be delivered, whilst those in case study B were less concerned with different modes of delivery but more aware of different levels of activity. In B, the PCTs appeared more able to agree to disaggregate activity data and accept what they termed differential performance.

Information

A further reason why PCTs in case study B seemed to collaborate more successfully than in C may have been the quality of the information. The quality of information available in case study C was considered to be very poor. The quality of information available in case study B was considered to be of a high standard. The poor information available in C was not to do with a reluctance to share information, but with poor systems and the poor use of systems. This lack of data for the commissioning process could have forced the PCTs in case study C to try to work together. They were perhaps not able to negotiate separate activity levels or separate delivery systems because they were unaware of their current and historic usage or the costs of this activity. This may explain why they were going through the

motions of joint working rather than being committed fully to it. PCTs in case study B had access to good quality information and data were disaggregated by PCT. This enabled the PCTs to make a positive choice to appoint a lead for each specialty to work on behalf of the others.

One justification for choosing a collaborative or network model of working in preference to undertaking separate negotiations could be to reduce transaction costs. Place *et al.* (1998) estimated the transaction costs associated with total purchasing by investigating the number of meetings related to contracting and calculating the budgetary cost of staff involvement. They included both the *ex-ante* costs of negotiation and the *ex-post* costs of monitoring and enforcement in their calculations. If the frequency of contracting meetings is used as a crude estimate of transaction costs in the case studies, then the number of SaFF-related meetings in case study C suggests that these costs were high. It should be remembered, however, that these case study meetings related to the *ex-ante* costs of information searching and negotiations, but not the *ex-post* costs of contract enforcement. Higher *ex-ante* costs may result in lower *ex-post* costs and vice versa. The use of meetings is not a sufficient measure of transaction costs unless this trade-off is recognised and accounted for. The point, however, remains that, in case study C, instead of choosing voluntarily to remove detailed contracting and monitoring to reduce transaction costs, it may be that detailed contracting and monitoring were not possible due to information deficiencies. The PCTs may have been forced into a collaborative model with each other and NHS Trust C. As a result of the information deficiencies, the collaboration was dysfunctional, at least in terms of agreeing a framework for the delivery of services and their costs. Case study C may have been going through the motions of colluding as principals in the wrong circumstances and for the wrong reasons.

Systems

One major difference in the commissioning methods of the two case studies was the way the finances were allocated. In case study B, NHS Trust B had been given their fair share of development funding at the start of the process with the proviso that if they failed to deliver services and meet targets from that funding, they could not return to the PCTs for more or blame them for not providing sufficient funds. All funds had been allocated equitably in advance. At all times during the SaFF

meetings, each organisation was discussing the provision of services from within this pre-defined financial envelope. This system was very similar to that employed by the Health Authority in case study A. It is interesting to remember here that case study C was a historically under-funded area whilst B was on target and A over target. Although case study C could expect a gradual increase in funding, at the time of the research, there was still a gap between the actual and a fair level of funding.

Case study C employed a different system to B. The PCTs provided the level of development funds that they considered were appropriate for NHS Trust C. The NHS Trust thought that they were not being given their fair share. From the start, this meant that there was an underlying tension between the NHS Trust and PCTs in case study C. The NHS Trust believed that the PCTs were allocating themselves a greater proportion of funds at the expense of the NHS Trust.

In addition, the area in which case study C was based had a history of different systems. The NHS Trust was sited on a boundary between health authorities. Each had their own systems and this caused some problems for the PCTs when they tried to work together. As one member put it, "*you feel that you're sort of adding up apples and oranges and then you have convert the oranges back to apples*" (Manager nPCT C 38/84). Each PCT thought that their own system worked best. None was willing to compromise and this undermined joint working.

Personalities and leadership

The majority of the directors in PCT C and their neighbouring PCTs had known each other for a number of years and worked in the area previously in different roles. More so than in the other case studies, they were very friendly with each other, to the extent that some believed they were not prepared to make difficult decisions that might damage those relationships. Friendship had become more important than achievement. The same people had been appointed to different posts in the health community each time the system had changed. This appeared to have resulted in an over familiarity called embeddedness (Uzzi, 1997). (It is interesting to note that this had not happened in case study A. There, the same people had been in the same posts for a number of years, despite system changes, but the familiarity had manifested itself by allowing these people to predict the actions of the others and plan in advance how to deal with differences.)

Case study B had some similarities with C in that a number of managers in the PCT and NHS Trust had worked previously in the area in different posts. However, there was a mix of new faces and old in each of the organisations, more so than in C, and the SaFF meetings in case study B were organised differently. They were bigger, with two or three representatives from each organisation at each meeting. In C's meetings only one person per organisation attended. In B, the feelings of loyalty to their own organisations seemed to be stronger than in C. There appeared to be some personality clashes between some PCT and NHS Trust members in B. They had respect for each other's capabilities, but did not appear close friends.

One of the relatively new faces in C (the NHS Trust Director of Operations) had been based initially in PCT C, with responsibility for the whole health community's development. The other newcomer (NHS Trust C Director of Finance) was in a temporary post and it was noticeable in the SaFF meetings that he was comfortable with asking difficult questions.

A major difference between the two case studies is illustrated by these comments from their PCT Chief Executives. PCT B's Chief Executive provided strong leadership that empowered individuals to take decisions, and allowed them to act independently of the NHS Trust.

> *... we are actually the commissioners so we can stand back from the debate and make a decision about how we're going to spend our resources ... my job is about making sure that my team are empowered to do that ... it is their role to make the decision... (Chief Executive of PCT B)*

PCT C's Chief Executive did not believe distinctions should be made between the PCT's role and that of the NHS Trust.

> *The idea that the commissioner is in charge is silly ... I do wonder why we get so upset about some of the words we use, you know. "If the PCT's leading on this it's outrageous, we're the people who do it", and I think does it really matter who leads on it? (Chief Executive of PCT C)*

Except for one member of NHS Trust C, all the regular attendees at the commissioning meetings were female. The Chief Executive of PCT C was female, as were those of two of the neighbouring PCTs. Many of the PCT finance directors were male, but they met at different times to the commissioning team. Case study B

organisations were each represented by a mix of genders. The role of gender in leadership is considered in the discussion chapter.

Trust

The lack of trust is another reason for the failure of PCTs in C to collude as well as in B. Despite a great deal of respect for some of the individuals involved, none of the PCTs in case study C trusted each other to act in the interests of the whole community, rather than in their own self-interest. This was despite the fact that they aimed to work in the community's interests. The lack of trust undermined any attempt at joint working.

In case study B, each PCT led in commissioning a broad specialty area. This lead PCT in effect acted as an agent for the PCT group as a whole. The PCTs in B voted with a united voice. This did not happen in case study C. The directors in PCT C had closer relations with the directors in NHS Trust C, particularly the Director of Operations, than with the other PCTs. PCT C was more likely to agree with NHS Trust C than the other PCTs on many issues. This seemed very unlikely to happen in B, although relations between the PCT and NHS Trust B were very good.

ii) Why did attempts at collusion weaken PCTs in case study C?

The second question to consider in this section is why attempts at collusion appeared to weaken the PCTs in case study C but not B. There are three reasons for this: a lack of clarity in roles, a feeling of being disempowered by higher principals and the pressures of policy expectations.

First, the PCTs in C were so unclear about their roles that the NHS Trust did not know to whom to turn for important decision-making. As a result, the NHS Trust made its own decisions.

Although the PCTs in B did not think that they worked together in a strong enough way, they had tried to do this and NHS Trust B perceived them to have achieved it. Those in C had never tried to agree roles. Some members of PCT C did not know the names or roles of their opposite numbers in the neighbouring PCTs.

In addition, attempts to blur the organisational boundaries, in particular between the NHS Trust and the PCTs, resulted in confused responsibilities and a lack of decision-making power. PCT C saw a need for clinical champions. The idea was

that it would not matter which organisation housed these champions. The appointment of clinical experts to lead in the development of service areas would have provided that focal point that the organisations were looking for. However, the inability and slowness of the organisations in agreeing leaders and in agreeing which organisations the leaders should be from, resulted in more ambiguity over roles.

Light (1998) suggests an idea that is consistent with but not identical to PCT C's idea of clinical champions. He suggests that NHS Trusts should have "supreme commanders" in the form of respected consultants who control everything "from work up to discharge". He believes that giving this commander the financial and organisational power to do this, and allowing teams to keep any savings, would remove any professional games. The difference is that Light's supreme commanders would be hospital based and funded, PCT C's clinical champions would be whole health community based and funded. This arrangement could create problems over boundaries and responsibilities.

Second, members of case study C felt that the commissioning process had been "*hijacked*" by the regional office. As a result, the responsibility for success in commissioning was shifted to an external organisation. This undermined the roles of the PCTs and NHS Trust by giving out a signal that they could not be trusted to carry their roles out successfully. The participants felt angry and de-motivated. As discussed already, the PCTs in this case study appeared to be struggling with the legitimacy of their roles. Although the Chief Executive of the Health Authority in case study B had attended one of the SaFF meetings, none of the respondents suggested their responsibilities had been removed or compromised in any way.

In addition to questioning the legitimacy of the organisations' roles, these external interventions resulted in a certain degree of individualistic behaviour from the organisations. NHS Trust C had become so concerned at the lack of decisions within the commissioning network that its managers had decided to act independently and inform the PCTs of their intentions. This desire to achieve came in part from the pressure to do so from the regional office. Some of this pressure was undoubtedly due also to the financial context of this case study. It may be that a certain amount of pressure can play a positive role, but too much reduces the chances of success.

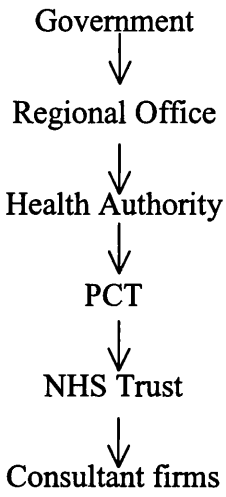
Third, the pressure from government policy to work in partnership within collegiate systems of commissioning may have forced the PCTs in case study C into a system for which they were not prepared or for which the circumstances were not appropriate. The PCTs were trying hard to create the illusion of a smooth running collegiate commissioning system when their hearts were not in it and the local context was wrong: their objectives were different and information inadequate.

In summary, the main issues that shaped PCTs' inabilities to work together included difficulties in agreeing objectives, a lack of good quality information, mistrust over the allocation of funds, overembeddedness and a lack of trust. Ambiguity over roles, confusions over organisational boundaries and responsibilities, and government pressure for partnership working in inappropriate circumstances all contributed to a reduction of power for the PCTs in case study C. These issues are explored at a macro level in the discussion chapter.

4) Tiers of principals and agents

This research set out to investigate the role of PCTs as commissioners of secondary care services. It aimed, therefore, to study a single principal-agent relationship, that between the PCT and the NHS Trust. However, it became apparent during the research that the strength of the principal-agent tiers immediately above or below that of PCTs and NHS Trusts affected the commissioning process and compliance with agreements. Managers stressed the importance of government and health authority roles, and clinicians commented on their lack of engagement in the SaFF discussions but the impact of the SaFF decisions on them. As a consequence, this section presents data on the respondents' perceptions of principals at three different tiers within the principal-agent chain: the government as principal, the PCT or HA as principal and the NHS Trust management as principal.

Typical elements of the principal-agent chain for commissioning secondary care services at the time of the research can be visualised as follows.



Theory suggests that the lower levels of a principal-agent chain collude. One would expect this to be even more prevalent if the lower levels are from one organisation and the higher from another. That is, one would expect that consultant firms and NHS Trust management would agree strategies for meeting their own organisation's objectives in preference to that of their PCT principal.

This analysis was undertaken using data related to the codes covering the concepts of *multiple tiers, objectives, agendas, incentives, systems, targets, power, creeping commissioning* and *micro-management.*

a) Case study A

In general, managers thought that the pressure to meet national targets was the most important driving factor for all organisations, but that this was not necessarily a bad thing. Clinicians felt the same pressures, but were more concerned with quality. The NHS Trust clinicians felt they were being used to meet management targets and as a result, there was a real danger that the clinicians would abandon the proper processes for agreeing new developments. The result would be developments occurring without prior agreement from the NHS Trust management, and certainly not the PCT.

Case study A was a special case in that there was a strong feeling that PCTs and NHS Trusts were equals, working to achieve the targets set by the Health Authority.

> *The health authority's there to hold both Primary Care Trusts and NHS Trusts to account, and to set the strategic framework that we are working to. So, that's a very clear*

hierarchical arrangement. Next question. Is there a hierarchical arrangement between Primary Care Trusts and NHS Trusts? It may develop but it doesn't currently exist, in process or in psychological terms. (Manager NHS Trust A 22/33)

... NHS Trusts are accountable to the health authority, and primary care trusts are accountable to the health authority. So if you look at the straight accountability framework, then basically it must be the decision of the health authority. And an NHS Trust and a primary care trust must basically work within that framework. (Manager HA A 23/14)

As a result, the PCT played virtually no role in the commissioning of secondary care services. The HA played the role of principal. This was illustrated earlier in the accounts of the SaFF meetings. The three tiers in the principal-agent chain in case study A are therefore Government to HA, HA to NHS Trust, and NHS Trust to consultants.

i) Tier 1: The government as principal: *"the only view that matters is the view of the Government"*

The predominant view was that government targets were driving the NHS. This view was held by managers and clinicians alike, and from all organisations. There was agreement from the managers that, as a political body, it was legitimate that the NHS should aim to reach politically set targets. There was also agreement that the national targets and standards were helpful although at times too controlling. Both GPs and consultants appeared less convinced of the merits of the targets and were more likely to view the targets as overwhelming and the central direction as interfering. The emerging divide in opinions was between the professions (managers and clinicians) rather than between, as might be expected, organisations (principals and agents).

NHS Trust and PCT managers put forward a view that, as a publicly funded body, the NHS should deliver what the elected government asked of it. If the government laid down clear targets, the NHS should deliver those targets.

There's a view that says the only view that matters is the view of the Government because it is the Government that is elected on mandate to do whatever it says it's going to achieve for the NHS. It raises the tax and it gives us the tax

funding to achieve objectives which it lays down very clearly for us. That's what we need to do. (Manager NHS Trust 22/14)

... we are a political organisation, a national service, I think a lot of us would actually welcome the fact that for the first time in most of the history of the NHS we've got national plans, national frameworks, national targets and you know, we do want to deliver. (Manager PCT A 85/19)

Whilst the importance of delivering the national targets was not in doubt, the validity of some of them was considered less than ideal.

... how do we measure access for elective surgery in hospitals – the number of people waiting. How silly an example is that? How silly a measure? Well, extremely silly because it doesn't matter how many are waiting, it's how long they wait. (Manager NHS Trust A 22/38)

There were views that the targets were too "*command and control*" and complicated the planning process on the ground.

... I think at the moment people would generally feel that the whole NHS is too centrally driven really, would be a view. (Manager HA A 23/76)

...with the recent changes, very much a command and control, lots more for command and control ... (Manager PCT A 85/13)

...we're constantly reacting to central new directions. ... throughout the year they're coming up with new white papers, initiatives, targets, which cut right across the planning process and make it a challenge. (GP PCT A 86/68)

The large number of targets was considered a problem. Questions were raised about the feasibility of organisations meeting such a range of objectives.

...you could say there are two targets: one, to deliver the NHS Plan and the other is to deliver the financial stability. But within those, there're a whole raft of targets. And that is where I think organisations find it difficult, because it is actually difficult to deliver over 500 different targets, you know, what other businesses will have that range of scattergram approach? I mean most businesses would focus

on ten core objectives. And I think that does present a problem. (Manager HA A 23/21)

However, managers suggested also that the result of such strong targets was a lot more clarity about what the NHS was attempting to do. This clarity meant that organisations were less likely to fail, and as a result of meeting their national targets, were more likely to be able to deliver local ones.

...there is this strong target approach ... I'm not saying that's bad in any way because I've seen other places in action and you could say the failure is because there isn't any targets. So it's good to get something that you can actually drive through and you can drive the quarterly agenda home with that. So I think it is a good approach. (Manager PCT A 24/25)

I firmly believe that if you deliver your central targets you've then got the space to develop your local targets. The problem is if you're not delivering your central targets you'll never have the space to deliver your local ones... (Manager PCT A 23/76)

An NHS Trust manager described the benefits of the targets well. He compared making decisions on standards of provision ten years ago with the present day. His conclusion was that today the objectives are a lot clearer and so the decisions a lot easier to make.

... coronary heart disease, in the early 1990s you could sit down, scratch your head and say I wonder what standards of provision we ought to be aspiring to and ensuring that we meet? ... now we've got a national set of standards and frameworks that set out what we ought to be aspiring to. ...it's made it a lot clearer, what it is we're trying to do. (Manager NHS Trust A 22/9)

Despite focusing on measurable topics, the targets were, on the whole, welcome.

So our energy, if you like, has been directed into achieving waiting lists and waiting times that are very high profile, as opposed to perhaps some of the more touchy, feely type things that our GPs might feel is good and we might all feel is a good direction to aim in future years. ... it is welcome as well. That's the long and short of it. (Manager PCT A 24/20)

Perhaps because the *"more touchy feely type things"* were not prioritised, neither GPs nor consultants mentioned any positive aspects of the targets.

ii) Tier 2: The health authority as principal: *"[the PCT is] a front organisation... for the health authority"*

The PCT did not play the role of principal to the NHS Trust in this case study. The PCT was considered at the time to be a very new organisation that was still finding its feet, and there was a view that the NHS Trust did not yet understand the role of the PCT.

> *...they're not sure what these PCTs are about and they do see them as second rate or new boys or whatever, new kids on the block... (Manager PCT A 85/76)*

Certainly the NHS Trust clinicians felt that the pressure on the NHS Trust to achieve did not come from the PCT, but from the Health Authority.

> *Our pressure actually doesn't come from the PCT, again it's the Strategic Health Authority that's saying these are the rules. The PCT does what it's told in relation to us. It's a front organisation (laughs) at the moment, for the health authority. (NHS Trust A Clinician 84/1)*

The PCT was an agent for the Health Authority in the same way as the NHS Trust. Therefore, quotes from PCT managers and GPs about their perceptions and experiences of the Health Authority as their principal are included here to help illustrate the style with which the Health Authority carried out its role. In general, the Health Authority was considered a strong leader, re-enforcing, and driving the local NHS in line with, government priorities.

> *If you look at our business plan and our Service Level Agreement, you can see a clear trail back to the SHA's priorities, ... and all Trusts basically have to live within that... (Manager PCT A 85/11)*

> *...that as far as I'm concerned is led really by our Trust trying to meet government demands but that may well mean that our Trust are being leaned on by the local PCTs but I don't think that that's the case because my understanding is that [health authority chief executive], who is sort of Chief*

Honcho, ... he has very strong objectives. (Surgeon NHS Trust A 87/8)

The perception that the Health Authority acted as a direct agent for the government was supported by the views put forward by Health Authority representatives in one of the performance meetings with the PCT. The PCT Chief Executive had expressed a concern that the PCT board members felt that the agenda was being driven by managers, not professionals, and by the NHS Plan, with many decisions being taken outside board meetings. This meant that many local issues were not being addressed. The Health Authority responded that the purpose of the PCT board was to focus on what they could achieve within given limits "*They do not have the gift of choice... their role is not to rule the world...*" (meeting code 3/30).

There was a strong feeling that the sheer number of targets set by the HA was overwhelming. One NHS Trust manager described the Health Authority's focus on access targets as like a "*straight jacket*". A GP talked about an *avalanche* and, as illustrated above, even the Health Authority respondent described a *raft* of targets.

...there's been an avalanche of those at the moment, it's getting ... the rate, the numbers of, the speed with which they're coming seems to be increasing. (GP PCT A 86/66)

There was some discrepancy over the actual number of targets, but the perception was that there were too many, up to "*eight hundred and fifty*" (GP 86/15). The Health Authority acknowledged that the targets they imposed were demanding and drove the process.

...targets and priorities, we actually focus probably on three things really which is financial balance, inpatient waiting times and outpatient waiting times ... and I think we do that very well. (HA PCT A 23/63)

The PCT managers agreed. In their role as agent for the Health Authority, they accepted that they had little choice in their priorities; some things were "must do's".

...there is this strong target approach and that's the driver behind all this. (Manager PCT A 24/24)

You know, you were at that mid-year review meeting and you may remember that we said two things we would like to focus on this year were access and intermediate care, I admit we

didn't have much choice about that: access is a 'must do'.
(Manager PCT A 85/101)

The PCT Chief Executive posed a question at the mid-year review meeting referred to in the quote above. He asked what the Health Authority's attitude was to "must do's" such as inpatient menus. The response from the Health Authority was swift "*You must do them*". There was no debate.

In considering the levers used by the Health Authority to extract high levels of performance from the NHS Trust and PCT managers, managers mentioned threats to their job security as an important influence.

> *...personal and organisational performance are now closely linked and so, you know, if your organisation is assessed say, as a nought star, or if you get a bad CHI report or you're had up for fiddling waiting lists, ... those will directly affect your own, your own job security. (Manager PCT A 85/22)*

Clinicians perceived the method as bullying. One consultant referred to the term "*corporate bullying*" as a tactic used to pressurise managers into achieving targets. This term had been used on a recent radio programme. Another respondent referred to the use of "*quiet words in corridors and Friday night phone calls*".

> *What was deftly referred to on the news was I suppose the process of... people regard it almost like corporate bullying really. You know, it's that sort of pressure ... for the Executives, you know, they're just told you've got to achieve this whatever and it's been part of the process. (Surgeon NHS Trust A 84/44)*

The PCT was aware that it should be taking on a more pro-active role as commissioner in the future, but was aware also that the NHS Trust may find invasive the PCT's level of interest in their actions.

> *...they don't want to be micro performance managed to death. ...there's a danger that we do ask them for too much information, we've got an interest in things that the health authority never did have ... I mean for them, changing a few clinics, it's pretty small beer stuff ... (Manager PCT A 85/75)*

There was unanimous agreement that the Health Authority in its role as principal was very strong and that it mirrored the drive to meet government imposed targets.

This implies that the Health Authority was a good agent for the government; the Health Authority's objectives were the same as the governments and it passed these objectives on to the next layer of the principal-agent chain using strong formal levers (such as threats to job security) usually associated with managerial bureaucracies (Whitley, 1999).

iii) Tier 3: NHS Trust management as principal: *"...without a doubt, our objectives are slightly different"*

As discussed, the aim of the research was not to look at how NHS Trust management acted as principals to their consultant agents. However, the consultants and GPs expressed very strong opinions about how these relations fitted with the commissioning system. This section therefore discusses the role of NHS Trust managers alongside their consultant agents.

Consultants perceived the objectives of NHS Trust management and themselves as different. Managers were seen as chasing government targets. Clinicians were concerned with quality and equity.

> *Without a doubt, our objectives are slightly different. The Trust is interested in numbers. Numbers, numbers, numbers, without a doubt. (Surgeon NHS Trust A 87/23)*

The result of these differing objectives was that the clinicians were often refused permission by NHS Trust management to make clinical developments because they did not help meet the financial and access targets. This consultant wanted to introduce a bone bank and already had part of the funds needed. However, he felt that the Trust was too afraid of committing any funds to the project and so it was not going to happen.

> *...there are some projects which I'm trying to get off the ground ... like I want to start a bone bank but I'm having difficulty doing that because of immediate financial, the Trust is afraid of spending immediate money although I've got funding for a fridge and funding for a nurse etc but they don't want to... (Surgeon NHS Trust A 87/13)*

The same surgeon continued to talk of another area that he was going to have to stop because of funding problems. He wanted to introduce a new type of resurfacing in hip replacements but had been told he could do no more in the current financial year.

> *... the Trust is saying no. I've been doing some here, I know my colleague in [town] hasn't been able to do any yet but I've been told that I can't do anymore in this financial year, although I have patients booked to have them done and that's going to be a problem. (Surgeon NHS Trust A 87/13)*

There were, however, two sides to the coin and the clinical director appeared to see both. On the one hand, he understood the clinicians' desires to develop new techniques and use new operations. On the other hand, he could see from the Trust management's point of view that these high cost operations could have major financial impacts. He implied that it would be better to have a more robust internal management system than at present to stop clinicians starting initiatives that would become too costly, but he didn't want a "*Stalinistic regime*". The role of the PCT in controlling new developments was not mentioned.

> *... there's a lot of concern at the Trust board level how this is controlled. Because at the moment it's not really controlled. Suddenly someone's doing this operation, you know, and it happens. And there's not a robust system that says well you can't do it. There never has been in the sense- one way you don't want to have too much of a Stalinistic regime. But at the same time if you are suddenly doing no procedures and in the next year you have done 30 procedures of a very complex major operation which incurs an additional cost of five to ten thousand pounds potentially per patient or something, the ramifications of that are quite enormous aren't they? So they have not got their handle on that but they are certainly very aware of it- or we are as a Trust. (Surgeon NHS Trust A 84/31)*

A colleague commented on the same issue. However, he did feel restrained by the NHS Trust's controls on decisions and felt demoralised because he was not able to learn and implement new techniques.

> *... it sort of puts me off, I mean there are so many new procedures, which I want to learn how to do but it puts me off going to learn to do them if I feel that I'm not going to be allowed to do them because I can't have the prosthesis, which I find is slightly frightening. (Surgeon NHS Trust A 87/19)*

When I asked what happened if new developments were introduced without prior agreement, he responded that the NHS Trust management reacted, not the PCT.

Respondent: You get lots of letters, because I know that my colleague did this and had lots of cross letters and things.
Interviewee: Cross letters from?
Respondent: From the Trust, the Trust board, from the financial director etc.
Interviewee: The NHS Trust?
Respondent: Yes, the NHS Trust, exactly. (Surgeon NHS Trust A 87/17)

One of the reasons why the consultants made changes without approval (in the case below, a new development, but the logic works equally well for removing services) was that the effort of going through the appropriate channels for approval, and the disappointment if approval was not given, combined with seeing colleagues ignoring the proper channels and being successful in initiating new developments, was demoralising. These unapproved changes can be seen as the result of having too much of a Stalinistic regime.

...I had to write a business plan with evidence proposing why I was doing something, costings, costings of alternate treatment, I had to provide sort of some justification for why I was doing it and I sort of provided them with the recent NICE report... and I've done all that and my problem is that colleagues who have tried to introduce things in the past have ignored all these policies and just introduced them and managed to do it and I did what I was told to do and I've had considerable difficulties having spoken to a lot of senior people in the Trust about it, so I think in the future the best way to do something is just to do it. (Surgeon NHS Trust A 87/14)

It was not clear from the data why the consultants who were interviewed perceived different levels of control over their decisions. One respondent was a clinical director, the other a consultant within that directorate. It may be that the clinical director imposed stricter controls in his directorate than the NHS Trust management imposed on him. Whatever the reasons, the result was the same: the introduction of new treatments without management approval. Weak control by NHS Trust management allowed new treatments to be introduced without approval. Strong control from clinical directors demoralised consultants and could encourage them to bypass the system.

In addition, there appeared to be an "us and them" attitude within the NHS Trust. Both consultants and GPs recognised this.

> *They [the consultants] see themselves working in a hospital, not as part of it. (GP PCT A 35/32)*

The hospital doctors often referred to "*the Trust*", meaning the NHS Trust management rather than the organisation as a whole. Some non-consultant respondents viewed the consultants as difficult to manage and the managers as trying hard to work with the PCT whilst the clinicians were not.

> *... there's a very strong conflict of interests. ... I think the managers are trying very hard in the hospital to get the waiting lists down. I think there's a fairly strong resistance to change with some of the clinicians. (GP PCT A 86/43)*

In one of the meetings between the Health Authority and the PCT, there was a discussion about how some of the NHS Trust's consultants had been "*most unhelpful*". There was a claim (by the Health Authority management) that some consultants undertook more private than NHS work and fitted their NHS clinics into lunchtime slots between their private sessions (meeting code 5/10).

The NHS Trust managers had slightly different views to each other about controlling consultants. One view was that the consultants had incentives to undertake less activity than under the internal market system because of the pressures to meet access times. To stop access times being breached, consultants were asked to do more private work; the incentive was therefore to undertake less NHS work in order increase the risk of breaching targets and so attract more private work. This manager commented also on the consultants' use of a local community hospital theatre. The theatre was underused. His belief was that the consultants preferred to use the newer facilities in the main hospital and so made excuses that the patients were not appropriate to be treated in the satellite facilities. He did not mention any ways in which the management tried to control this.

An alternative view was that the direct employment relationship helped the NHS Trust management to control the consultants. This manager was describing how the relationship between NHS Trust management and NHS Trust clinicians had moved on since the 1990s when consultants had perceived themselves as "*autonomous practitioners with clinical freedom*".

> *We have moved that relationship on to something that is much more legitimate bearing in mind we spend one and a*

half million pounds of public money a week, which says the public has got reasonable expectations of what we can achieve ... and you, senior clinical staff, [your] job, the reason that you are paid is to deliver that, right?
(Manager NHS Trust 22/31)

Both GPs interviewed were frustrated with consultants who had refused to discuss changes or share decisions. One described a consultant not only refusing to share the workload in a community theatre with a GP, but also refusing to allow his own management to manage his waiting lists.

... as long as he keeps his waiting times high, presumably that keeps his private income high so there's all sorts of vested interests... (GP PCT A 86/45)

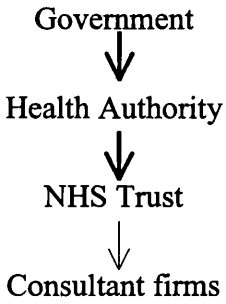
Another GP commented on the lack of discussion before changes. He made two points: it is quite common for a consultant to decide to stop providing a service without consultation, and consultants do not appear to realise that their decisions impact on others. The latter suggests that it may not be deliberate hiding of information that causes rifts, but a simple lack of understanding.

...the consultant decided he was closing a clinic. This is a common thing. I'm not going to do an outpatient clinic any more down in, you know. And you think, hang on a minute, nobody's actually mentioned that to anybody else. They've no concept really of any of the impacts on anybody else. I understand why because why would they think of it, it's not... but it's like starting out. I think I'll start a clinic in [local town], but you actually forget that the whole thing needs support. It sounds like really simple stuff but it makes major impacts on everyday life. Discussion doesn't happen. (GP PCT A 35/28)

In summary, the influence of the government on the Health Authority and the Health Authority on the NHS Trust in case study A seemed strong. Both tiers were target driven in a command and control style. The Health Authority control over the NHS Trust was characterised by strong leadership. However, the commissioning system broke down to some extent at tier 3; although the hospital management had agreed with the Health Authority to meet the government objectives, the hospital clinicians did not necessarily follow the same agenda. The management and clinicians had different objectives. The internal NHS Trust processes for gaining approval for new developments seemed to be strict but not well enforced. Consultants were frustrated

and their enthusiasm dampened by frequent disappointments. As a result, there were calls for a more robust internal management system at the same time as there were threats to bypass the system for being too restrictive. There was no mention of the use of incentives in any tier. There was a reliance instead on the power of employment relations: NHS Trust management were threatened with job security and consultants expected to conform as employees of that management. Although many respondents viewed consultants as deliberately awkward, a lone voice suggested some problems might be the result of a simple lack of understanding of the impact of their actions on others.

The principal-agent chain illustrated below corresponds to respondents' perceptions of control in case study A.



The solid arrows between the government and Health Authority, and between the Health Authority and NHS Trust represent strong management. The fine-lined arrow between the NHS Trust and its consultants represents weaker control. The PCT in this case study did not enter the hierarchy in relation to commissioned secondary care services.

b) Case study B

Views in case study B were similar to A but more likely to be negative with respect to targets. The respondents felt driven but also trapped by the national targets. They felt that there was little room to develop other issues of local importance. Although it might be expected that these negative feelings would result in clinicians becoming more demoralised than in A, and hence initiating more un-agreed developments, in fact, this was not perceived as the case.

i) Tier 1: The government as principal: *"The first line has to be to meet the various Government directives"*

The overwhelming view, as in A, was that the organisations had to meet the government targets before anything else. The most well known targets were associated with secondary care services (predominantly access targets).

> *I think clearly the top of the list in terms of objectives is delivering access targets and those key targets identified in the national plan. (Manager PCT B 33/14)*

> *The first line has to be to meet the various Government directives. That can be a bit frustrating because they consume more than all your mental energy and more than all your finances. (Manager nPCT B 34/19)*

It was not just the PCT that felt trapped by the pressures of the national targets. NHS Trust management felt equally trapped and recognised the difficulties the PCTs faced as a result of the whole health community's problems.

> *...the overwhelming thrust is to meet the "must do" targets for the Government... The whole health community finds itself in an horrendous stressful position whereby it's having to pick up an underlying deficit from previous years, so the bulk of the resources gets eaten up by the deficits and then whatever's left is really available to hit the "must do" targets. (Manager NHS Trust B 30/8)*

> *...we have those which are P45 issues... These are national things and they're non negotiable, P45s are sacking offences. Although the NHS Plan came out with three or four hundred objectives, there were some which are P45 issues and there were others where locally we have to make a decision as to whether we think that we can do it, or we can't do it and why we can't. (Manager NHS Trust B 37/1)*

Although management accepted the targets, they were not necessarily considered to reflect the most important aspects of care. The implication in the first quote below is that national pressures result in local developments being squeezed out. Indeed, the second quote is from a GP who stated specifically that local objectives were being neglected in the SaFF.

> *... the things that we will be judged for at the end of the year as an organisation are whether we are balanced financially*

or whether we've hit our waiting list targets. ... I think there is a difference between what any of us individually believe to be an important thing to be spending money on and what's most important in terms of performance management from the centre to us. Those are the only things that anybody ever loses any sleep over, the only things we ever get asked about. (Manager NHS Trust B 28/9)

Locally, there are one or two things which we have to do, so substance misuse services in [city]. Through the SaFF we didn't find some money but through another route we've identified funding, and I think if we hadn't done that ...a lot of GPs would be saying why have we become a PCT, which has got to be about making local decisions for local problems... (GP PCT B 27/33)

There were no comments from any of NHS Trust B's management or clinicians that were positive about the national targets. Unlike in case study A, no one said they helped focus objectives. None of the GPs referred to any clarity from the targets either. The PCT managers, however, did have a few positive words.

... the national stuff is about shorter waiting times and getting a consistent standard and I think that's helpful... (Manager PCT B 27/32)

...can we just take as red that as managers when we talk about meeting targets and providing services we are actually assuming that that is the right thing to do for patients. So that's at the backdrop of it all, we don't forget that meeting the targets aren't the end all. You have to assume the targets are a proxy for a better service. (Manager PCT B 26/12)

Increasingly, the pressures felt by both PCT and NHS Trust management were shared. Although respondents viewed the PCTs as principal, they discussed briefly the roles of the regional office and StHA. The roles were as bodies to which the respondents were answerable.

The waiting list targets are increasingly becoming seen as part of their problem as well as ours, although I think there is still a bit of movement in that direction to be had. I mean it isn't the PCT Chief Exec. that gets the calls from the regional office saying what's the position going to be like at the end of the month on the waiting list front. (Manager NHS Trust B 28/13)

The PCT actually felt that they would be held to account more than the NHS Trust if the agreed targets were not met.

> *...strictly speaking we're all accountable to the Strategic Health Authority but if we weren't delivering our accountability agreement, I have no doubt both organisations would be called to account and we'd be asked to stay behind and called to account a bit more...*
> *(Manager PCT B 33/113)*

ii) Tier 2: The PCTs as principal: *"where are you going to put the money? ... in your own..."*

The consensus appeared to be that the PCTs had a right to commission services but not to manage the NHS Trust. Their commissioning should be in a hands-off manner. Not all respondents perceived this to be the case and there was a degree of mistrust on both sides.

There was a feeling that the general public saw the job of PCTs as commissioning secondary care services. Secondary care targets dominated the primary care agenda.

> *I'm sure if you asked people locally what does the PCT do, I'm sure most of them would say they commission services from acute hospitals. So it feels fine that that's what we do but I do feel it dominates the agenda more than I would like it to do. (Manager PCT B 33/83)*

However, the NHS Trust had an agenda that included developing tertiary services in addition to secondary services. This caused some tensions in the commissioning of secondary care services as the PCTs felt that the NHS Trust was more concerned with tertiary than secondary care.

> *As a Trust we've also got a big agenda in terms of developing tertiary services ... And that to an extent creates a bit a tension within the process [between] us and the PCTs ... that is an objective that is very different from the PCTs.*
> *(Manager NHS Trust B 28/10)*

The PCTs appeared to be very aware that they had no managerial responsibility for the running of NHS Trust B.

... it's not our job to run the hospital... (Manager nPCT B 34/86)

... at the end of the day I have actually no managerial responsibility for the way in which they spend money, and that would be getting into what they call micro-management. (Manager PCT B 26/36)

However, they planned to become more involved in the detailed management of the Trust if the Trust was failing to meet its targets.

...if things are going well they get more space, if things are going badly they must expect us to take more interest in the detail. (Manager nPCT B 34/99)

Contrary to these intentions to remain at arm's length, the PCTs did want to know in detail what the Trust was doing to deliver its targets. Both the NHS Trust management and clinicians were concerned about the PCTs' tendencies for micro-management.

...it feels people in a primary care commissioning position are trying to manage a hospital, make decisions, or more often not allow us to make decisions, which are about how we run the hospital. ... the Trust management team [need to be] free to manage a hospital within a broad framework agreed with the PCT and don't have to get every "i" dotted and "t" crossed ... (Surgeon NHS Trust B 83/24)

There was an acceptance that perhaps the PCTs were appearing to take on more of a management than commissioning role, but that the process was new and they all had to begin to understand their roles relative to each other.

I think at times it must feel to them that we're trying to manage their organisation because we're really in there quite a lot and that's some of the feedback that we've had is that actually we're there to commission not to manage. But it's also about [NHS Trust B] and us all beginning to understand what it's like to have a PCT commissioning services and that we are trying to make some decisions jointly rather than just let a particular unit go off and do whatever they feel is best and the real issues are around replacement consultants and job plans and closure of beds, ward re-configuration, all of those things which we insist on knowing about and that can feel a little bit close to them, I think, because it starts to take away some of their previous freedoms. Before perhaps they didn't have to ask or seek

agreement around the configuration of consultant posts or funding new posts. (Manager PCT B 33/71)

Despite the views from the NHS Trust that they did not want the PCTs interfering with operational matters, one PCT respondent explained having to turn down an invitation to meetings that were operational.

I was invited to a series of fortnightly meetings about A & E services, and I just had to say that anything that's happening fortnightly is operational. We can only help them change over a timescale that you measure probably in years, certainly months. (Manager nPCT B 34/98)

There was an alternative view from the NHS Trust management that the PCTs did not engage with them in terms of monitoring their agreements as much as they should. The NHS Trust was surprised by this and did not think it would reflect well on the PCTs if the NHS Trust failed to achieve the agreed targets.

We have a twenty-minute chat about [the] waiting list position and how it's going about once a month, if that, but it's all pretty informal. Now I'm surprised by that – I know other areas in the country, the performance monitoring meeting between the Trust and the commissioners is a, you know, pretty major bun fight every month where the great and good turn out and dust off their best suits. ... I think maybe giving us the freedom to get on with it is good but perhaps even within that they're slightly more hands off with everything than they should be. ... It's a difficult balance but I think we're too far towards the laissez faire end of the spectrum at the moment. (Manager NHS Trust B 28/67)

Notwithstanding this concern, other members of the NHS Trust management team were adamant that the PCTs had no right to ask questions about how the NHS Trust was trying to achieve its targets, and if they did ask questions, they would receive no answers.

... if I want to appoint a couple of nurses to a ward, I'm not going to go and ask their permission for it, ... but they may want me to, but I wouldn't, because I see it as internal business. I think they have a right to say "and what are you delivering, what are you doing around that service, you are not meeting the target, you're not doing x, I want to know why". No problem with that ... if we agree a target that we will do 1000 inpatients in this speciality, say, that's what I expect them to monitor us on, in terms of the 1000 and if we

go wrong on that, then they can ask for more information. What I don't expect them to do is to say and how are you going to do it? Because I think the how you are going to do it is our business. (Manager NHS Trust B 31/47)

The GPs felt that there was some jealousy from the secondary care clinicians and a culture of blame. This issue is exemplified by a comment that some of the rivalry between secondary and primary care was caused by primary care having control of the funds.

I think there is antagonism a little bit because we've got the money and the secondary care doesn't. (GP PCT B 82/84)

There was a concern that in the health community as a whole there was a tendency to blame the PCTs if services could not be prioritised due to financial limitations. One GP raised the interesting point that all the organisations had the same objectives (to improve health care) but placed different priorities on how this should be achieved and it was that, linked with the way in which funds were controlled by the PCTs, which resulted in the tendency for blame. Despite belonging to one organisation (the NHS) with one broad set of overriding objectives, the different units of the organisation had different ideas about how to meet specific objectives. This issue had arisen also in relation to the joint working of the PCTs in case study C.

I think there is now still a culture of blame. "You can't, you can't have that because the PCT won't fund it", is something that we're using. "You can't have that because it is not a health community priority" is the message, not because the PCT won't fund it! We're all in health care, and we're trying to get the best health care improvement for the population, and you know, there are other more important priorities is the overall, well that's the message. (GP PCT B 29/16)

In addition to this culture of blame, the NHS Trust management showed a degree of mistrust about how resources were prioritised by the PCT.

... if you've got the money to buy services for a whole health community and you, yourself actually provide some of the services, where are you going to put the money? ... You're going to put in your own, aren't you? Because they're your staff, all those staff work for you, all those doctors work for you. Are you going to go and put it in an organisation 10 miles away? ... It's human nature that you're likely to be

drawn to do something even though it may not be the right thing to do. (Manager NHS Trust B 31/78)

This mistrust was possibly held only at management level. A theory held by one of the GPs from PCT B was that clinicians communicated well across the primary-secondary care interface and had a good understanding of each other's needs. The problems, he believed, arose when the NHS Trust management became involved in discussions.

I'll tell you just one little theory I have about this. You get clinicians talking to clinicians, and you get a good understanding. And you tend not to have any throwing of toys out of prams. What seems to go wrong is when the PCT clinicians communicate with the secondary care clinicians via management, and particularly via [NHS Trust B] management. (GP PCT B 29/13)

iii) Tier 3: NHS Trust management as principal: *"the management hasn't come to grips with managing clinicians"*

NHS Trust doctors perceived the NHS Trust management to be following a different agenda to the clinicians. They saw their management as more constraining than that in general practice, whereas the GPs saw it as less constraining. The GPs perceived the financial control problems in the NHS Trust as a consequence of having weak budgets for directorates, whereas the clinical director perceived his management of these budgets as very strong.

There was a feeling by the hospital clinicians that the NHS Trust management had little interest in them. The management were concerned only with issues important to themselves.

I think doctors perceive they're working for a Trust but they would like to think that the Trust is doing something for them, but their perception is probably that they're working for the Trust and the Trust has no interest in them. (Surgeon NHS Trust B 89/57)

What is considered to be important by management is monitored but what is considered important by clinicians isn't monitored. (Surgeon NHS Trust B 90/36)

Perhaps part of the reason for this gap was that the management and clinical agendas were different.

> *I don't think we actually sit down and identify the differences in agendas. ... I don't think people have really grasped the nettle. We push it away. ... I think those two things are different and I think unless you're, if you're rowing the boat in different directions, the boat ain't going to go is it?*
> *(Surgeon NHS Trust B 90/18)*

There was a perception that management were driven by targets, and consultants felt this management drive interfered with their clinical practice. The result was a perception by consultants that the management saw them as un-co-operative.

A hospital manager summed up the trade offs between the management and clinical priorities; the NHS Trust was going to be "*crucified*" if it did not meet access targets, but the really important concerns from a clinical point of view were about providing timely advice to GPs on difficult patient management issues. However, these were not government, and therefore not NHS Trust management, priorities.

> *... we've got all the waiting list targets that we're going to be crucified if we don't achieve but there are a lot of other things that the GPs and the doctors here believe to be clinically important, things like endoscopy waiting times and MRI and CT and all those sort of things, which don't form part of something that will get, you know, a caning for nationally... (Manager NHS Trust B 28/37)*

There was a perception from the hospital doctors that they were constrained by their management and the finances available for developments, more so than GPs. One consultant talked about the frustrations caused by the relative lack of freedom that hospital clinicians had over the use of their budgets. He believed that the management in the NHS Trust controlled the budget and that was frustrating.

> *... we're much more tied to an institution ... which has quite a strong managerial structure. General practice is more of a loose affiliation of self-employed practitioners, it's changing to some extent, yes, but you do have more control over your own budget... (Surgeon NHS Trust B 89/29)*

In contrast, there was a view from primary care that the NHS Trust management were not strong and were not managing their clinicians appropriately.

I do feel still that still in [NHS Trust B] the management hasn't come to grips with managing clinicians. It's a very difficult thing to do. We, clinicians, are very individual people but if it can happen in some Trusts, and they don't have these enormous waiting lists, I would have thought it should be able to happen over here. (GP PCT B 88/14)

In addition, the problems were perceived as worse in the NHS Trust precisely because the consultants did not have control over their budgets. Whether it is true or not, the perception that hospital doctors do not have control over their budgets is a factor that added to the discord between primary and secondary care.

Consultants do not get given a budget for their particular department or their particular directorate ... I really do feel that if they were given a budget to run their department, the financial side of things in a big hospital would be far improved because they'd have responsibility for what they did and they wouldn't be able to go and put in ten new hips with a particular metal in it because their budget wouldn't run to it that year, they would have to look at ways of saving money before they did that. (GP PCT B 88/34)

Another view, analogous with that put forward in case study A, was that it was just too difficult to get a decision made by going through the appropriate channels. Whereas in case study A, the process was viewed as time consuming and demoralising because requests were turned down when they did not help to meet targets, here, it was the middle managers who were perceived as too afraid to make decisions.

There's concern that there's forever more tiers of management going be put into the system ... it slows the process down, it adds more to the sort of treacle layer and... my concept of a treacle layer is you have this layer of management who won't make decisions because they're afraid to, so if you're sitting below the treacle layer you have to break through that and it's treacle because it's very difficult to break through because there's a lot of people saying oh, I can't do that, and I can't do that, because they won't take responsibility because they're afraid to...
(Surgeon NHS Trust B 89/1)

This frustration by clinicians with management was augmented by the perceived use of sanctions rather than incentives as a means of control.

> *All we get is sticks ... rather than carrots. We're told that if we do not achieve this, XYZ management people will lose their job, the hospital will lose money ... it's all stick, stick, stick, rather than if you achieve this we'll get a new nurse, we will get the new equipment, we will be able to do new procedures, ... it's continually no, you can't have this, no, you can't have that. ... We all know you can't talk to intelligent people with sticks. They fall about laughing. (Surgeon NHS Trust B 90/24)*

Whether these sticks came from the management directly or were implemented by the heads of the directorate was not clear. One consultant had strong views about what he called "*creeping commissioning*". This term referred to the introduction of new services or techniques without the prior agreement of the NHS Trust management. The reason he referred to it as creeping was because once services had been started, it was hard to stop them and they crept into the steady state of commissioned services in the following year. He saw one of the reasons for creeping commissioning as enthusiasm for innovations.

> *... a new procedure on the operating side of things, people start saying, I'll just botch it together and I'll borrow a bit of kit from the drug company and they'll fund the first couple of implants or bits and pieces and then by the time the third patient comes along they say well I've done two, you know we're doing this. And it's very difficult then as manager or the clinical manager to turn round and say well hang on a second. (Surgeon NHS Trust B 89/26)*

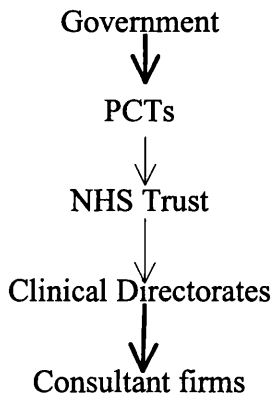
The only way he saw of controlling these developments was to be a very tight manager. As a clinical director, he saw it as his role to say no to developments that had bypassed the funding system. He was in effect siding with the NHS Trust management against the desires of his fellow clinicians.

> *I make myself not the most popular person by preventing these things from taking off until we've got them properly funded. So I'm probably perceived as quite a tight clinical manager from that point of view. I say I'm sorry, until we've got this right, in spite of all the frustrations, we're not going to do [it]. (Surgeon NHS Trust B 89/33)*

In summary, the managers in case study B were target driven but less convinced than those in A that the targets reflected best care. The PCT and NHS Trust shared the responsibility for meeting the targets. The PCT had a tendency to try and micro-

manage the NHS Trust but was not seen to engage fully in monitoring progress. The NHS Trust did not feel that the PCTs had a right to know how the Trust was working, only whether or not it was achieving its agreed activity. There was a degree of mistrust and jealousy between primary and secondary care by both managers and clinicians, despite a counter claim that clinicians worked well together when management was excluded. The NHS Trust management concentrated on different objectives to their clinicians and blamed this difference on government pressure. In general, primary and secondary care clinicians did not appear to understand the worlds in which each worked: both saw the others as having greater financial freedoms. Secondary care clinicians complained of a lack of positive incentives and the inability of management to make decisions, although directorate management was strong.

In case study B, the drive to meet the national targets was just as strong as in case study A. The control by the PCTs of NHS Trust B was not as strong as that by the HA in case study A. Incentives were not used at any level. The methods of control from the NHS Trust management to the consultants were seen as weak by primary care but strong by consultants. New treatments had been introduced without prior agreement, but the control at clinical director level was seen as strong.



c) Case study C

Similarly to case study B, respondents in case study C saw the national targets in a predominantly negative way. They too felt trapped by the demands of the national agenda and few said anything positive about them. The hospital surgeons felt they

were being driven by a management agenda and as a result claimed to be constrained in their service developments.

i) Tier 1: The government as principal: *"the targets are generally not negotiable"*

As with case studies A and B, the predominant view was that of being driven by the national agenda.

> *...hitting the targets because, I know I keep going on about it but that's actually what matters to Government ministers... (Manager NHS Trust C 39/102)*

> *Everybody's really only aiming at national targets. (Manager Regional Office 80/69)*

> *...the targets are generally not negotiable... (Manager PCT C 36/19)*

One of the results of the national agenda was that there was no time and no inclination to discuss other issues of importance. Although many people were eager to plan for a better local service, the opportunities were not there because of the needs to meet the national requirements.

> *We should be looking at development of services, looking at pathways and all that sort of thing but it gets squeezed out, that's the problem. (Manager PCT C 92/6)*

> *...until you can get beyond 'do we have any "waiters" after 15 months', it's very difficult, or patients waiting on trolleys or not even getting as far as waiting on trolleys, waiting in ambulances because there's no trolleys available, it's very hard to move beyond that ... it's sort of like talking about what will happen when you win the lottery, well first you need to win! (Manager nPCT C 38/32)*

Just as in case study B, targets were not necessarily seen as pushing in the right direction and were seen to be irrelevant to but taking priority over local needs.

> *...that comes down from the politicians very much so and it doesn't seem to actually bare any relation to what's needed in the local community, it's about hitting the, the fifteen and twelve month targets that we all think are a croc. (GP PCT C 93/5)*

In a very similar vein to one of the comments from a manager at NHS Trust A, there were concerns about the point of some targets, in particular in having a target that counts the number of people waiting for treatment or targets that seem to have little meaning for patient care.

> *How many people are on the waiting list? Now what meaning does that have? I don't care how many people are waiting for a hip replacement if I'm waiting for one. It has absolutely no relevance whatsoever. But, national target. (Manager PCT C 36/50)*

> *And a lot of them have been very ill thought I think, by the, but not by the management here obviously but by the government and they are unrealistic targets and they're, and they're targets that a lot of the time don't actually have a lot of meaning in terms of patient care. (Surgeon NHS Trust C 94/38*

The theme that central control was too strong emerged again. In talking about the freedom to develop patient pathways of care, this GP felt that it was not possible, due to the constraints of the national agenda.

> *...it's almost given to you on a plate, you know, go and commission services, this is what we have to go and commission. (GP PCT C 92/76)*

The PCT managers had very little to say about clarity in the targets. One PCT manager suggested that focusing on the "must do" issues improved achievements but there were no other comments in this vein.

> *...the job tends to get done better but it tends to be focused on achieving targets because that's what we are told are our 'must do's'. (Manager PCT C 91/9)*

One comment suggested that the general direction of policy provided some clarity, but not the targets themselves.

> *...actually a lot of that is taken out of our hands because the Government's very clear about what the next 5 priorities are – cancer, coronary heart disease, mental health, access and you know, can't remember the fifth – older people. So we know what our priorities are. ... Policy development comes from the National Plan. We've got a policy. (Manager PCT C 32/12)*

The NHS Trust managers made limited comments on the helpfulness of the national targets, but they could see their value as long as they remained stable.

> *[They] give it a sense of purpose and direction. Very clear about what we've got to do, how we do it. I think they leave us some flexibility on the "hows" and just tell us what the "what" is. So I'm quite glad as long as the framework remains the same and doesn't get changed and comes out at a reasonable time. (Manager NHS Trust C 39/132)*

The NHS Trust clinicians gave no positive comments about the targets.

ii) Tier 2: The PCTs as principal: *"...we [the PCT] don't trust them [the NHS Trust]"*

The PCTs in this case study did not play an active role as principal. Many of the comments from the interviewees were about the lack of involvement of the PCTs in commissioning decisions. Despite the collaboration apparent between some members of PCT C and NHS Trust C shown in the previous section on multiple principals, there was a feeling that the NHS Trust and the PCT management did not work well together. In fact, the management of PCT C did not trust the NHS Trust.

There was a view from PCT C that part of the role of NHS Trust C's management was to ensure that the NHS Trust met the PCT's objectives rather than those of its own clinicians.

> *If I thought [NHS Trust C] had an organisational culture which ... conspired with pockets in order to subvert the PCT, that's when I would start talking about [NHS Trust C] as a, you know, as not running the way I want. ... I don't think it's got the ability to do that kind of deliberate subversion. We're back to the role of the Chief Executive, and the role of the Chief Executive in [NHS Trust C] is to work with me to make sure that doesn't happen. (Manager PCT C 32/131)*

Despite this view, none of the respondents discussed how the PCTs attempted to achieve this alignment of objectives. There seemed to be an underlying assumption that it would just happen. However, contradicting this, the PCT did not trust the NHS Trust to meet the PCTs' objectives.

> *...we don't trust them. We need to be honest about that, and I'm honest- it's because we don't think they have got the same agenda as us. Because we think we've got a population based*

agenda and a whole systems approach. ... we've got this sense that they're still in the Acute Trust model and that what they believe on is delivering more beds in the Acute Trusts because that's what the clinicians are interested in and that really they are about building the service in the hospital.
(Manager PCT C 32/77)

Given this desire for alignment of objectives and the lack of trust in the NHS Trust, one would expect that the PCTs would introduce a contract with strong incentives. As we saw earlier, they did not. Instead of using incentives, the PCTs appeared to be restricting the funds available to the NHS Trust. In the section on multiple principals, NHS Trust management views were reported that showed the PCTs were perceived as allocating more funds to themselves than to the NHS Trust. Here, a consultant makes a similar point, that developments were being stifled through lack of funding.

And in terms of resource as well it's things like trying to persuade the purchasers that we need more consultants here because that's one of the other problems we have in surgery. We're not - looking at the national average – we're actually quite under-staffed in terms of consultants and we're finding it quite difficult to actually get any funding for new consultants. *(Surgeon NHS Trust C 94/26)*

The NHS Trust management felt that the PCTs were not engaging with them either to make decisions or to monitor progress.

I mean it's not that the PCTs have been saying "come on, we've got to set this up and have a performance monitoring meeting in place", they haven't, they have done nothing along those lines... *(Manager NHS Trust C 39/62)*

We saw earlier that the NHS Trust felt that it had to make decisions itself about the amount of funds it would be spending in the absence of effective negotiations with the PCTs. In a specific example, this NHS Trust manager described the Trust's plans to purchase a three-dimensional computerised scanning and planning system for patients with cancer. The NHS Trust had the funds to pay for the equipment but needed the PCTs to support the running costs. The PCT had refused to discuss the issue with the NHS Trust. The NHS Trust management were frustrated that, on the one hand, the PCTs complained that the NHS Trust initiated new developments without discussing them with the PCTs, but on the other, when they tried to discuss

these issues, the PCTs did not want to be involved. The result was that the NHS Trust management were going to introduce the new system without PCT approval. This is exactly the situation the PCTs were trying to avoid.

There were no claims in this case study that the PCTs were trying to micro-manage the NHS Trust. This might have been because the information available to do so was so poor. However, the fact that the commissioning group that negotiated the SaFF was called the Operational Group suggests that the PCTs were very close to the internal operations of the NHS Trust.

iii) Tier 3: NHS Trust management as principal: *"we are actually working for the management so they reach their targets"*

This section illustrates how the surgeons in NHS Trust C felt strongly that their Trust was expected to meet the national agenda. As a result, management and clinician priorities differed and the managers were seen to have a poor understanding of clinical work. Some services had been introduced via the "back door".

> *[T]he Trust just wants to break even really, which you can understand, because that's what they're, er, forced to do by the government really. (Surgeon NHS Trust C 95/25)*

Part of this force was perceived to be a fear by the NHS Trust management of being disparaged by the Department of Health.

> *Obviously at the moment we have to comply with hitting the targets, but I think the Trust is more interested in hitting certain deadlines so that they won't be penalised and targeted, you know, the subject of derision by the Department of Health. (Surgeon NHS Trust C 95/10)*

Importantly, there was a feeling amongst clinicians that it was the clinicians that must meet the requirements of the management, but the management that would be penalised if the targets were not met.

> *...it does feel as though we are actually working for the management so they reach their targets in a way and if they don't reach their targets then in fact they're going to be the ones that suffer... (Surgeon NHS Trust C 94/37)*

There was, however, a view that the pressures from targets were advantageous and empowering to NHS Trust clinicians. An NHS Trust manager in case study A also

expressed this view. The hospital doctors knew that the government was so keen to meet its own targets that money would be found from somewhere to ensure they were met. There was therefore little point in the hospital doctors trying hard to meet the targets themselves or to modernise services.

> *... orthopaedics, the PCT, unless they get their waiters down, you know, the management's all going to be sacked and there's going to be a load of special measures and things, so the orthopods know that money will come in and they can carry on working as slowly as they want to because the patients will be taken elsewhere to hit the targets. (GP PCT C 93/44)*

The objectives of the clinicians were different from management. Clinicians wanted to deliver the best clinical care they could. Although some aspects of good clinical care coincided with access targets, a specific target on access was not considered priority.

> *Our objective is really to offer a good service and be clinically the best we can be. ... we don't want to have a long waiting list, [but] I think we would not have a specific target on that. (Surgeon NHS Trust C 95/9)*

Although there was no animosity shown towards the Trust management, there was a feeling of uncertainty about accountancy driven managers running a clinically based organisation and a suggestion that management were entirely separated from the clinical staff. This suggests that not only were the different objectives important but equally so were the different experiences and understanding of how clinicians (as agents) worked.

> *... a lot of the clinicians still feel that the management is a completely separate entity ... they're running an organisation that involves medical treatment and they're not, and they don't know anything about medical treatment as such. They're more on a sort of financial and accountancy type of basis and not the practical side of things so they're running a team of doctors or clinicians and they don't know what it's like to be a clinician. (Surgeon NHS Trust C 94/34)*

Clinicians felt that they were subject to very strong financial constraints. There was an understanding that unless a change was cost neutral, it would have to be approved through the internal NHS Trust system.

... if it involved minimal change and was cost neutral I think we would perhaps get on with it. But most things seem to cost money! (Surgeon NHS Trust C 95/14)

However, the view from outside the NHS Trust was that the organisation as a whole was so de-compartmentalised that it was analogous to a set of organisations within an organisation. As such, the constraints were not equally strong in all departments and each was able to make independent decisions, the impacts of which may not have been considered at the higher level. Not only were different departments independent, but also decisions made at a higher level were not always communicated effectively.

...discussions take place at the very senior level and it hasn't cascaded through the organisation so they're being unclear about what they're meant to be doing ... people develop their own little closed walls between each department, don't they? ... it's been a series of organisations within the organisation. (Manager PCT C 91/40)

...it has been very departmentalised and, yes, all the departments are compartmentalised so, you know, for example the diabetologists want more diabetologists and don't want any more general physicians. (GP PCT C 93/21)

The PCT wanted the NHS Trust management to be strong enough to control its clinicians, but as shown earlier, did not want it to be so strong that it was able to conspire with its clinicians to its own benefit rather than the health community's.

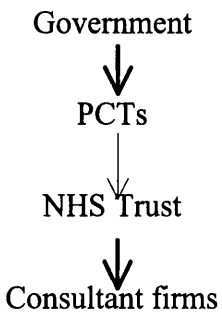
... they need to be influential because they have the day-to-day relationship with the clinicians and they can influence the clinicians into this model of we're all in it together. (Manager PCT C 32/87)

The consultants did not mention any form of "creeping commissioning". However, one PCT member recalled her experience of a number of methods used by consultants to avoid the formal process of approval for developments and to introduce treatments by the "*back door*". One method was to apply direct pressure to the PCTs by referring to cases previously approved and the inequity of then refusing to treat additional cases. The other method was the application of pressure via patients, blaming the PCTs for not funding their treatments.

> *...when an individual patient who would be suitable for this treatment comes along then they bring it to the attention of the PCT for individual approval and then, sort of, get in by the back door because once you've approved four, how could you not approve the fifth. Or the consultants sometimes say things to patients like "here's a treatment that I would love to be able to give to you but your PCT won't pay for it". Or, they'll say helpful things like "here's the treatment I would love to offer to you but it is not available on the NHS but you can have it privately", and all these sorts of things which twist one's arm and make it very difficult and very unpopular to say no to.* *(Manager nPCT C 34/56)*

In summary, targets in case study C were seen as restraining and unhelpful by many respondents, although a few felt that they gave some direction. Perhaps related to the poor financial context of this case study, government scrutiny was seen by many to drive objectives. The NHS Trust management's objectives in particular were seen to be different to their clinicians. This is similar to case study B. The PCTs expected NHS Trust C to meet the PCTs' objectives but did not trust it to do so. However, they did not introduce incentives to encourage this. Instead, the PCTs were seen to rely on restricting the funds available to the NHS Trust and refusing to engage in discussions. These methods appeared to encourage creeping commissioning at the NHS Trust level, rather than at the consultant level. Consultants felt that they faced and complied with strong financial constraints, but the PCTs gave examples of methods used to initiate unapproved developments. As in case study A, consultants were seen to have been given greater power as a result of government pressures to meet targets.

Case study C was more similar to B than A. The pressures from the targets were felt throughout the organisations, but again, the clinicians did not admit to trying to bypass the system, although the PCTs believed they did. The control in tier 2 was very weak.



d) How did the strengths of the principal-agent tiers affect compliance with commissioning decisions?

A principal-agent chain arises when an organisation (X) is a principal with another organisation (Y) as its agent, but organisation Y is also a principal with its own agent (Z).

Principal-agent theory predicts that principals and agents in the lower and middle tiers are likely to collude by hiding information from those in the higher tiers. A common example given in the literature is that of a legislative body responsible for monitoring and regulating an industry. The legislature employs an industry regulator to carry out this function. The firm that the regulator is monitoring has an incentive to collude with the regulator in order to hide its real costs from the legislature and so avoid profit cutting regulation or taxes. Efficiency is therefore reduced unless the legislature sets incentives for the regulator to be truthful.

In the context of commissioning, we would expect clinicians to collude with NHS Trust managers against their higher principals, the PCTs. We would expect clinicians to work with NHS Trust management to hide information about costs, activity and productivity in order to advance the consultants' objectives. A result of this would be so called "creeping commissioning", that is, the introduction of service developments without the approval of the PCT. To counteract this tendency, PCTs should ensure that the incentives faced by the NHS Trust management to achieve the PCTs' objectives are stronger than their incentives to collude with their clinicians.

In fact, incentives were not used by the PCTs and it appeared that NHS Trust managers and clinicians communicated rarely about commissioning issues. In case studies A and B, it was more likely for PCT and NHS Trust managers to work together to achieve shared objectives than for NHS Trust managers and their clinicians to work together. In case study C, it was more likely for the NHS Trust management to make decisions independent of the PCTs, but not through deliberate collusion with the consultants.

Despite claims to the contrary, creeping commissioning did exist. There were examples in each case study of new services or techniques being introduced without

prior agreement from the commissioners. In case study A, creeping commissioning appeared to be initiated mainly at consultant level; in C it was initiated at NHS Trust management level. In B, it was not clear at which level creeping commissioning was initiated. It may have been taking place at both levels. A possible reason for these differences was that, compared with C, the commissioners in A (the Health Authority) had a greater degree of control over their NHS Trusts and as a result a greater alignment of objectives. The NHS Trust management was therefore more likely to work in collaboration with the commissioners. In C, the control by the commissioners of the NHS Trust was weak and the level of shared vision of the future low. The NHS Trust management, not the consultants, therefore initiated new developments without the agreement of the PCTs. In B, the situation was mixed. The strongest control appeared to be at the level of clinical director.

Creeping commissioning is the result of a lack of appropriate control of agents by their principals. The remainder of this section considers why creeping commissioning emerged at different levels in these case studies.

i) National targets versus local control

The strength of the government drive to meet national targets affects commissioning in a number of ways. Targets can be seen as generally helpful as well as inhibiting local developments. They can increase the likelihood of managers in different organisations having the same objectives. They can also increase the likelihood of managers and clinicians in the same organisation having different objectives. In addition, the perceived need by NHS Trust management to meet government targets can encourage them to place less emphasis on the demands of their commissioners if these demands are not consistent with government targets. The pressure that each case study found itself under may have contributed to the degree of collusion between managers, consultants and organisations, and therefore the level at which creeping commissioning emerged.

One reason for the difference between managers and clinicians in compliance with the targets may be the way in which responsibility for meeting targets is structured. Targets are seen as management targets, not clinical targets. Targets can be set only for measurable events. As such, they are not related directly to the clinical quality of care. If targets are not reached, it is the management that are penalised, either by

stricter monitoring and control from external bodies, or more personally through the loss of their jobs. Clinicians are penalised only through the effects of working in an organisation that has failed to meet its targets. There is no direct personal incentive to meet the targets.

Pressure can come in many forms, but in these case studies was either local pressure through strong management or external pressure through government demands.

NHS Trust A was subject to immense pressure from strong Health Authority management. NHS Trust C was under the most severe pressure from government to meet access and financial targets; they were in deficit and failing to meet many targets. NHS Trust B lay between the two. NHS Trust B did have a large deficit and some long waiting times but local management pressures were less strong than in A and government pressures less strong than in C.

Through the strong target approach of the HA and its strong control of the NHS Trust management, NHS Trust A's management objectives were aligned with their principal's, the HA. This strong control appeared to create a backlash by the consultants. The consultant and management objectives were different. NHS Trust management expected their clinicians to meet the management's requirements. The consultants felt that some of their autonomy had been taken away. They were therefore likely to initiate unapproved developments. To solve this problem of creeping commissioning, stronger internal controls were needed in the NHS Trust. The controls at tier 2 were stronger than tier 3 and so creeping commissioning was evident mainly at tier 3.

In case study C, control of the NHS Trust management by the PCTs was not strong, nor was there strong alignment of objectives. The PCTs did not trust the NHS Trust, expecting them to try to follow a model of service delivery focused on acute care. However, the PCT did not introduce incentives to compensate for this. The NHS Trust management were frustrated that they were not able to negotiate service developments with the PCTs and so decided to introduce what they considered to be important initiatives without prior permission or funding. Consultants claimed that they were restricted in their freedoms to initiate new developments not only by their own internal management but also by external monitoring. Creeping commissioning in this case study appeared at the level of NHS Trust management. The weak level

of control by the PCTs (at tier 2) combined with the strong pressure from the government may have led to NHS Trust management into attaching a higher level of importance to government than PCT objectives.

Case study B is a difficult case because the views and the evidence are divided. The NHS Trust management undoubtedly introduced services (or at least allowed their introduction) without the knowledge or agreement of the PCTs. Discussions held in the SaFF meetings about the status of funds and the sharing of deficits as a result of new developments illustrate this. Similarly, the clinical director discussed his methods for trying to reduce creeping commissioning, which he accepted existed at consultant level. Again, the managers' and clinicians' objectives were different, predominantly because of the pressure on management to deliver government targets. The PCTs' control of the NHS Trust management was not through incentives but through the allocation of funding envelopes and negotiated agreements. The relatively weak (compared to A) control of the NHS Trust management and the relatively weak (compared to C) control of consultants resulted in the clinical director level having to take responsibility for constraining creeping commissioning.

ii) Styles of control

The methods as well as strengths of control in the different principal-agent tiers impacted on compliance with commissioning decisions.

Despite a lack of trust by all commissioners of their NHS Trust agents, incentives were not used in commissioning. Case study A commissioners tended to rely on command and control methods such as threats to job security and a stringent financial regime. Case study C PCTs attempted to mirror this by restricting the funds available to the NHS Trust, but did not have the same power as the HA commissioner in A to "bully" the NHS Trust into co-operating. Case study B PCTs attempted to have a hands-off approach. They restricted funds but tried to trust the NHS Trust to achieve its targets within those funds. However, they did not in fact have a sufficient level of trust and showed "micro-management" tendencies. In case studies B and C, the introduction of incentives to influence the NHS Trusts' behaviour should increase co-operation and decrease the need for micro-management at tier 2.

Control by commissioners was undoubtedly strongest in case study A. Indeed, a management view from case study A was that, due to the lack of sufficient numbers of high-calibre leaders, the NHS should be organised around effective leaders rather than organisations. So what was it about Health Authority A that gave it such control over the objectives of NHS Trust A? One reason may be that the Health Authority in A was working within a principal-agent system, but one in which the NHS Trust was treated as an internal agent. That is, the methods being used to control the NHS Trust were consistent with those an employer may use to control his employees (Whitley, 1999). The system was a managerial hierarchy rather than a contractual relationship (Goodwin, 2000). However, as we have seen, this resulted in a loss of autonomy for agents. Wall *et al.* (2002) in their review of empowerment and performance suggest that empowerment of lower levels in a hierarchy can promote a broader perspective among employees. If NHS Trust doctors are considered to be at a lower level of the hierarchy, the command and control style in case study A disempowers them and as a result may narrow their perspective. A narrow perspective may mean that service developments are implemented that benefit individual patients and professionals but at the expense of the broader community objectives.

Also in case study A, a further form of pressure and a reason for consultant defiance of the commissioning rules may be related to "hard organisation". In their in-depth study of the contracting process over a three-year period in a health authority in Wales, Hughes *et al.* (1997) compared their results with previous research on compulsory competitive tendering in local authorities. Both showed a process of change, from a "'hard' form of quasi-market organisation" to a more collaborative approach (Hughes *et al.*, 1997: 272). In each, attempts to implement contracts along commercial lines had resulted in a loss of trust and co-operation between the organisations.

Although the SLA in case study A did not resemble an incentive contract and the methods can not be considered "hard contracting", they could be considered a "hard" form of negotiation and agreement between organisations. There was no equality in the partnership between the NHS Trust and the Health Authority in reaching the agreement, and no involvement of clinicians.

This strong hierarchical system of control appeared to be a successful model of achieving the important process measure of agreeing funding and the level of commissioned services. As such, control at tier 2 was strong. However, the NHS Trust clinicians felt so controlled that they became demoralised and were tempted to cheat the system and initiate new developments that had not been agreed. The internal control within the NHS Trust was not sufficiently robust to stop this from happening. This is consistent with the suggestion by Hughes *et al.* (1997) that non-co-operation by consultants was an important factor in the inability of management to deliver agreed activity in commissioning.

Case studies B and C appeared to be less hierarchically organised than A with weaker control over the NHS Trusts. The financial control from the commissioners was not as strong. It follows that NHS Trust managers in B and C were in a stronger position than in A to initiate new developments without going through the formal commissioning channels, that is, without having developments approved by the PCTs. The NHS Trusts as a whole (rather than individual clinicians) were therefore in a more powerful position to initiate developments outside the commissioning system. The desire for hospital clinicians to cheat their own management may have been lessened because the management themselves were working in, relative to NHS Trust A, an uncontrolled environment.

One would expect that weak management would provide the opportunity for consultants to make unilateral decisions. There was some acknowledgement that control systems within NHS Trust A were not robust. Consultants in NHS Trust B complained that middle managers were weak; the complaint was that there was a "*treacle layer*" – a layer of management that was not prepared to make decisions. Creeping commissioning was perceived to occur at tier 3 in both these case studies. The difference in C was that the weak management and fear of making difficult decisions lay at PCT level, that is, in tier 2 of the principal-agent chain.

iii) Mistrust

There was a degree of jealousy and mistrust between the consultants and the GPs that may have impacted on their willingness to comply with commissioning decisions. This appeared to be due mainly to a lack of understanding of the context in which each set of clinicians worked.

Many of the secondary care clinicians interviewed commented that GPs had more financial flexibility to develop their own clinical practice than did their hospital colleagues. Many of the GPs interviewed commented that the secondary care clinicians did not have ownership of their directorates' budgets and as a result could not be trusted to provide care within budget. It was considered also that GPs had control of the consultants' money. As a result, there was friction and the GPs were blamed for not funding developments. GPs tended to blame NHS Trust management for being too weak and not controlling the consultants. There was mistrust by the GPs because they saw vested interests; they believed that the consultants kept long waits in order to keep their private work high. On the other hand, both GPs and consultants were aware that any problems caused through initiating or stopping services before gaining agreement may be through a lack of understanding rather than any deliberately self-interested reasons. Neither professional group was aware of the impacts on others of their actions. There was also a view in case study B that clinician-to-clinician relationships were more positive than clinician-to-management relationships.

These differences of opinion may have resulted in increased loyalties to their own organisations and increased blame on others for failures. There was little belief by GPs that consultants were meeting community interests, and blame by consultants on GPs (as budget holders) that they were restricting developments. This lack of trust may have led to the consultants being tempted to remove their co-operation and proceed with developments unilaterally. The situation was similar in each case study.

There was also a degree of mistrust between the managers of the different organisations. Managers in both NHS Trusts B and C said that they felt naked in front of the PCTs. They felt that the NHS Trusts had to bare all whilst the PCTs kept on their clothes. The Director of Operations in NHS Trust B was adamant that if the Trust had to bare all, so should the PCTs. There was a strong feeling that, as the PCTs were providers as well as commissioners, the PCTs should also be open to health community scrutiny of their provider arms. This tendency to mistrust and question the legitimacy of PCTs may have resulted in a feeling of unity between the NHS Trust management and clinicians. This would suggest that non-compliance with commissioning decisions would be likely at tier 2, as was the case in case

studies B and C. This would be unlikely to occur in case study A where the legitimacy of the Health Authority as commissioner was not questioned.

iv) Dependency

Principal-agent theory assumes that markets are contestable. That is, principals can move to alternative agents if they are dissatisfied with the service provided, and vice versa. In the NHS this is not necessarily the case. Organisations are more dependent upon each other, and this may result in a greater tendency for compliance with commissioning agreements.

The managers in the PCTs and NHS Trusts in case studies A and B felt that they were dependent on each other. Some of PCT A's patients had access to an alternative provider within approximately a half hour drive. However, the management in NHS Trust A felt that they and PCT A were dependent upon each other; the term used was "*mutually assured destruction*". Case study B was chosen because, for PCT B, there was no alternative local NHS provider. Equally, PCT B provided approximately 50% of NHS Trust B's funding. The two organisations felt that they were bound together and the impact this had on them was to encourage them to work well together. They knew they had to work through any problem areas because neither had a choice to shift elsewhere.

In contrast, PCT C did have a choice of provider for at least some of its patients. Case study C was selected for study because the PCTs had access to more than one NHS Trust provider. The PCT managers in case study C felt a loyalty to NHS Trust C and felt that many of their patients would not wish to use an alternative provider, but accepted that they had this option if chosen. One view by NHS Trust C and PCT C management was that if the PCTs moved some of their services to another provider, this relieved the pressure on NHS Trust C and helped it to achieve its own access targets. The view from primary and secondary care clinicians was that such disloyalty to the local NHS Trust merely destabilised the local economy and created problems for the future through a reduction in investment, when one of the reasons for the NHS Trust struggling to meet its targets was under investment.

> *Would you prefer to invest in your local corner shop than to go three miles down the road...? The answer's yes ... you'd want to support your local DGH... Taking money elsewhere*

isn't going to help solve their problem or your problems in the long run. (GP PCT C 92/37)

As a result of these dependencies, NHS Trust managers in A and B may have been less likely to initiate unapproved developments than those in C. In A and B, the managers had to depend on each other's support; they could not buy or sell services elsewhere. In C, the PCTs were more able to shift services to another NHS Trust, and equally, other PCTs were more able to shift services to NHS Trust C. The organisations were therefore not as dependent on each other and so perhaps more likely to follow their own agendas. Kirkpatrick (1999) suggests that years of fragmentation in quasi-markets have reduced loyalty and co-operation in the public sector. NHS Trust C, as a result of being situated near competitors, may have suffered such fragmentation and therefore been tempted to follow its own agenda and comply with the commissioned decisions of the PCTs less so than in the other case studies.

In summary, it seems that the following factors affected the degree of co-operation with commissioning decisions by different layers of clinicians and managers in these case studies: the ability of hospital management to bypass the commissioning system; the level and type of pressures felt by the key players in the system; the degree of "hardness" in management styles; mistrust and jealousy between players; and feelings of organisational loyalty and dependency.

These issues and those arising from the analysis of multiple principals and a common agent are discussed at a more macro level in the next chapter.

Chapter Five: Discussion

This chapter summarises the evidence presented in the previous chapter and takes a broader perspective to discuss the findings at a macro level and in the light of other research. The first section summarises the main findings and aspects of the three case studies' commissioning styles that conform to a principal-agent model as suggested by policy or to alternative models of organisation. Section two discusses the main factors that affected the commissioning relationships in these case studies. Section three offers some policy recommendations and section four speculates on the impact of these recommendations on the three case studies. Finally, section five considers the limitations of the research.

1) Summary of results: principals, agents or neither?

This section offers a brief overview of how and to what extent the case studies' commissioning styles reflected a principal-agent model of commissioning in line with that put forward in policy guidance. The findings for each case study are summarised. The aspects that conform to a principal-agent framework and those that do not conform are then drawn out.

A basic assumption of principal-agent theory is that principals are active in attempting to align agents' objectives to their own through incentive contracts. Agents are active only in their response to the contract (or choice of contracts) offered by the principal. The principal must choose a payment schedule that depends on outcome, the state of the world, the action taken by the agent and other costlessly available (and often imperfect) information. Good quality information is important as payment schedules depend upon variables that both principal and agent can observe (Rees, 1985a).

Given current policy for commissioning health care in the NHS, one would expect that a PCT should attempt to align an NHS Trust's objectives with its own through incentive payments stated in Service Level Agreements. An NHS Trust should respond by either accepting or rejecting the SLA. Given the geographical nature of the NHS and the relative lack of choice of alternative commissioners and providers,

an NHS Trust is likely to attempt to influence the content of an SLA rather than reject it in its entirety.

Total purchasing pilots were shown to achieve change and exercise control over resources by using contracts as a mechanism for regulating the transfer of resources between purchasers and providers (Robison, 1998). I expected at the start of this research that this would be the case for PCTs as well. It seemed likely in addition that information asymmetry and monitoring issues would be important. I expected that NHS Trusts would hide information from the PCTs, in particular, information about their costs. This would be consistent with previous findings. Ranade (1995) found that information deficiencies and a reliance on block contracts resulted in providers claiming for increases in costs, a claim that purchasers found difficult to verify. McCarthy (1998) found also that asymmetry of information about costs was important. He showed that NHS Trusts were able to alter their initial prices when they found out the health authority's allocations and could also shift their cost pressures onto the health authorities in the form of higher prices. The long-term relationships and lack of competition prevented the health authorities from having the power to deal with this. In addition, McCarthy stated that many pressures, that the NHS Trust in his study claimed were due to admissions, were perceived rather than real, but without the appropriate information commissioners could not verify this. For these reasons, I anticipated that SLAs would be service specific, and monitoring of activity and expenditure within contracts routine.

In fact, none of the case studies developed incentive-based Service Level Agreements as predicted by principal-agent theory. Only one of the case studies (A) agreed an SLA at the start of the financial year. The Health Authority led in the drafting of this agreement. Case study C reached an agreement for the SaFF shortly after the start of the financial year and used the same document as an SLA. Case study B planned to write an SLA but this remained in draft until the following financial year. NHS Trust B led in the drafting of this agreement. In each case, the agreements were treated as performance management tools, not incentive contracts to align objectives. The alignment of objectives had taken place before the SLAs were written. All the case studies used SLAs as formal statements of the levels of service provision and finances that had been agreed previously. Some participants considered them performance management tools; no one described them as incentive

contracts. This is consistent with previous findings that contracts in the quasi-market system were "best understood as resource allocation and accountability tools" (Allen, 2002b: 172). When participants were interviewed, information asymmetry between the PCTs and NHS Trusts was not perceived as a problem. Monitoring by the PCTs was considered poor, although in A and B good quality information was available for monitoring. It should be remembered that all of these case studies were discussing only new growth money. The majority of spending was in line with historical patterns. This is contrary to Wilkin *et al.* (2002) who infer from their survey findings that there may be a limited reliance on historical spending patterns.

Despite these general observations, the extent to which, and certainly how, the case studies reflected a principal-agent approach was quite diverse.

Case study A was selected because it was of average size with a large proportion of rural patients. It was classified as "over resourced", with a distance from target allocation in 2000/1 of 5.57%. Its host health authority was 2% over target. There was one main acute trust that the majority of patients attended for secondary care services, although another NHS Trust was situated approximately 15 miles away but was rarely used by the PCT. Another PCT commissioned services from NHS Trust A, but at the time of the study PCT A was not involved in any joint commissioning for secondary care services.

The research has shown that the Health Authority acted as the principal to the NHS Trust agent in case study A. The PCT played no direct role in commissioning secondary care services. The SLA was used as part of the performance management framework and contained no incentives. The objectives of the Health Authority were dominant and the Health Authority dominated discussions in SaFF meetings. Both PCT and NHS Trust considered themselves accountable to the Health Authority and driven by external targets. Pressure from the principal on the agent came in the form of a strong leader and hierarchical, command and control style management. There were no financial freedoms or choice of commissioning model because the local hierarchical model was imposed. The system for commissioning broke down to some extent at the consultant level; the consultants did not follow the same agenda as their management or the Health Authority. The Health Authority's control of the NHS Trust management was considered effective but the NHS Trust management's control of consultants less effective.

Case study A conformed to the principal-agent model of commissioning in a number of ways. The Health Authority, as principal, aligned the NHS Trust's objectives with its own. But this alignment was not achieved through the use of incentives. It was achieved through authority, exercised through the power of the Health Authority Chief Executive, backed up by threats to job security, a method normally associated with intra- rather than inter-firm relations (Whitley, 1999). The NHS Trust accepted the SLA set by the Health Authority with little question.

There are a number of ways in which case study A did not conform to the expectations of principal-agent theory. The NHS Trust did not act as an agent for the PCT. The NHS Trust and the PCT were seen as equals to each other, both subordinate to the Health Authority. The SLA was not an incentive-based contract; it was used as a performance management tool that stated separately the services to be delivered and finances available.

Case study B was selected for study because it was the largest PCT in its region. The PCT was almost exclusively urban, with only 1.8% of its patients classed as rural. It was slightly "over resourced", with a distance from target allocation in 2000/1 of 1.03%. Its host health authority was 2% over target. One main acute trust provided secondary care and also tertiary care to PCT B. PCT B commissioned services jointly with another PCT and a PCG. NHS Trust B had some problems achieving access and financial targets.

The PCTs in case study B acted as joint principals. The SLA between PCT B and NHS Trust B was seen as a performance management agreement and was used by NHS Trust B as an internal management document. However, the SLA remained in draft and unsigned throughout the whole of the financial year. The SLA did not contain any financial incentives, although some activity was restricted in volume. NHS Trust B was involved actively in debates with the PCTs in SaFF meetings. The PCTs were not always successful in aligning the agent's objectives with their own; the NHS Trust was able sometimes to force its own agenda on to the PCTs. The NHS Trust appeared to treat the PCTs as legitimate principals. The PCTs worked well together in SaFF negotiations but did not share a contract with the NHS Trust. They had shared access to information about NHS Trust B and their broad objectives were shared. The PCTs were concerned that their local objectives differed and that they no longer worked as closely as they had initially. The PCTs' collective

decisions increased their power over the NHS Trust. The parties felt dependant upon each other. Trust was publicly high although privately there were tensions and mistrust.

The community followed a model for commissioning that was a midpoint between a quasi-market and network. It was essentially a collaborative approach with the proviso that the PCTs retained financial control. Leadership of all organisations was strong and the leaders showed a lot of respect for each other. The PCT and NHS Trust management had different agendas, as did the NHS Trust management and clinicians. Although the PCTs appeared not to engage fully in monitoring the NHS Trust, they had a tendency for micro-management. There was a degree of mistrust between the PCTs and NHS Trust. Clinicians in primary and secondary care did not appear to understand the financial constraints within which their counterparts worked. This caused misunderstandings. The PCTs' control of the NHS Trust was moderate. Consultants saw the control of them by NHS Trust management as strong and based on sanctions only, but primary care saw it as weak. Control at directorate level was strongest.

Case study B conformed to the principal-agent model in some ways. The PCTs shared objectives and information and, as predicted by principal-agent theory, joined forces to act as joint principal. They worked together and presented a single voice on the majority of issues. The PCTs' power came from out-voting the NHS Trust. One of the advantages of collaboration between PCTs in commissioning has been shown to be a perceived increase in leverage over providers (Wilkin *et al.*, 2002) but the reason for this sense of increased power has not been illustrated. Generally, NHS Trust B acted as agent for the PCTs.

However, other aspects of this case study were not as expected from a principal-agent perspective. The PCTs were not wholly successful in aligning the NHS Trust's objectives with their own. The PCTs chose to allocate a funding envelope to the NHS Trust, which all concerned considered a fair proportion of the health community's development funds. (This is consistent with the finding by Walsh *et al.* (1999) that PCGs are more likely to succeed in making changes if they work inside current arrangements rather than trying to make radical shifts in finances.) The PCTs did not link funds directly to particular services or activities. The NHS Trust was permitted to use these funds in the way that it saw as most appropriate in

achieving its targets. The NHS Trust did not see itself as a passive agent; it was active in agreeing the services to be delivered. The SLA was not an incentive-based contract; it was perceived as an internal performance management tool developed for (and by) the NHS Trust. The SLA remained in draft for the whole of 2002/3.

Case study C was chosen because it was slightly above average size. Although it was predominantly urban, 8.6% of its patients were classified as rural. The PCT at the time was classed as "under resourced", with a distance from target allocation in 2000/1 of –4.52%. The host health authority received approximately 1% under its target budget. PCT C had one main NHS provider for secondary care services but a sizeable minority of patients used a neighbouring NHS Trust approximately 10 miles away. Four PCG/Ts commissioned services jointly from NHS Trust C. NHS Trust C was failing to meet many access and financial targets.

The principals and agent in this case study appeared to have less distinct roles than in the other case studies. NHS Trust C appeared to accept the legitimacy of the PCTs as principals, but the PCTs themselves did not. The SaFF document was used also as the SLA. It did not contain any incentives. The agent's issues dominated the SaFF agenda, possibly as a result of their problems in meeting targets. The PCTs did not work well together. They appeared to be acting independently from each other whilst creating the illusion of working together. The PCTs had equal access to information about NHS Trust C but that information was poor. The PCTs did not have shared objectives. There was jealousy and mistrust between the PCTs. Members of PCT C and NHS Trust C worked closely together despite a degree of mistrust. Managers from all organisations accepted that they were not good at making difficult decisions. The pressure from the government on NHS Trust C was very strong. The NHS Trust management's objectives were seen to be different to the clinicians'. The PCTs did not trust the NHS Trust to meet the PCTs' objectives but did not introduce incentives to encourage them to do so. Leadership was weaker than in the other case studies, possibly due to an overly friendly approach between the leaders of the different organisations. The PCTs' control over the NHS Trust was weak and therefore non-compliance by the NHS Trust with commissioning decisions appeared to be easier than in the other case studies. Control of consultants' activity by NHS Trust management was seen by consultants to be strong.

Case study C therefore offers few parallels to a principal-agent model of commissioning. The NHS Trust appeared to want to act as agent for the PCTs, but the PCTs did not appear inclined to act as principals. The NHS Trust wanted to know what the PCTs' objectives were, but the PCTs were not clear about these themselves. The PCTs did not present a united front. The SLA was not an incentive-based contract; it was an agreement stating the services to be delivered within agreed finances. The participants in case study C were more likely to use the terms "joint planning" or "joint development" than "commissioning". The separation between principal and agent was not clear. The participants tried to work as if organisational boundaries did not exist.

The findings have shown that these case studies were not acting wholly, or even largely, in accord with principal-agent theory. Complex interactions and different contexts have influenced the commissioning process in these case studies. This is not unusual. Others have indicated the importance of institutional frameworks (Bartlett *et al.*, 1998b) and the interaction of different governing structures over time and space (Exworthy *et al.*, 1999). Exworthy *et al.* (1999) suggest that governance structures may mix like a chemical reaction, with elements reacting in different ways under different circumstances. The uncertainty surrounding the interaction of these elements suggests that "the execution of hierarchical and contractual systems is by no means predetermined, and their interaction with local networks means that outcomes will be specific to particular areas and contingent upon prevailing policies" (Exworthy *et al.*, 1999: 20").

The spectrum of models of organising co-operation and exchange ranges from hierarchies to markets. It is assumed usually that networks and quasi-markets fall between the two. There also exist hybrid forms of organisation comprising features from more than one system.

Hughes *et al.* (1997) state that firms in long-term relationships often move away from market contracting to integration and internal organisation. NHS Trusts and their commissioners are by nature in long-term relationships; their populations are overlapping and geographically fixed. The quasi-market in the NHS was based on a degree of market contracting. With the shift in emphasis towards long-term partnership and collaboration (albeit whilst retaining contracts and choice), health care organisations are being encouraged to move away from market contracting, but

to what? The following gives an overview of how the case studies reflect alternatives to quasi-market contracting.

Hierarchies and networks were defined and discussed in relation to the language of principal-agent theory in chapter two. In brief, a bureaucratic hierarchy is characterised by highly centralised policy-making and resource allocation with a limited degree of autonomy at the periphery. A hierarchy operates through a system of surveillance, evaluation and direction (Ouchi, 1980). Such types of organisation are often labelled "command and control". They are "command in terms of policy goals and objectives, control in terms of the mechanisms to achieve such goals" (Exworthy *et al.*, 1999). Case study A is a good illustration of a hierarchical arrangement between principals and agents. Incentives were not used. Instead, the Health Authority relied on its strong leaders, the enforcement of a stringent financial regime and its power over the security of managers' employment. As discussed in chapter four, the relationship between principals and agents in this case study was one of managerial control rather than contractual control. Neither of case studies B or C demonstrated a hierarchical model of control by PCTs over NHS Trusts, although PCT B did show a tendency towards micro-management.

One reason for co-ordinating organisations as internally managed hierarchies is to reduce transaction costs. Transaction costs arise when the value of the goods or services to be exchanged is not easily determined. In a competitive market system where goods are traded regularly, the value at which they are traded is taken as legitimate. When goods or services are not traded via a competitive market, a third party may be called upon to estimate the value of the product and ensure that both seller and purchaser perceive the value as equitable (Ouchi, 1980). However, employment of a third party to help value services can be costly. To avoid this and other costs, the organisation purchasing the services may choose to provide those services in-house.

In the provision of health care in the NHS, there is no competitive market to legitimise the value of services. Transaction costs associated with agreeing and enforcing payments can therefore be high and it is feasible that a third party could be employed to determine a value of services perceived as fair.

It appears at first sight, in case study A, that a third party was employed to help value the services to be provided. Health care services and finances were exchanged between the NHS Trust and the PCT. The Health Authority met independently with the NHS Trust and with the PCT and could therefore be seen as a third party.

However, on closer inspection, the purpose of those meetings was not to agree with the PCT and the NHS Trust a value for the services offered by the NHS Trust. These meetings were to agree, with the NHS Trust only, the services to be offered by the NHS Trust within given finances. The PCT later signed the agreement (the SLA) but played no part in its negotiation. Therefore the Health Authority was acting as a principal to the NHS Trust, internalising the arrangements as if the NHS Trust was a firm within a firm; it was not acting as an independent third party on behalf of both the PCT and NHS Trust. It was acting as a principal within a hierarchical structure.

It may be that some of the differences between the case studies are explained by transaction cost issues. Case study A had traditionally used a managerial hierarchy to control its agents. Perhaps the success of this approach in the past and concern about the potentially high transaction costs associated with negotiation rather than command had led A to remain faithful to the hierarchical approach. Indeed, if the number of meetings required to agree SaFFs and the cost of the staff attending those meetings is used as a proxy for transaction costs (see, for example, Posnett *et al.*, 1998 and Place *et al.*, 1998), transaction costs were kept low by holding a minimum number of formal meetings in case study A. In contrast, in case study B, many high-powered individuals attended monthly meetings to agree the SaFF. In C, a smaller number of equally high-powered individuals attended more frequent meetings. Although the costs of negotiations taking place outside the main meetings are not known, and neither is the relationship between *ex-ante* and *ex-post* costs, the visible costs of SaFF negotiations in A were less than either B or C.

Within the NHS organisations that are being discussed, there is no direct employment relation. Executives of both NHS Trusts and PCTs are employed by their own organisations, not the host health authority. Nevertheless, both are held to account by the health authority, that is, they are answerable to their health authorities. This gives health authorities a degree of legitimacy. Case study A is an illustration of strong leadership from the top of the hierarchy and as stated by Exworthy *et al.* (1999), there is little room for manoeuvre at the periphery. The NHS

system of command and control by the centre has been implemented more locally in case study A.

Although the system for agreeing the SaFF was very different in case study B, there were some parallels with the hierarchical model used in case study A. The system for agreement in B was based on providing each organisation with an equitable share of the overall resources and discussing their use during meetings attended by all organisations. PCT B did not have the same legitimate authority over NHS Trust B as Health Authority A did over NHS Trust A. In comparison with case study A, the cost of these meetings in B seems high. However, in discussing the future arrangements for commissioning services, the Director of Finance at PCT B intimated that she preferred the low transaction cost method of discussing and agreeing service delivery with the NHS Trust and then trusting them to deliver, rather than the higher cost method of employing additional staff to monitor the NHS Trust more closely. This attitude may have important implications for the successful adoption of the new system of payment by results using standard tariffs (Department of Health, 2002c). The use of standard tariffs for the commissioning of certain specialties and the detailed monitoring that is required for PCTs to withdraw funds, if necessary, on a quarterly basis will increase the costs of enforcing SLAs.

Case study C did not show any signs of working to a hierarchical model.

If a return to a hierarchy is an appropriate way to deal with high transaction costs, as suggested by Kirkpatrick (1999), it seems that a legitimate and powerful leader, as seen in case study A, is required. The point of interest here is that where the PCTs do not have strong control and are not using incentives, they are tending instead towards micro-management. This will become costly. If policy is dictating that there should remain a separation of purchaser and provider and that direct control is not an option, then to decrease transaction costs, PCT should rely more strongly on incentives rather than micro-management.

Another option is to use networks to influence agents. Networks are often considered to be an alternative form of organisation to a hierarchy or market. However, the sustainability of networks in the NHS has been questioned (Goodwin, 2000). Whilst some have suggested that networks should be temporary forms created to solve specific issues with key players leaving once their interests have

been met (Uzzi, 1997), others see their advantage in long-term relationships that continue even when contracts are open-ended or unspecified (Exworthy *et al.*, 1999; Kirkpatrick, 1999).

Of the three case studies, C is the one that found the process of agreeing a SaFF the most difficult and time consuming. Case study C was also the group that appeared most closely to resemble a network. No one organisation or individual took the lead role in negotiations in case study C. The Director of Operations at NHS Trust C played an important role in arranging meetings and agendas, but the Director of Commissioning in PCT C appeared also to play an important role. Other members of PCT C and neighbouring PCTs did not seem inclined to let any one person or organisation dominate. The result of this "flat" approach to decision-making in case study C appeared to be a chaotic format and lack of final agreement. PCT C felt strongly that there should be clinical champions to lead the commissioning process. If these leaders had been in place, the network may have been given more focus and the result could have been a more systematic approach.

Information was constantly requested by the PCTs from the NHS Trust for the PCTs to use in their decision-making. This suggests that the network type was one of, in Goodwin's (2000) terminology, upward flowing information, with information assisting decision-makers. However, there was a lack of good quality information in this case study. The lack of available information may have contributed to the inability of the network to agree the details of commissioning within allotted timescales and to the poor functioning of the network.

Case study B showed some signs of acting as a network. The PCTs and the NHS Trust seemed to be willing to co-operate in agreeing the SaFF and at least some members of each team showed trust in each other. Other members however did not trust each other. Case study B therefore appeared to be part quasi-market model and part network with little evidence of hierarchy.

The organisations in case study A showed no signs of working as a network in the commissioning round studied.

In summary, incentive-based contracts were not considered important by any organisation. Wilkin *et al.* (2002) support this finding; they reported that 88% of PCG/Ts had not introduced financial incentives or penalties into SLAs.

Organisations had other means by which they attempted to establish agreements. Case study A retained a hierarchical model, which is consistent with the move towards integration and internal organisation suggested by Hughes *et al.* (1997). Case study B appears to be moving towards a network model but still adhering to the quasi-market model in terms of negotiations and relationships although it has abandoned the importance of contracts. Case study C has de facto become a network model.

None of the case studies can be described as having adopted in full the principal-agent approach suggested in policy documents. This suggests that a principal-agent model is not an exact description of reality for these case studies. However, neither do the case studies follow a single rival model. Each illustrates some aspects of a principal-agent relationship and some other forms of relationship.

2) Influences on commissioning relationships and styles

The basic assumptions of principal-agent theory are that there is information asymmetry between the principal and agent and they have different objectives. It is assumed that payment schedules are based on some combination of information about risk, uncertainty about the state of the world, outcome and any other available information. The results have shown that payment schedules as conceptualised in theory were not used and that information asymmetry, uncertainty and risk sharing were not considered major issues for the commissioning process in these case studies. The organisations did, however, have slightly different objectives.

This section discusses the complex interactions and contexts that have influenced commissioning relationships. They are discussed under the main headings of pressure, accountability and power, public service ethos, leadership, trust and history.

a) Pressure

Principal-agent theory assumes that, where there is no direct employment relationship or the relationship is between organisations, any pressure the principal puts on the agent is in the form of incentives. Incentives can be financial or non-

financial, and positive or negative. However, when the agent is employed directly by the principal, particularly when the agent is an individual rather than an organisation, the pressure may be applied through direct commands (Whitley, 1999).

In this study, pressure has been shown to exist in two main ways: national pressures on organisations to meet access and financial targets, usually imposed by the government (or its agents), and local pressure on individuals, applied predominantly through threats to job security and credibility. In each case, the amount of pressure may motivate high performance. Alternatively it may be so intense that it results in de-motivation. In addition to these two types of pressure, the effects of these pressures may make organisations feel that to be seen to be complying with policy is as important as actually complying.

i) Nationally imposed pressures

The government applies pressure to NHS organisations in order to achieve politically important targets. Pressure can be positive or negative and is imposed top down by the Department of Health in a number of forms, including star-ratings and franchising. In addition, all organisations are expected to develop and implement Local Delivery Plans that show how government targets will be met under local capacity assumptions (Department of Health, 2002b). The pressures to achieve financial balance, improve access, achieve national targets and implement National Service Frameworks have been shown elsewhere to be key factors in shaping commissioning priorities (Wilkin *et al.*, 2002). They have also been shown to be key factors in discouraging the involvement of GPs in commissioning (Regen *et al.*, 2001).

Public sector managers work within a highly politicised context and with an intense media spotlight (Goodwin, 2000). Goodwin argues that health service leaders should have the ability to turn such constraining external environments into opportunities by helping others to make sense of situations. This appeared to be the situation in case study A where the Health Authority leaders ensured that if the NHS Trust (and PCT) worked within government constraints, they created "space" to develop local initiatives. This was not the case in case studies B and C. They felt that they were under direct government pressure to perform.

In case study B, the pressure appeared to be sufficient to bring the community together and encourage all the organisations to work towards making the whole greater than the sum of the parts. The organisations in B could see the road to recovery. In B it appeared that the pressure on the organisations was sufficient to encourage them to work together whilst retaining some organisational self-interest. In case study C, the context appeared to be so pressurised that organisational self-interest became paramount and any desire to compromise for the greater good of the community diminished.

The NHS is currently driven by the government's desire to achieve targets laid out in the NHS Plan and National Service Frameworks. Politically, the most important targets are those that the general public is aware of; these are the access targets for secondary care and the need to achieve financial balance. The drive to achieve these two targets has been reflected directly in the annual Service and Financial Frameworks. All organisations must achieve financial balance at the same time as modernising service delivery and meeting access targets. The rewards for meeting these targets are non-financial. They include star-ratings and positive (or at least, no negative) publicity. Targets for reducing outpatient and inpatient waiting times have been met more successfully than locally set targets, for example, to improve discharge arrangements (Wilkin *et al.*, 2002). This suggests that it is the nationally set targets that take priority. The reason for this is the relative strength of the penalties for not achieving national versus not achieving local targets.

Kunz and Pfaff (2002) makes the point that in business environments, people expect to be paid in return for providing labour, and so rewards are considered the norm. In the NHS this is also the case, but the tendency appears to be to use negative rewards (i.e. penalties and threats) that as one consultant suggested are not likely to be effective when dealing with a highly educated and caring profession.

The correct use of incentives has been shown to be effective in changing behaviour (see Burgess & Metcalfe, 1999 for a review). However, too much pressure can result in players working strictly in accordance with those pressures or incentives that have the greatest impact. In this case, the threats of zero star-ratings, of poor national press coverage and of the franchising of management systems result in organisations aiming solely to meet the short-term goals of annual targets. It is likely that health service managers are keen to meet the targets because their jobs

depend on it; the numbers of chief executives and directors of poorly performing NHS Trusts to have resigned or been suspended in recent years bears testament to this. Organisations that have historically been funded poorly are more likely to have accumulated problems and hence face greater pressures currently. Case study C was chosen because it was under its target funding allocation. Of the three case studies, it faced the greatest external pressures and had the poorest joint working.

ii) Locally imposed pressures

This research has shown that some of the local pressure applied to individuals is perceived to be close to "corporate bullying". In organisations where the financial and waiting time target pressures are severe, there is little requirement for additional local pressures to be imposed. Where these external pressures are not severe, they may be replaced by pressure from local leaders. For example, in case study A there were fewer immediate pressures on the organisations to improve than in cases B and C. NHS Trust A was in financial balance and meeting the majority of its access targets. The pressure felt by all respondents in case study A came from the Health Authority leaders, the Chief Executive in particular.

The pressure from an individual is not related directly to the structure of the system. That is, the system may change but if the individuals in positions of power remain, the personal pressures remain also. It is not possible from this research to conclude that achievement in terms of meeting commissioning deadlines in case study A were due to or even associated with a forceful approach by the Health Authority Chief Executive. However, it does suggest that external pressures may be replaced with internal pressures. However, those internal pressures on individuals to maintain performance may become so intense that there are repercussions elsewhere in the system. For example, the NHS Trust clinicians in case study A felt constrained and demoralised by the pressure imposed by the Health Authority. As a result, they threatened to by-pass the commissioning process.

This finding is consistent with research by Frey (1997) who formulates his theory of motivations and human behaviour within a principal-agent framework. He shows how different types of rewards, sanctions and other controls can have either positive or negative effects on overall performance through their impact on internal motivation. Whilst some argue that internal motivation is a poorly specified

hypothetical construct with little evidence to confirm its existence (see Kunz & Pfaff, 2002 for a review), the consensus is that certain methods of control do have detrimental effects on performance, for reasons not yet agreed upon.

iii) Pressure to demonstrate compliance with policy

There are two policy requirements with which the case studies felt they should be seen to be complying. The first was using Service Level Agreements. The second was working in partnership.

Service Level Agreements were drawn up even though those developing and using them did not value them as incentive contracts. The view from the case studies in this research was that SLAs were an unnecessary hangover from the internal market and not meaningful in the new commissioning environment. They were developed as contracts even though they were not incentive contracts and did not add anything to the decisions and agreements that had been made already through negotiations. The case studies were developing something that they called an SLA merely to be seen to be conforming to policy requirements. The fact that there was a signed SLA between the commissioner and the provider at the beginning of the financial year in only one of these case studies suggests that, for them, SLAs were not considered an essential element of the commissioning process.

It is interesting to compare these results with those of Hughes *et al.* (1997). They studied commissioning in a health authority in Wales in the mid-1990s and described a similar finding. The authors showed that there was a discrepancy between public and private understandings of statements in official documents. Hughes *et al.* suggested that what appeared to be important in contracting in that study was the public visibility of penalty clauses in contracts as a symbol of commitment to centrally imposed goals. In private, the stated penalties were not as inflexible as they appeared. What appeared to be important for the case studies in my own research was the visibility to the regional offices and ultimately the Department of Health of having followed the correct procedures. These procedures included the drawing up of documents labelled Service Level Agreements.

The second element of policy with which the case studies felt they should comply was joint working. The need to be seen to be working in collaboration and partnership was so strong that case study C, in particular, appeared to be doing so

even when it was not in their best interests. The result was a degree of chaos. Government policy states quite clearly that "*[w]here a service or centre covers the population of a number of Primary Care Groups or Health Authorities, Primary Care Groups are* ***expected and encouraged to enter into collaborative commissioning arrangements*** *with other Primary Care Groups within the area...*" (NHS Executive, 1998b paragraph 51 (emphasis added)).

There is no mention in the government documents about what constitutes a positive environment for partnership working. The PCTs in case study C have attempted to follow the guidance and work in partnership despite a lack of shared objectives, a lack of trust between the organisations and poor quality information.

b) Power and accountability

A principal has a degree of power over its agent to ensure that the agent meets its obligations. In the context of a principal-agent chain, a high-level principal must ensure its agent meets requirements, and that agent must in turn ensure its agent lower down the chain meets its respective requirements. In commissioning, a health authority must ensure through performance management that a PCT meets its requirements and a PCT must ensure through commissioning that an NHS Trust meets its requirements. These power relations flow down the length of the principal-agent chain from principal to agent.

At the same time, an agent is accountable to its principal and as such must explain its actions to its principal. One would expect therefore that in a chain of principals and agents, a lower level agent would be accountable to its direct principal, and that principal would in turn be accountable to a higher-level principal. These lines of accountability flow up the length of the principal-agent chain from agent to principal. In commissioning, an NHS Trust should consequently be accountable to its PCT commissioners, and the PCTs should be accountable to their host health authorities.

In fact this is not the case. The lines of accountability do not flow up the principal-agent chain in a way that mirrors the way that power flows down it. Ambiguities in accountability lines have been shown to result in a disproportionate amount of time being devoted to managing the interface between organisations and the political process (Goodwin, 2000).

The issue here is whether, in the NHS, the upward flowing lines of accountability should mirror the downward flowing lines of power. In essence, should there be only one organisation responsible for ensuring an agent meets its requirements, and only one organisation to which this agent is accountable? Furthermore, should these be the same organisation? If not, are PCTs strengthened or weakened as a result?

i) Power and lines of accountability

In the standard case of a principal and its agent, the lines of power and accountability are that the principal tries to ensure through contracts that the agent meets its requirements, and the agent is accountable to the principal. For example, in private firms based in a market economy, the principal has the power to "hire and fire" and search for an alternative agent if the original agent does not perform satisfactorily. This is the case for a firm contracting work to another firm as well as for the relationship between an employer and employee.

This, however, breaks down in the case of PCTs and NHS Trusts, primarily because of the intervention of a third organisation: the StHA. Whilst the commissioning structure implies that the PCTs should ensure that the NHS Trusts deliver the requirements of the PCTs, policy dictates that StHAs should ensure that NHS Trusts deliver government targets. Therefore, NHS Trusts have two principals: PCTs and the government/StHAs. If the government (or its regional office or StHA agents) is stronger than the PCTs in sanctioning NHS Trusts if requirements are not met, then NHS Trusts' first priorities will be to their national not local commissioning requirements.

Furthermore, in a non-market context such as the NHS, where there is little practical choice of agent, the market power of the principal that permits it to "hire and fire" its agent is absent and replaced with a policy on accountability. However, this policy does not make NHS Trusts accountable to PCTs. Government policy dictates that both NHS Trusts and PCTs are accountable to Strategic Health Authorities (Department of Health, 2002d; Department of Health, 2002b). Both PCTs and NHS Trusts are therefore agents for a shared principal: the StHA.

The issue of concern is that an NHS Trust has different principals with different roles and the relative power of these principals is different also; that of the StHA is greater. Moreover, a PCT must treat its StHA as principal; a PCT is placed therefore

on an equal level with an NHS Trust. For these two reasons, the power of a PCT as principal to an NHS Trust is weakened.

Respondents in the case studies made a number of comments. These included a belief that StHAs ought to hold to account PCTs more than NHS Trusts, because it was the PCTs that were commissioning services from NHS Trusts. This line of argument is consistent with the notion that lines of accountability should flow upwards, in the reverse direction but along the same pathway, as the lines of the principal-agent chain for commissioning, with PCTs higher up the accountability hierarchy than NHS Trusts. Respondents understood also that the power of PCTs was diminished because they were not the organisations that had the power to dismiss the managers of failing hospitals, that is, NHS Trusts were not accountable to them. It should be noted, however, that PCT managers did not want to take on this duty.

An alternative view is that the lines of accountability should be different, for the following reason. If PCTs were made accountable to StHAs for the performance of NHS Trusts, this may increase the potential for their collusion. McCarthy (1998) claims that some health authorities in 1996/7 overspent by millions of pounds because of high claims by NHS Trusts. The health authorities did not wish to see their Trusts fail financially (this would reflect poorly on the health authorities) and so they used their reserve funds to pay the NHS Trusts' deficits. PCTs have been made responsible recently for the performance of NHS Trusts. PCTs are judged now on patients' waiting times for inpatient and outpatient appointments by the star-rating system (see www.chi.nhs.uk/eng/ratings/ for details). This ought to give PCTs an incentive to stop NHS Trusts from failing to meet access targets. This could be achieved through strict contracting frameworks, but as shown, contracts and incentives do not appear to have played an important role in commissioning in these case studies. More likely, NHS Trusts will take advantage of the situation (that PCTs do not want NHS Trusts to be seen to be failing) by asking the PCTs to fund additional services to meet targets or to fund deficits.

The PCTs in B and C played the role of principal in commissioning services. In case study A, the Health Authority played this role. In all the case studies, the NHS Trusts were performance managed by their health authorities. Performance management includes ensuring that national targets are delivered. Therefore NHS

Trust A served one principal for commissioned local and national services whereas NHS Trusts B and C served two. It is logical that NHS Trusts will focus their efforts in meeting the requirements of the organisation that imposes the severest sanctions or greatest incentives. That organisation, at the time of the research, was the health authority, and is now the StHA. It was not the PCTs. NHS Trusts may not have taken PCTs as seriously as they might should they have had the same power as health authorities or been their sole principals.

ii) Clinical freedoms and lines of accountability

Clinicians are accountable (that is, answerable) to their own professional bodies for the quality of their clinical care. This breaks the standard line of accountability between agent and principal and plays a part in the potential failure in the NHS of the principal-agent chain for commissioning. Themed editions of the British Medical Journal (22 March 2003) and the Health Service Journal (27 March 2003) have highlighted, and suggested possible solutions to, the different perspectives of doctors and managers, but neither considered their different lines of accountability. This research suggests a number of factors may be important.

First, hospital management does not have the power to hold fully to account hospital doctors for the amount or type of services they provide. If a consultant fails to meet the targets set by the government or local management, s/he will not be sacked. The management might be. Consultants will usually be sacked or struck off only if they breach clinical practice guidelines or provide a sub-standard quality of care. Consultants are perceived to be a scarce resource in comparison to managers and are not in fear for their jobs. Their professional power and separate line of accountability gives them the freedom to provide patient care as they judge best, not as the management might decree. Management power is therefore weakened with the result that meeting commissioned levels of service cannot be guaranteed.

Second, if the relationship between a hospital manager and consultant is viewed as a principal-agent relationship, there is the standard problem of information asymmetry between the principal and agent. The management are trying to manage a clinical system in which they have no experience of working as clinicians and, more importantly, they have no knowledge of what constitutes effective care. Doctors can therefore develop their own areas of interest and expertise without the management

being able to identify whether or not it is in the patients' or NHS Trust's best interests. One way to deal with this problem is through the standard principal-agent route of setting incentives for doctors to align their objectives with those of the management. Alternatives are to strengthen the direct employment relation in an attempt to oblige consultants to achieve certain objectives on behalf of their employers or to involve clinicians directly in management decisions.

In addition, the inability of hospital managers to see and understand the implications of actions taken by the doctors can result in a delay in information moving further up the principal-agent chain. That is, if a hospital manager wishes to share information with his counterpart in a PCT in order to plan their joint strategy, he will not be able to do so unless he first extracts this information from his own agents, the doctors. In this case, the ability of the NHS Trust agent to meet the requirements of the PCTs is weakened.

Third, an NHS Trust is not a single entity. An NHS Trust is not a simple, uni-dimensional firm producing a single product for its principal. An NHS Trust is comprised of a large number of sub-organisations that each act independently. It may be the case that there is little purpose in a PCT contracting with an NHS Trust to deliver care when the NHS Trust is merely a name for a number of diverse organisations. Likewise, "the PCT" is merely a name for a number of diverse general practices. The important thing is perhaps not relationships between organisations, but relationships within them. The key to ensuring objectives are met may lie in setting incentives at directorate and practice level. Government policy does encourage the use of incentives at practice level for commissioned services, but few incentive schemes have been implemented (Baxter *et al.*, 2001). Other research has also found that the implementation at practice level of incentives associated with commissioned services is low, with only 10% using such schemes and three fifths having no plans to introduce them (Wilkin *et al.*, 2002: 28). As for incentives at the directorate level, these may be introduced in part by the new consultant contract and its local alternatives (Department of Health, 2002a; Department of Health, 2003).

c) Public service ethos

Principal-agent theory assumes that all parties are driven by self-interest (Uzzi, 1997; Walker, 2000). Self-interest may include an element of "other interest", that is, one

individual's well-being may be affected by the well-being of others. A public service ethos means that people are driven at least in part by their desire to serve the best interests of the general public. This public service ethos complicates the notion of self-interest of principals and agents because each is concerned in a large part with the interests of the NHS as a whole and of its patients. However, although the broad objectives of the organisations in the NHS may be related, each organisation's conceptualisation of what constitutes the public interest, and how this should best be met, may differ. This was apparent in the case studies. PCTs had similar broad but different local objectives; NHS Trusts felt that the public's interest could be served by advances in secondary or tertiary care whereas the PCTs felt that primary care was more important.

The public service ethos within the NHS reduces the divisions between NHS organisations. The boundaries between principals and agents may not be as distinct as those between private firms in a market system. In essence, NHS Trusts, PCTs and health authorities are sub-sections of one large firm, the NHS. Each is aiming to maximise the well-being of the public with regard to health, albeit in different ways. When the sub-sections are treated differently, this brings about a feeling of inequity between them. For example, PCTs provide primary and community services. NHS Trusts provide secondary and tertiary care services. These services are provided in the main to the same populations and for the same reasons: to improve health. However, NHS Trusts were required to discuss and agree their provision of services with the PCTs. The PCTs were not required to discuss their own provision of services with the NHS Trusts, even though that provision might impact on the level and type of care to be provided by the NHS Trust for those same patients. Effectively, the PCTs were free to hide information about their own provision of services from their NHS Trust agents. Both NHS Trusts and PCTs saw that giving PCTs a provider as well as a commissioner role created a conflict of interest. The question is then why these organisations felt uncomfortable with the PCTs having a dual role of commissioner and provider when in other large organisations it is acceptable to choose when to contract with an external provider and when to produce in-house? The NHS Trust managers felt that the problem arose because the NHS is a public service where organisations are funded from a single source to serve shared patients. It was considered by some to be important for the PCTs to be open about

their own funds and provider services even though this was not required by the system. This suggests there had been a breakdown of trust between the organisations that may be rectified if the PCTs were more transparent in their own decision-making.

Within organisations, some of the clinicians (both GPs and consultants) suggested that their own motivation was being destroyed through repeated disappointments. These disappointments were caused by management refusing to allow new service developments because of the limited availability of funds. Consultants felt that they were not able to continue to develop their expertise because they were not given the opportunities to use newly acquired skills that could benefit patients.

This finding is entirely consistent with Frey's (1997) propositions that the type of activity undertaken by agents and the uniformity of external interventions affect internal motivation. Frey suggests that when the type of activity undertaken by the agent is interesting, the agent's internal motivation will be high and external interventions will be perceived to limit self-determination and thus reduce internal motivation. He suggests also that if the same external interventions are applied to all agents regardless of their level of internal motivation, those agents with a high level of internal motivation will be most severely demoralised because they will feel that their competence is not recognised.

More generally, these underlying motivations and the public service ethos can affect the implementation of policy. Changes in public sector management practice that are based on private sector practices and are imposed politically can fail because they are at odds with public service values (Goodwin, 2000). Koperski (1999) makes a similar point in comparing the changing role of primary care in the UK with that in the USA. He emphasises the importance of the different cultural values and speculates that one reason why the internal market reforms in the UK "did not succeed" was that the NHS has a culture of equity and national planning with tight, fixed budgets and the reforms were "contrary to important social values" (Koperski, 1999: 143). Moreover, where contracts between purchasers and providers are not complete (and in health care they are not), some other form of guidance is essential, and in the past this has been from the professional culture of the clinicians (Dixon *et al.*, 2003).

d) Leadership

My empirical work has shown that the style and effectiveness of local leadership affects the approach to commissioning. With regard to principal-agent theory, if a strong leader is also the principal, the system may be strengthened. If, however, the leader is not the principal, but the agent, or if the principal is not seen as a legitimate leader, then the relationship may be weakened.

The importance of leadership to most people is self-evident, no matter what the setting (Van Wart, 2003). Leadership has been described as the ability to inspire others and cope with change (Goodwin, 2000) and to be based on assertive task-related behaviour as well as the evaluation of that behaviour in a given situation (Ridgeway, 2001). Goodwin (2000) stresses the need for a change in emphasis in leadership research from a person-person to a person-context focus, to take into account how leaders can be successful in constrained environments. Outstanding leaders have the ability to have a substantial emotional impact on their work force (Javidan & Waldman, 2003). In addition to high quality goods and services, effective leadership should provide a number of positive outcomes (Van Wart, 2003). These include high levels of satisfaction in those conducting the work, a healthy mechanism for innovation and creativity, and an overarching sense of direction and vision.

In all of the case studies, strong leadership was considered important even where the main PCT itself was not a strong leader. In case study A, the Health Authority dominated the system of commissioning; it sat at the top of a command and control style hierarchy and played the role of principal. The Chief Executive of the Health Authority was perceived as a very strong leader with a strong sense of objectives and ideas about how they should be achieved. In case study B, the Chief Executives of the PCTs and NHS Trust were perceived as strong leaders within their own organisations. However, the power of the PCTs as principals over the NHS Trust agent came from the PCTs' greater number and so their ability to out-vote the NHS Trust. In case study C, the Chief Executive of PCT C appeared to be influential within the PCT but there was no obviously strong leader for commissioning amongst the different organisations. The organisations used a flatter structure for commissioning decisions where there was no clear role of principal or agent. Clinical champions were visualised as the leaders of the future, independent of

organisations. Walsh *et al.* (1999) conclude from their evaluation of total purchasing that leadership is important. Without a strong leader, they suggest that progress will be slow and unfocused. However, with a leader who is too dominant, the activities of others may be stifled.

Principal-agent theory does not state explicitly the importance of strong leadership. Implicitly, the theory assumes that the firm or individual that is the principal plays the role of leader through the assumption that the principal has the right and the ability to set a contract for the agent. The existence of tiers of principals and agents and of multiple principals complicates the leadership roles by introducing more than one potential leader.

The main differences in the case studies with respect to leadership are the perceived legitimacy of the principal to play that role and the danger of embeddedness (the lack of separation of principal and agent). An additional concern was raised that the number of top quality managers available nationally was not sufficient.

i) Legitimacy of leaders

Ridgeway (2001) discusses the problem of the worthiness of a leader's status. She labels this as legitimacy and describes the perceived legitimacy of low-status groups acting with authority towards others. Legitimacy brings with it power from the normative support of others; if subordinates do not perceive a leader to be legitimate, they may resist attempts to assert authority (Ridgeway, 2001). Cable and Judge (2003) define legitimacy as consistency with organisational traditions.

Principal-agent theory in economics does not consider legitimacy. It assumes that by choosing to become agents and acting in accordance with the market process, agents empower principals with a legitimate right to set contracts for them.

Within the NHS, the roles of principal and agent have been imposed through government policy on PCTs and NHS Trusts respectively. Although there may be a need and a desire for a strong leader, that leader (whether it be an organisation or an individual) has to be legitimate in the eyes of those over whom it has power. This may not be the case in the NHS as it is structured at present or in the recent past. The agents of total purchasing pilots did not always perceive them as legitimate commissioners of secondary care. Research suggests that the health authority in one

case provided legitimacy to a TPP's decision by adding its approval to a proposed service change (Goodwin *et al.*, 2000). Walsh *et al.* (1999: 74) refer to the issue of legitimacy as "followership". Within the BIPP total purchasing pilot, they found that there were varying degrees of acceptance of the lead GPs by the non-lead GPs, that is, non-lead GPs did not always see as legitimate the role of the lead GPs.

With regard to the case studies, the Health Authority in case study A provided a strong and legitimate leadership. The PCTs and NHS Trusts in its area accepted the Health Authority's level of authority. The hierarchical structure in A, with the NHS Trust and PCT being placed as equals below the Health Authority, removed the problem of competition for status between the NHS Trust and PCT and the lack of perceived legitimacy of the PCT as principal. With NHS Trusts being larger organisations, employing a bigger workforce and with senior staff members being paid substantially more than their counterparts in PCTs, it is unlikely that NHS Trusts are ever going to feel that PCTs have a legitimate place higher up the NHS hierarchy.

Although in the other two case studies there was no legitimate authority comparable to the Health Authority in case study A, the NHS Trusts in case studies B and C seemed to accept that the PCTs had been given the role of principal and were willing to work within that system. However, whilst the PCTs in B accepted this role, those in C did not. The PCTs as a group did not accept that they had a right to demand services from the NHS Trust, nor did they accept that PCT C had a right to act as leader for the group as a whole.

This finding, that it is the principals who do not accept their own legitimacy, rather than the agents that do not accept the principals' legitimacy, is in contrast to that suggested in the sociological literature. The sociological literature (see Kiser, 1999; Simon, 1991) questions the validity of the assumption in economics that organisations have a right to act as principals; it is, however, the legitimacy of the imposed principal as perceived by the agent that is questioned, not the legitimacy of the principal as perceived by the principal.

ii) Collaboration between leaders

Where there are multiple principals, principal-agent theory predicts that these principals will collude if their objectives and access to information are the same.

Although the theory predicts that contracts will be made jointly, and the sharing between principals of risks and output will be agreed in advance, it does not offer any insights into how colluding principals should *organise* their collusion.

PCTs in case study B adopted a principal-agent approach to this problem. Each PCT acted as a lead PCT (in effect, as an agent) for the other PCTs for one specialty and these inter-PCT relations were kept separate to PCT-NHS Trust relations. There were in effect two sets of principal-agent relations: one was between the group of PCTs and the lead PCT; the other was between the lead PCT and the NHS Trust. In both cases the principal was considered legitimate.

In case study C, the PCTs and NHS Trust attempted to work as partners in a network system rather than as principals and agents in a system resembling a quasi-market. No PCT took a strong leadership role. This network of PCTs was not distinct from the network set up to work with the NHS Trust. There was no obvious or legitimate principal in case study C. The main players were very friendly with each other but lacked an ability to make decisions. The organisations worked in circumstances that came to represent "overembeddedness".

Overembeddedness occurs when there is a small number of buyers and suppliers in a market (Gluckler & Armbruster, 2003) and results in the social aspects of exchange superseding the economic imperatives (Uzzi, 1997). With small numbers, organisations inevitably have repeated contacts with each other and build up a degree of knowledge about each other. The result is that organisations are likely to be biased towards choosing partners that they have worked with previously. Kirkpatrick (1999) suggests that feelings of friendship and obligation become so great between firms that one becomes the "relief organisation" of another and innovation is resisted. There is a danger, he suggests, that, because network models of working between organisations are intended to be temporary alliances to work on specific issues, long lasting networks can become overembedded.

In the NHS, there are very small (and in the short-term fixed) numbers of participants in the market. In addition, there may be common attitudes between professional types (for example, managers) across principal and agent organisations. This may influence behaviours and actions (Hughes *et al.*, 1997) to the extent that

these actions become very similar, further decreasing the distinction between principals and agents.

Case study B had avoided overembeddedness by retaining some facets of a quasi-market style principal-agent relationship. The main players showed respect for each other's abilities but were not afraid of making unpopular decisions and remained loyal in the first instance to their own organisations. However, as discussed in chapter two, if agents are active and decision-making is joint, decisions are more likely to be implemented successfully (Coleman Selden *et al.*, 1999; Walsh *et al.*, 1997). Whilst it may be important that individuals work well together, it may be equally important that their own organisation's interests remain a priority. This would maintain a healthy debate and aid the implementation of agreements at the same time as ensuring results are not impeded by overembeddedness.

It is important to remember that until recently these organisations, particularly PCTs, did not exist in their current forms and their managers were employed often in their predecessor organisations. A similar situation is evident in the Netherlands where the social insurance market is characterised by a long history of co-operation; that strong co-operation is now limiting the effectiveness of the recently introduced market system (van den Brink *et al.*, 2002). The authors state that it was not surprising that a high level of co-operation existed as the "circle of people charged with the negotiations [between hospitals and health care insurers] was often extremely small and those involved had known each other long before the system changed" (van den Brink *et al.*, 2002: 209).

Another factor that may pre-dispose organisations to collaborate is gender. The senior managers in case study C were predominantly female whereas those in B were mixed and in A all male. A number of factors can affect the style and success of female leadership (Ridgeway, 2001). These include collaboration. The issue of collaboration is linked closely with legitimacy; it is not perceived as appropriate for women to act in assertive, hierarchical ways and so they are forced into using collaborative methods.

The managers and style used in case study C appear to relate closely to a softer, more collaborative approach associated with female leaders. In complete contrast,

the managers and management style in case study A undoubtedly conform to a traditional male dominated hierarchy.

There is a large literature on gender and leadership style (see Eagly *et al.*, 1995 for a review) and a suggestion that "women senior managers generally have a harder time than their male colleagues" (Broussine & Fox, 2002: 91). The importance of so-called "hard" skills associated with resource management, legal and other technical knowledge are often linked with a male approach to management, whereas a female style is associated with "softer" skills such as staff motivation, empowerment and consensus building (Broussine & Fox, 2002). These translate, respectively, into the traditional styles of leadership such as command and control and more collaborative approaches such as networking. Carli and Eagly (2001) suggest that people are more receptive now to the idea that women may exercise power in a different way to men.

iii) Workforce calibre

As discussed, the government has imposed the roles of principal and agent on organisations. This top down approach to deciding the number of principals and agents in the system brings with it the problem that the number of high quality effective managers available to take on the leading roles in these organisations may be less than the number required. Indeed, the successful implementation of policy without considerable additional capacity in the form of, among other things, leadership training, has been questioned (Dowling *et al.*, 2002; Wilkin *et al.*, 2002).

Shifting the Balance of Power (Department of Health, 2001) takes account of this potential problem by offering training to PCT Chief Executives.

> *"... The Chief Executives must be top rate managers. To help get the best people it is planned to update the competencies for PCT Chief Executives in the light of the roles, relationships and responsibilities set out in section 13 to 22. It is also intended to provide accelerated development and support for existing PCT Chief Executives."*

Despite this promise, there are still concerns about the size of the task in front of PCT managers, and NHS Trusts still regard PCT Chief Executives and Directors as second best when compared to their NHS Trust counterparts. The gap in the rates of pay and the relative newness of PCT managers accentuate this problem.

Respondents from the case studies believed that they were lucky in their own areas to have high quality managers, but that other areas were not as lucky. A concern was raised that a system that required as many high calibre managers as the current one was almost destined to fail. An alternative suggestion was made that the structure of the NHS should be designed around the available good quality managers. Implicitly, this comment suggests that it is the management of the system, that is, the leadership, not the system itself, which results in success or failure.

e) Trust

Trust can affect principal-agent relationships by either undermining or reinforcing interactions. A lack of trust may also undermine other models of commissioning.

Trust (and the lack of trust) was evident in the case studies in a number of ways. The first major theme was that the principals tended not to use contracts as binding agreements but as conduits for discussion. This could suggest either that agents can be trusted to meet requirements without fully specified contracts or perhaps that they cannot be trusted to meet requirements even with contracts. Second, the agents showed a lack of trust in the principals where allocation of funding between NHS Trust and PCT provided services was concerned. This was a problem to do with the dual role of PCTs as commissioners and providers. Third, trust between principals was shown to be a potential issue where there were multiple principals. In case study C, not only did the principals not trust the agent, but the principals lacked trust in each other as well. In case study B, the principals did trust each other and their system worked well.

The definition of trust is straightforward. Trust exists when "an actor states that (s)he will perform some way [and] (s)he will indeed perform in this manner, i.e. (s)he will not distort the true nature of her/his intentions" (McMaster & Sawkins, 1996: 150). This can mean that an individual is expected to comply with an agreement, and does so. It can mean equally that an individual is expected to renege on an agreement, and does so. In the majority of the literature, trust is assumed to be synonymous with "positive" trust, that is, that an individual is expected to act in a way that is beneficial to others, and does so. McMaster and Sawkins continue that trust removes the need to use sophisticated governance arrangements to protect exchanges and that the need for trust is greatest for non-routine, complex tasks.

They are talking here about positive trust. Mills and Ungson (2003) give a different definition that also applies to positive trust. They define trust as an atomistic belief or faith that compensates for incomplete information due to uncertainty and risk, and as such, trust is an acceptance of risk. To comply with the use of the term trust in the general literature, trust here is defined as the belief by one person that another will act in a way that is seen to be appropriate.

Mills and Ungson (2003) take the idea of trust one step further and sub-divide it into routine and basic trust. Routine trust is a belief in the competencies of an individual and is built up over time. It is based on the knowledge of an individual. Basic trust occurs when there is little information about the object of trust. The latter is more closely associated with blind faith and can lay open the doorway to abuse through opportunistic behaviour.

Principal-agent theory does not discuss trust. Implicitly, the principal does not trust the agent to act in the principal's interest. This is why the principal sets incentives for the agent.

In the three case studies, the NHS Trusts' performance was not controlled through incentive contracts. Trust can impact on the reliance on contracts in a number of ways. The need for contracts or costly control mechanisms in economic transactions is reduced if the participants trust each other to make appropriate decisions (Mills & Ungson, 2003). In contrast, if the agent is not trusted (i.e. is expected to make inappropriate decisions from the point of view of the principal), contracts may need to be so detailed that they cannot be specified fully and so another form of control is necessary. Williamson (1975) in his treatise on markets and hierarchies discusses the importance of a high trust culture in business. He makes two important points in relation to the present research. First, businessmen operating in competitive industries with a culture of trust will find that they incur excessive costs and render their business non-viable should they insist on contractual completeness and exacting execution of such contracts. Second, he cites work that has shown that the nature of contracts is more casual and their enforcement less exacting in business than is supposed by academics and other economists. This is consistent with my finding that discussions between primary and secondary care clinicians were more amiable when managers were not involved. It may be that the managers' training

and government guidance encourages managers to rely less on trust and to rely more on contracts than do clinicians.

In addition, if the principal does not trust the agent to comply with the contract, or where effective monitoring is not possible, there is little point in having one. Previous research (see McCarthy, 1998) has suggested that health authorities have very little power over NHS Trust spending. Health authorities do not want their hospitals to go out of business, so may subsidise an overspending NHS Trust in order to maintain existing levels of service. (This issue was discussed also in relation to accountability.) A view from NHS Trusts in my own case studies was that the government would never allow an NHS Trust to go out of business. Whether this is true or not, the belief by NHS Trusts that they will always be bailed out weakens the incentive effect of potential bankruptcies as a result of not complying with contracts.

If NHS Trusts cannot be trusted to comply with contracts, other methods of control need to be used. The different case studies worked in a variety of ways. In the command and control system in case study A, the Health Authority did not trust the NHS Trust to carry out the Health Authority's objectives and so imposed a command and control system. In case studies B and C, there was also a lack of trust by the principals of the agents, but this was combined with the lack of an alternative, effective method of control. This resulted in attempts to micro-manage the NHS Trusts. A lack of trust combined with weak control appeared to result in attempts at hands-on management by the principal. Ultimately, this is akin to attempting to internalise the agent within a traditional hierarchy. Case study A illustrates the result.

The second major area of interest was that agents did not trust principals to allocate funds fairly or to commission alternative care (this issue was discussed also in relation to a shared public service ethos). NHS Trusts could not understand why PCTs had been given a provider role. They saw this as a conflict of interest and did not trust the PCTs to be fair in resource allocation. If PCTs were more open in their reasons for making funding decisions then the problems may be alleviated. However, given the potential erosion through the commissioning system of the historical power of hospitals, and the fact that all NHS organisations are aiming to achieve the same general objective of improvements in population health but in

different ways, it may be that the competition for funds and the temptation for PCTs to hide information will remain. Regen *et al.* (2001) likewise stress the importance of openness, trust and clarity in the demarcation of roles and responsibilities, albeit their findings relate to PCT boards and their executives. PCT B attempted to be as open as possible with how it made decisions about resource allocation but was not open about how it was spending its money. In case study C, the NHS Trust questioned percentage increases in funding allocated by the PCTs. The NHS Trust believed it was being treated unfavourably in comparison to the PCTs.

This conflict of interest arises in part from the NHS being a single entity with the funding available being limited explicitly and shared between NHS organisations. Any additional pound from a PCT's overall funds allocated to services provided directly by the PCT results in a pound less being available for secondary care services. Wilkin *et al.* (2002) showed that these concerns are not unfounded. Up to half the PCG/Ts in their survey were shifting expenditure between budgets; the most common pattern was a shift away from hospital services towards community services, practice infrastructure and prescribing.

In addition to this link through funding, PCTs and NHS Trusts are also linked through their patients. NHS consultants do not trust other providers. They feel that they have to compensate for mistakes and complications resulting from care provided by GPs or non-NHS hospitals. If PCTs choose to commission European care or to provide care themselves, not only are they seen to be taking money away from NHS Trusts, but also potentially to be increasing the demands for NHS Trust services. These links are not standard in principal-agent relations. The actions of the principal (in particular, if the principal chooses to provide services in-house) do not normally affect the ability of the agent to achieve the principal's wishes.

Light (1998) addressed similar conflicts of interest. He asked whether the UK government in the first half of the 1990s was a provider trying to make performance look good, or whether it was a purchaser that evaluated performance by standing back. The same question can be asked of PCTs. Are they providers, providing services alongside NHS Trusts, aiming to improve the health care of the community, or are they commissioners, commissioning services at arms length with a disinterested evaluation role, aiming to improve the health of the community?

The third area of interest in relation to trust is another unexpected one. There was a lack of trust between PCTs. This was noticeable especially between the PCTs in case study C, despite the fact that they appeared very friendly on a personal level.

Trust between organisations may have been lost to some extent through the contracting mechanisms of the internal market. In the market for local authority services, short-term contracts and time frames for re-tendering have been shown to have undermined confidence and trust and contributed to increased insecurity of providers (Vincent Jones, 1997 cited in Kirkpatrick 1999). The stability (or at least lack of competition) within the NHS acute sector should limit any feelings of insecurity, but the undermining of confidence and trust remains. Once that trust has been lost, it is not clear how it can be rekindled. This loss of trust is usually interpreted as being between principals and agents; it is unusual in these case studies that it is between groups of principals. This lack of trust may be related to the perceived illegitimacy by PCTs of their roles as principals and the imposition of these roles by government.

f) History

The traditional patterns of working and the histories of local management influenced the current patterns of working in the case studies. Local context and history was found to be important also for the development of total purchasing pilots (Goodwin *et al.*, 2001). Where people have been in the same area for some time (even in a variety of posts) there is likely to be some attachment to the past and this may make significant changes in working styles more difficult to achieve. The effect of a policy based on principal-agent relations may therefore be weakened through local variations.

The importance of history in the development of systems is supported by the notion of path dependency. Path dependency is about continuity (Greener, 2002) and the "historical makeup" or inherited institutional structure (van den Brink *et al.*, 2002). A path dependant sequence of changes is one in which important influences on the outcome can be dominated by remote or chance elements rather than systematic forces (David, 1985). David (1985) explains the path dependency argument through the example of the world's adherence to the QWERTY keyboard. Marginal changes to a layout designed originally to avoid jamming keys have resulted in a keyboard

layout that is universal but not optimal for today's requirements. As Greener (2002: 164) suggests, "the path dependency approach focuses on theorising how policy can become so institutionalised and historically embedded that it becomes nearly impossible to break free from the established policy 'path'".

Principal-agent theory does not take history into account. It assumes that principals and agents have no prior knowledge of each other. Dixit (2002) does consider issues of prospective timescales, for example, the use of incentives when an agent undertakes a task several times and the principal observes this task several times. There is, however, no discussion of the previous history of relationships or knowledge of partner organisations. Indeed, the problem of adverse selection arises precisely because of a lack of such information. In practice there is not always such a lack of information. In the NHS, relationships are usually long-term and despite organisations regularly having undergone transformations that have affected their management and geographical relations, the histories and reputations of their senior staff are often well known.

Greener (2002) uses path dependency as a framework for analysis of the reforms in the NHS in the late 1980s and early 1990s. One of his conclusions is that agents, be they individuals or institutions, provide the "conjunctural" element of change. A conjuncture is the coming together of a number of events across time or space that make changes possible. He confines his discussion, however, to political agents and the role of the medical profession's representative bodies. He does not discuss the role played by agents low down the hierarchical structure. As shown, agents further down the principal-agent chain play an important role in commissioning.

Torfing (2001) refers to the common use among social scientists of path dependency to explore the impact of institutional contexts on the actions of social and political agencies. Torfing uses the path dependency argument to analyse changes in the Danish welfare system. He concludes that there are a number of types of path dependency that all play a role and should be separated in discussions. Most relevant here is historical institutionalism which is concerned with the impact of tradition.

Those principals and agents that have been successful in the past in achieving their aims are likely to continue to use the same methods regardless of policy. The

approach used in case study A had been a hierarchical command and control approach for a number of years, led by the same senior directors. Despite a series of policy changes since the early 1990s, the system there had remained intact. The senior staff in the Health Authority and the NHS Trust were accustomed to working in that style. Although the PCT as an organisation and its staff were new, the previously entrenched system remained.

In case study C, the system had been less defined for a number of years, and remained so. One of the problems in case study C was that the four PCTs tasked to commission services from the NHS Trust were spread across three health authorities. The style of working in the three areas was different. The health authority boundaries had changed a number of times in the past, making the hospital directly managed by one health authority and then another. The recent restructuring of the health authorities into StHAs had resulted in the NHS Trust being situated on the boundary of two StHAs. PCT C expressed strong feelings that boundaries between organisations were not important; what was important to them was patient pathways of care, led by clinical champions. It may be that the history of boundary changes had made these organisations nervous of the implications of adopting a system that was not robust enough to remain stable through any future boundary changes. Their previous experiences had therefore forced them into a collaborative network approach.

McCarthy (1998) lends support to PCT C's view. He suggests that contract negotiations can be problematic if they are based on provider boundaries rather than on health programmes that straddle organisations. Nonetheless, only where funds were ring-fenced by the Department of Health for certain diseases did he find in his case study that contracts accounted for provision by different organisations.

It was discussed earlier that the roles of principal and agent have been imposed on PCTs and NHS Trusts from above. They have not chosen them voluntarily. Similarly, the boundaries between organisations are often arbitrary, at least to the extent that they are based on practice catchment areas and previous health authority boundaries rather than population need. Goodwin (2000) suggests there should be a move away from leadership of institutions with defined boundaries to leadership of collaborations between services and professional groups. Any such move may be restricted by path dependant tendencies and policy requirements that encourage

traditional systems of commissioning using contracts between conventional organisations.

3) Policy recommendations

To date, policy messages from the centre have been mixed, some call it confused or "pragmatic" (see for example Allen, 2002b). The rhetoric is of devolution and local empowerment (Department of Health, 2001) whilst in reality there is a feeling of tighter central control. PCTs are told that they have the freedom to commission services appropriate for their local populations but in reality the tight structure imposed through national frameworks, targets and the ring-fencing of funds restricts these freedoms. Guidance suggests that commissioning should be undertaken via a contracting mechanism, but at the same time organisations should work in partnership to plan services jointly (NHS Executive, 1998b). The amount of services delivered annually must be increased to meet targets whilst at the same time services should be restructured to meet long-term modernisation goals. There is an expectation that clinicians will be engaged fully in the commissioning process whilst it is the managers that are charged with making decisions and who are penalised for failures.

This section sets out policy recommendations based on the findings of this research.

The use of incentives in SLAs should be encouraged. None of the PCTs studied used incentives in their SLAs and all perceived SLAs as performance management tools rather than incentive-based contracts. Strictly speaking, performance management tools should manage performance and incentives are an appropriate method for doing this. According to policy, Service Level Agreements should "*incorporate levers for quality and efficiency*" and "*include rewards for gains in outcomes and extra efficiency*" (NHS Executive, 1998a: Appendix A). To compensate for the lack of influence through incentives, the commissioners in these case studies used either command and control methods and micro-management, or network methods (albeit poorly). If the purchaser/provider split and use of contracts is to be maintained, the use of incentives as the main means of influence, in preference to these methods, should be encouraged.

The introduction of payment by results as described in *Reforming NHS Financial Flows* (Department of Health, 2002c) does create financial incentives for NHS Trusts. By receiving an average price (known as a standard tariff) for particular volumes of services, NHS Trusts with costs higher than the standard tariff will face an incentive to become more efficient and those with costs lower than standard tariff will be rewarded implicitly for their already efficient provision. In addition, PCTs are encouraged to withdraw funding from providers on a quarterly basis where those providers are not delivering agreed plans (Department of Health, 2002c: 23). This policy removes the need for PCTs to know NHS Trusts' costs as part of the commissioning process and hence removes this potential problem of information asymmetry. It should also free organisations from negotiations around costs and allow them to concentrate on the planning and service development process. If monitoring is effective, the ability of PCTs to ensure that NHS Trusts comply with agreements for commissioned services should increase. However, without a prior agreement about the sharing of risks, there is an incentive for NHS Trusts to build up deficits which they can then impose on the whole health community. Organisations should be made aware also that the new style of contract is likely to increase the costs of monitoring. In addition, as discussed in chapter two, contracts have not been specified fully thus far in the NHS, and, where there are incentives, there is a danger that effort will be increased in service areas subject to incentives relative to those not subject to incentives. These potential problems do not preclude the use of incentives, but they do show that the type of incentives imposed must be chosen carefully.

Compliance with commissioned agreements depends in part on compliance by clinicians with those agreements. The strength and variety of methods of influencing the compliance of clinicians with commissioning agreements should be increased. Although this study aimed to explore commissioning relationships between PCTs and NHS Trusts, one of the findings is that the relationships between NHS Trust management and clinicians appear to be a weak link in the principal-agent chain. If government targets and frameworks are to be met through commissioning, it may be more appropriate to concentrate future efforts on aligning clinician with NHS Trust objectives as well as NHS Trust with PCT and government objectives. Although there are aspects of the NHS that make it function as a single

firm, there are others that suggest it is a multiplicity of firms. Even individual organisations are not single entities. An NHS Trust is comprised of a number of directorates and specialties; a PCT is comprised of a number of independent practices. Incentives within organisations may be at least as important as those between organisations. This is consistent with current efforts to influence the working patterns of consultants in English hospitals through either the new consultant contract (Department of Health, 2002a) or local schemes based on annual bonuses to consultants for improving productivity, access, quality and service development (Department of Health, 2003). This research has not considered compliance by GPs with commissioned secondary care agreements. However, the dependency of NHS Trusts' activity on the demand created in part by GP referrals suggests incentives should be strengthened in both primary and secondary care.

Recent attempts to introduce the new consultant contract have not been successful in England. Local agreements are currently being negotiated. Some of the concerns voiced about the new consultant contract have been related to greater management control of clinicians' time and organisation of workload. Some consultants in this study complained that the management control was already too strong and that the methods used relied on rules and sticks rather than carrots. Such methods of control were felt to remove self-determination and result in demoralisation. Local agreements with consultants should emphasise the greater degree of self-determination that can be gained through making choices according to incentives and should concentrate also on using incentives rather than sanctions. If incentives are set in accordance with local commissioning agreements they should help NHS Trust management by making it easier to meet these agreements and help PCTs by curtailing the problem of creeping commissioning. They should also help consultants by giving them the freedom to make choices, albeit within financial limits. In a financially constrained system such as the NHS, this may not be perfection, but a good option given the circumstances (see Roberts, 1997).

With regard to primary care, the White Paper *The New NHS: modern, dependable* (Secretary of State for Health, 1997) envisaged that PCG/Ts would allocate their practices indicative budgets for commissioned services. A Health Service Circular a year later (NHS Executive, 1998b) gave details of financial incentives to be used in conjunction with indicative practice budgets. Using these schemes, individual

practices would face incentives to manage their referral patterns and other use of hospital services to remain within budget. There has been slow progress in the implementation by PCTs of indicative practice level budgets and incentives for the use of these budgets (Wilkin *et al.*, 2002). This may be because PCTs have been focusing on other tasks, but as they become more established in their roles, re-emphasising the benefits of these policies should become a priority. Such incentives should ensure that PCTs' own use of services (through referrals) is not excessive in comparison with the commissioned level and as a consequence does not create problems of provision for NHS Trusts. With the introduction of payment by results as described in *Reforming NHS Financial Flows* (Department of Health, 2002c), devolving and monitoring indicative budgets at practice level for at least some specialties should become more straightforward.

This research has highlighted in addition the fact that clinicians in primary and secondary care do not always understand the impacts of their actions on other areas of the health service, and have misperceptions about the financial constraints or freedoms in which each sector works. Joint educational seminars should increase understanding and at the same time build upon the levels of goodwill that exist already between primary and secondary care clinicians.

The organisations to which NHS Trusts are accountable are confusing and should be clarified. Currently, NHS Trusts are tasked to meet nationally set targets as laid out in the NHS Plan; for these, they are performance managed by their StHAs and given star-ratings by the Commission for Health Improvement. NHS Trusts are commissioned by one or more PCTs to provide secondary care services; PCTs are responsible for ensuring these services are delivered. However, the meeting of NHS Plan targets, and access targets and financial balance in particular, take priority. NHS Trusts are held to account by StHAs. Failure to meet national targets and requirements results in national shaming of NHS Trusts. As a result, locally commissioned services particular to local populations can take a back seat. This can happen in two ways. First, if commissioning agreements include the delivery of services particular to the local population and these services do not assist the achievement of access targets or financial balance, delivery of these services will not be a priority for the NHS Trusts (Wilkin *et al.*, 2002). Second, in agreeing the annual SaFFs, for NHS Trusts already finding difficulties in meeting access targets,

it is unlikely that funds can be found within the budget available to develop locally needed services in addition to meeting the national requirements. The solution to these competing priorities is difficult. A balance needs to be found that ensures NHS Trusts take seriously and meet the local requirements of their commissioners at the same time as meeting national requirements.

As discussed, if NHS Trusts are faced with more than one principal, they will prioritise meeting the requirements of the organisation that imposes the strongest sanctions or incentives. However, if this problem is removed and NHS Trusts are faced with just one principal within a tier of principals and agents, for example a PCT, this introduces a new problem: the possibility of collusion. Without a realistic choice of alternative providers and the ability to remove custom and funds from an incumbent NHS Trust, making PCTs alone responsible for ensuring NHS Trusts' delivery of services, and making PCTs accountable for this to StHAs, could result in greater collusion between NHS Trusts and PCTs rather than greater control.

PCTs have been made responsible recently (through star-ratings) for inpatient and outpatient waiting times and waits in A&E. This is consistent with the argument that PCTs should be the sole principal responsible for ensuring the delivery of NHS Trust services. But, PCTs must also "*hold provider organisations to account for the services they have commissioned*" whilst StHAs must "*hold all NHS organisations to account for performance*" (Department of Health, 2002b: 9). Thus, NHS Trusts are still expected to serve two principals. In addition, it is not clear what, if any, sanctions a PCT will face on top of poorer star-ratings if NHS Trusts fail to meet access times for that PCT's patients. If sanctions for failure are strong or incentives for truth-telling weak, it appears that the conditions for collusion resulting potentially in the manipulation of waiting list figures have been created. The role of the StHAs must be to ensure that this does not happen. PCTs should be made responsible for ensuring NHS Trusts meet national targets as well as locally commissioned services by imposing local incentives and sanctions for their achievement. NHS Trusts must, however, be accountable to (that is, must explain their actions to) StHAs who audit financial and activity data and who have the power to terminate both PCT and NHS Trust executives' contracts if manipulation of the figures is proved. **PCTs alone should be made responsible for ensuring the provision of services (and for these, PCTs should impose incentives and**

sanctions) but StHAs should hold NHS Trusts to account (that is, NHS Trusts should explain and justify their actions to StHAs).

PCTs need to be open with NHS Trusts about the proportion of funds they allocate to their own provider services if they are to allay any fears that they are favouring themselves. The level of trust by NHS Trusts of PCTs, as well as vice versa, is variable. PCTs have been given the dual role of providing services as well as commissioning them. This in itself may not be a problem, but is complicated by the fact that both organisations are providing services to the same population. This means that one organisation's provision of care impacts on the demand for the other organisation's care and its financial ability to provide it. If PCTs are honest about why and how they have allocated their funds, NHS Trusts' fears may be allayed and, if not allayed, conflicts can at least be resolved openly.

PCTs should be helped to feel comfortable with their role as commissioners. This research has shown that a potential problem in the commissioning process is the reluctance of PCTs to make and implement difficult commissioning decisions. This reluctance stems from a feeling by some PCTs that their position as commissioners of secondary care services, which places them above NHS Trusts in the NHS hierarchy, is not legitimate. Not only do NHS Trusts have to accept that the "*new kids on the block*" control the finances but the PCTs need to accept that although they are new organisations, they have been given an important leadership and decision-making role. Failure to accept this role will result in confusion and a lack of direction. One reason why PCTs do not feel legitimate may be the emphasis in policy documents on collaboration and partnership working. On the one hand PCTs are tasked with being the lead organisations for commissioning and on the other they are expected to work in collaboration with those organisations over which they have been given a lead role. Different health communities may interpret these requirements differently and place a different emphasis on the importance of the lead role relative to the importance of partnership working. This research has shown that where there is no clear lead person or organisation, the commissioning process suffers. **Emphasis should therefore be given to the role of PCTs as commissioners rather than the role of PCTs in ensuring that the health community works in partnership at all times.**

In addition, to ensure that PCTs are perceived by other organisations as competent commissioners of secondary care services, PCT executive officers should be trained to a standard necessary for the role. Concerns were raised in this study that the number of appropriate calibre leaders across the country was insufficient. This issue has been recognised by the Department of Health and is being addressed through the Modernisation Agency, in particular the Leadership Centre. One of the roles of the Leadership Centre is to "*develop current and future NHS leaders and managers at all levels*" (http://www.modern.nhs.uk/). In addition, the Workforce Development Confederations have roles that include changing the ways in which staff are trained and educated, and to develop and spread new ways of working (http://www.doh.gov.uk/workdevcon/guidance.htm). These initiatives should be continued.

PCTs should be encouraged to work together in their commissioning of secondary care services only where the conditions for joint working are appropriate. PCTs should be encouraged to agree with each other, prior to any discussions with an NHS Trust, which services they can commission jointly and for which services this is not appropriate. Contrary to expectation, this research has shown that relationships between PCTs can be as problematic as those between PCTs and NHS Trusts. Although the broad objectives of the PCTs were the same, and those of the NHS Trusts were similar as well, the specific local objectives of PCTs and the ways in which the different organisations thought they should be reached, varied. Where PCTs do not share objectives, or are not able to reconcile local objectives, where commissioning information particular to individual PCTs is poor, where local capacity differs or where there is a lack of trust between the PCTs, joint commissioning will be problematic. A recognition and acceptance of these differences is important. If differences are recognised, they can be debated and resolved. If organisations refuse to take into account different agendas, they run the risk of alienating each other. For commissioning processes to be successful, there needs to be a positive local environment. Health Service Circular 1998(228) (NHS Executive, 1998b) states quite clearly that collaborative commissioning should be encouraged. It does not state under what circumstances it should be encouraged. Although a single agreement covering a number of PCTs makes the negotiation and provision of services simpler for an NHS Trust, attempts to make such an agreement

where circumstances are not ideal results in problems for both NHS Trusts and PCTs.

Local patterns of working should not be allowed to dictate the degree to which policy is implemented. Current policy has been implemented in very different ways in these three case studies and these levels of implementation appear to be related to historical patterns of working and the perceived success of these patterns. If the aim of the Department of Health is for the NHS to achieve NHS Plan targets, then the method by which they are achieved should not be paramount. If, on the other hand, the aim of the Department of Health is to devolve responsibility to frontline staff and empower local organisations, as well as to achieve targets, then the method by which targets are achieved becomes important and that suggested by policy should be implemented. Part of the role of StHAs should be to ensure that appropriate styles of working are being implemented on the ground, and that organisations are not simply following procedure in name only. Organisations should be encouraged to break away from traditional methods of working and take on their new roles with conviction.

Finally, it is essential that StHAs have a strong regulatory role. If PCTs and NHS Trusts are not able to resolve their conflicts alone, another body must provide the mechanism to do so. The potential for lack of trust between organisations, lack of shared objectives and feelings of illegitimacy all suggest the need for an independent arbitrator. StHAs have been given this role (Department of Health, 2002d: paragraph 2.2.6) and should use it.

4) The "success" of the case studies

This section examines how "successful" the case studies were and how modifying them in line with these policy recommendations might improve their success. In order to do this, first the term "success" needs to be defined.

Often, success is measured in terms of outcomes, and in the case of health care, health outcomes. This thesis has evaluated decision-making and relationships associated with commissioning; it has not been about the health outcomes of commissioning. It is not therefore possible to assess the relative impacts of the case

studies' different styles of commissioning on the population's health. Instead, other definitions of success are needed. Multiple definitions are considered here.

First, a successful commissioning process could be seen to be one that has followed closely the process set by central policy. Briefly, central policy dictates that PCTs should act as principals to commission services from their collaborative NHS Trust agents through contracts called Service Level Agreements, with neighbouring PCTs as partners. Second, successful commissioning could be seen to result in the meeting of centrally imposed targets and frameworks. In this case, conforming to policy would be secondary. Third, a commissioning process that has been completed with low transaction costs could also be seen to be a success. Fourth, a process that provides the ability to make (rather than avoid) commissioning decisions could be viewed as successful. Here, there is a trade off between the speed of decision-making and the level of involvement of, and agreement by, all concerned. Fifth, a high level of staff morale may be considered an important measure of success. Short-term success in achievements may be offset by longer-term demoralisation.

Each of the case studies demonstrated success in different ways. The following discussion illustrates in which areas the case studies were most successful, and how making changes in line with the policy suggestions could help them achieve a higher degree of overall success. The policy suggestions are:

1. A greater use of incentives both as part of commissioning agreements between organisations and within each organisation.
2. Clearer lines of accountability and responsibility.
3. Greater openness by PCTs about their provider function and its costs.
4. Promotion of PCTs' roles as commissioners in preference to being guardians of partnership working.
5. Further training to improve the appropriateness of workforce competence.
6. Encouragement of joint working only where the conditions are appropriate.
7. Encouragement of policy implementation rather than the status quo.
8. Use of StHAs as regulators and arbitrators.

Case study A was not successful in following the commissioning process set out in central policy. Although the appropriate processes appeared to be followed and the appropriate documents were signed, the Health Authority, not the PCT, led the process. There was no collaboration between the commissioner and provider; the provider was expected to supply the services that the commissioner requested. The process was one that resembled a hierarchical, intra-firm agreement rather than a quasi-market principal-agent relationship between two firms. If the government rated success by *how* commissioning results were achieved, this case study would have failed. However, this case study did appear to be successful in achieving central targets. There was a history in the case study area of, in the main, achieving waiting time targets and financial balance. If the government were concerned about achievement more than process, this case study would be a success. Likewise, if low transaction costs of commissioning are considered a success, case study A appeared to be more successful that either B or C. This measure is, however, using a loose measure of transaction costs, that is, the number of major commissioning meetings and attendance at those meetings. Consideration of the fourth criteria, the ability of the system to result in decisions, suggests that case study A was successful here also. However, the ways in which agreements were reached were not inclusive and conflict with the fifth success criteria of maintaining staff morale. The hierarchical system of commissioning excluded debate and negotiation between the parties concerned. This failure is linked to the failure to comply with commissioning policy, which includes collaboration and partnership working. It was perceived also as being very "command and control" and as being lead by the managers' drive to meet targets with little room for clinical input. This augmented the low morale of NHS Trust clinicians. Managers did not demonstrate low morale, but did feel constrained by the local system.

Case study A therefore failed on two main points. It did not follow the commissioning process outlined in policy (including a failure to involve fully all parties to agreements) and it failed to maintain a high level of morale amongst its NHS Trust clinicians. The question must then be asked, if case study A were modified in line with the policy recommendations suggested, would it be considered, overall, more or less successful than at present?

Turning to case study B, the PCTs did act as principals, collaborate with the NHS Trust and work in partnership with each other. The PCTs agreed between themselves their joint objectives before entering negotiations with the NHS Trust. Once negotiations had begun, efforts were made to obtain agreement by all concerned with the commissioning decisions, but where this was not possible, the PCTs were aware that, as commissioners and budget holders, they should have the final say. As such, they were successful if success is measured as complying with policy. However, they were less successful than case study A in achieving financial balance or waiting time targets. Organisations in case study B had large debts and were failing to meet some waiting time targets. As for transaction costs, commissioning in case study B took place in monthly meetings attended by a number of very senior staff from each organisation. Compared to case study A, transaction costs appeared to be higher. There was no advantage over case study A in terms of the group's ability to make commissioning decisions. Both seemed able to reach agreements; case study A was quicker in doing so. However, in case study B, decisions were made in a more inclusive manner. Prior to the main commissioning meetings, two meetings were held at the NHS Trust for primary and secondary care clinicians to debate and agree priorities. Some clinicians also attended some commissioning meetings. Perhaps as a result, morale appeared, from managers and clinicians interviewed, to be higher than in case study A. However, it must not be forgotten that PCT B and NHS Trust B failed to sign a Service Level Agreement for 2002/3. This was still in draft in June 2003, three months after the end of the financial year, due to an inability to agree certain finances.

Case study B therefore failed on two criteria also: it failed to meet centrally imposed targets and it failed to operate within minimal transaction costs.

Finally, case study C. With regard to complying with commissioning policy, case study C complied in as far as collaboration and partnership working were concerned, but failed to take on the role of principal and failed to write a contract for the delivery of agreed services. (They used instead the SaFF document for reference.) They failed also to meet national access and financial targets. For this criterion, they were the least successful of the three case studies. However, NHS Trust C had financial and access problems prior to the creation of PCT C and its neighbours. If the government used either of these criteria to judge success in commissioning, case

study C would fail. In addition, this failure was accompanied by what appeared to be high transaction costs and an inability to make decisions. Although only one individual per organisation normally attended commissioning meetings, on occasions the commissioning meeting was held jointly with the finance meeting, a series of meetings running in parallel. There were therefore some hidden costs as commissioning decisions could only be agreed once the finances had been agreed also. The two sets of meetings were therefore dependent upon each other. Moreover, the number of meetings held was often bi-weekly and at times weekly. Despite this, commissioning decisions were often not reached with PCT managers being accused of "*ostrich management*". Management morale appeared higher in the PCTs than the NHS Trust. Clinical morale appeared higher in the NHS Trust. All interviewees felt trapped by the financial context of their organisations.

Case study C therefore failed on all the stated criteria, but retained hope. If the policy recommendations suggested were implemented in these case studies, what would be the result?

First, what would be the effect of introducing incentives, both between PCTs and NHS Trusts as part of the commissioning process and internally for both organisations? None of the case studies were using incentives related to commissioning. If incentives for commissioning were introduced in line with *Reforming NHS Financial Flows*, rather than "command and control" in A, the NHS Trust might realise greater freedoms in how to achieve the commissioner's objectives. However, PCT A had traditionally been funded generously (that is, over its target fair allocation). This generous funding would have been passed on to the NHS Trust in the past. Under *Reforming NHS Financial Flows,* the same prices are to be paid to all hospitals, regardless of their costs or past funding. It is likely therefore that NHS Trust A would see a reduction in its funding which may result in difficulties in maintaining its performance in relation to targets. In C, however, the opposite would apply. Organisations in case study C had been funded well below their target allocation. NHS Trust C should therefore receive more funding under the *Reforming NHS Financial Flows* rules and may as a result increase its ability to meet central targets. However, this could happen only if the PCTs were funded in line with their target allocation, otherwise the PCTs would not be able to afford to maintain current service levels, and targets would not be met. PCT B was funded

about on target and NHS Trust B had average reference costs and so this policy would make little difference to success in achieving targets.

As for internal incentives in NHS Trusts, these should give NHS Trust clinicians a greater say in how they think the objectives should be reached. Staff morale, particularly in NHS Trust A, should increase as a result of these greater freedoms. However, transaction costs may rise as more individuals from the different tiers of the organisations are involved in decision-making, and decisions themselves may be harder to reach. However, once decisions are reached, implementation should be more successful.

Turning to accountabilities, in B and C, the NHS Trusts were answerable to their health authorities, and both health authorities and PCTs were responsible for ensuring the NHS Trusts' provision of services. However, PCTs had little power other than through commissioning discussions. In A, the NHS Trust was accountable to and commissioned by its Health Authority. The PCT had no role in commissioning. Making PCTs responsible for NHS Trusts' delivery of services could work only if PCTs introduced incentives. If PCT A were made responsible for the provision of local services and the meeting of national targets by NHS Trust A, but NHS Trust A was made answerable to the StHA, the current strong hierarchical structure would be lost. This would be replaced either with a flatter structure where the PCT and NHS Trust collaborated as equals or by another hierarchical structure where the PCT attempted to act in place of the Health Authority but without its legitimacy. The result of that may be that there would be a loss of control over the NHS Trust that, without the use of strong incentives, could compound into a loss of control over financial balance and the achievement of targets. In B, the situation would not change dramatically; perhaps the only improvement would be that the PCTs would have greater authority over the NHS Trust. PCTs in B, however, felt already that they had that authority by virtue of being commissioners. In C, the PCTs would be forced into taking on more responsibility. That could improve the commissioning process, particularly with respect to compliance with policy processes and the achievement of local and national targets.

NHS Trusts in B and C mistrusted the PCTs over their allocations to their own provider services. These allocations are important because both organisations serve the same populations and the provision of care by one impacts on the other.

Openness about the levels of these allocations, why they have been decided and how the funds will be used can only improve relations. The problem had not been an issue in A due to the commissioning structure. A greater understanding of other organisations needs and plans could help to increase collaboration and joint planning, thus compliance with policy processes and perhaps achievement of targets.

PCT C was more successful in promoting partnership working than in taking responsibility for commissioning, and as a result was not prepared to take difficult decisions. Encouraging PCTs' lead roles in commissioning should help to combat some of the indecision in case study C. If PCT C took the lead in defining the direction of development for the local community, and if it stated these intentions in a contract, backed up by financial or other incentives for the NHS Trust, then decisions could be made earlier. Indeed, NHS Trust C stated that it had reluctantly had to take a leading role in decision-making to fill the void left by the PCTs. PCT C intended to implement a system of commissioning lead by clinical champions. If this succeeds, it may fill that void. PCT B felt already that it had the right to take the final decision in commissioning; the balance between partnership working and leading commissioning appeared about right. PCT A had not had the chance to explore these trade-offs but given the strength of its Health Authority's backing and style, it is likely that commissioning would take priority over partnership working.

Although most respondents in these case studies felt that their colleagues were well trained and capable of undertaking their roles, additional training could help to hone skills in relation to commissioning. Of particular note, the Chief Executives of the PCTs and NHS Trusts in case studies A and B had all been trained through the NHS Management Training Scheme. Both PCT Chief Executives had held senior management positions in secondary care. None of the respondents in case study C had followed the same training route; the Chief Executive of PCT C had never worked in the secondary care sector. Support and training relevant to their commissioning roles could enhance effective working in case study C, however defined.

PCTs in C struggled also with joint working whereas PCTs in B did not. If the PCTs in C feel under less pressure to collaborate with each other for commissioning, they may be able to set objectives for their own PCTs and make decisions about their implementation individually with NHS Trust C. Decision-making would be speeded

up and the NHS Trust would be able to plan its delivery in a more timely fashion. Although the NHS Trust may find that meeting the different requirements of up to four PCTs difficult, it should be easier than dealing jointly with four commissioners who cannot agree objectives. PCTs could collaborate in the commissioning of certain services only.

Case study A was failing more than the other case studies to meet policy requirements with regard to the process of commissioning. This appeared to be as a result of a history of successful outcomes gained through the use of a hierarchical approach. A greater compliance with policy in A may result in a lesser achievement in terms of targets. It seems then that the Health Authority in case study A may have to allow the PCT to take some responsibility for commissioning and accept the risk of some deterioration in meeting targets. In case study C, the history of joint working and the problems of embeddedness were not stopping organisations from conforming to policy requirements for partnership working, but were created problems for leadership and taking responsibility. These issues could be addressed through training as discussed.

Finally, if the StHAs took on a role as regulator and arbitrator, the PCTs in each case study could be supported and encouraged in their commissioning role. The Health Authority in A was taking on this role already, although arbitration was not an issue given the commissioning structure. The health authority in B took a low profile in commissioning but their presence was felt (for example, they chaired an occasional meeting) when progress was slow. In C, the health authority also took a low profile, but a strong regulator and arbitrator could help the organisations to succeed in all the areas considered. If the PCTs were supported in accepting the legitimacy of their role as commissioners, compliance with policy and perhaps achievement of targets may increase.

5) Limitations of the research

This research has been undertaken in a period of change. Many researchers have struggled with the problems of evaluating policy in a changing and complex policy environment (Collins *et al.*, 1999; Le Grand *et al.*, 1998a; Leese *et al.*, 2001; Mays *et al.*, 2001a). The first PCGs were created in April 1999 and the first PCTs in April

2000. The PCTs in this study became PCTs in April 2001. The observations of meetings took place from November 2001 to March 2002 and the interviews from April 2002 to January 2003. The commissioning relationships in preparation for the financial year 2002/3 were studied. As a consequence, the year under study was, for these case studies, the first year in which they had undertaken the whole of the commissioning process as PCTs. Some of the phenomena observed may have been particular to this early phase of development. At the end of the data collection period, for the year 2003/4, PCT A in particular was expected to take on a different role; it was planned that PCT A would become more active in commissioning once the original Health Authority had been superseded by the StHA. However, the organisation of the other two case studies was not due to be changed. The fact remains that all three case studies were in the early stages of learning their new roles. The trust between the organisations and the feelings of legitimacy may increase with time and experience.

In addition, the policy framework within which the organisations were working changed also. During the research period, a number of major policy reforms relevant to commissioning were announced and initiated. These include the following: *Shifting the Balance of Power within the NHS: Securing Delivery* (Department of Health, 2001), *Shifting the Balance of Power: the Next Steps* (Department of Health, 2002d), *Reforming NHS Financial Flows* (Department of Health, 2002c), the new consultant contract (Department of Health, 2002a; Department of Health, 2003) and the inclusion of NHS Trust access times in the criteria for star-rating PCTs (see www.chi.nhs.uk/eng/ratings/). Each affected the ways in which the PCTs and NHS Trusts were working at the time of the research and planning to work in the future. Inevitably, these and future policy changes will alter the ways in which services are commissioned and delivered. This research has concentrated on relationships between organisations. The general nature of these relationships should remain and therefore the findings of this research should remain relevant despite detailed changes in specific areas of policy.

The sample of case studies was chosen according to a sampling frame and quota that depicted characteristics relevant to a principal-agent framework. This quota included one small and one large PCT, one rural and one urban, one with a level of funding below target and one above, one where PCTs had no choice of provider and

one with a choice, one where the NHS Trust dealt mainly with a single PCT and one where a number of PCTs used the same NHS Trust. Except for the size criteria, all of these conditions were met. Of the case study PCTs, one was average sized (23 practices), one slightly above average (27 practices) and one was very large (over 35 practices). None were small. One PCG and one PCT had declined to take part in the research. Both of these were smaller than average. The PCT comprised 13 practices and the PCG 19. The PCG declined to take part because they were in the process of merging with a neighbouring PCG. The PCT agree to take part but later declined because the PCTs with whom they collaborated for commissioning did not wish to have an observer present at commissioning meetings. In addition, the case study PCT of average size had been a small PCG of 16 practices but had recently merged. As a result of these mergers and refusals to participate, this research has not been able to consider the effect on commissioning of a very small organisation that potentially has increased flexibility in terms of being able to shift services between providers. Others (see Wilkin *et al.*, 2003) have, however, considered the relationships between size and performance in primary care organisations, and concluded that optimal size is likely to vary for different functions.

I have explored commissioning by following the SaFF process. Negotiation and agreement of the SaFF may not be considered by some to be synonymous with commissioning. In fact, one respondent commented that commissioning was something that went on in spite of the SaFF. However, in my initial approach to the case studies, I requested permission to observe the commissioning process and interview participants about that process. The Chief Executives of the PCTs, or their delegates, in each case study independently, directed me to the SaFF process. This suggests that, for them, the SaFF round was at least analogous to commissioning. In addition, the SLAs could be drawn up only after the SaFF had been agreed. In one case study the documents were identical. The SaFF process was the main process by which the PCTs in these case studies agreed what services the NHS Trusts were to deliver. Since the research took place, the SaFF process has been abolished and replaced with three year planning and priorities frameworks called Local Delivery Plans (Department of Health, 2002b). These are working documents that should be amended to allow for corrective action and new initiatives. They are community-wide plans, although PCTs are responsible for creating local plans to incorporate

community needs and national priorities, and each NHS Trust is responsible for creating its own plans which show how they will deliver national and local priorities "*and fit within the plans of its PCT commissioners*" (Department of Health, 2002b: 7). Despite having a different label, these plans are not dissimilar to SaFFs and necessitate joint working between, amongst others, PCTs and NHS Trusts. The results of this research are therefore pertinent to these new arrangements.

I considered, in the early stages of the research, looking at commissioning by specialty. This did not at the time, at these case studies, appear possible. Commissioning did not appear to take place at specialty level. As the research progressed, it became evident that there were discussions at a lower, sub-group level, but these discussions fed into the SaFF process and ultimately the SLAs were developed based on SaFF agreements, not negotiations around individual specialties. SLAs were not specialty specific but based on broader areas of care. These processes have changed for 2003/4. *Reforming NHS Financial* Flows (Department of Health, 2002c: 4) states that for "*at least 6 surgical specialties, SLAs should be set at specialty level*". For 2003/4 and 2004/5, the use of the standard tariff in specialty level SLAs is only for "*volume growth above 2002/3 SLA/plan level*" (Department of Health, 2002c: 18). By 2005/6, both baseline and volume growth services will be commissioned in this way. If the research were to be repeated now and in the future, the participants' experiences may thus be different. However, the broad issues, such as competing lines of responsibility, compliance by clinicians with commissioning decisions, levels of trust and problems of joint working, would likely remain.

I observed only meetings relating directly to the agreement of the SaFF, and only a proportion of those meetings in some case studies. Other smaller meetings and discussions between individuals took place that I did not observe. On a practical point, it was not possible as a single researcher to be present at all relevant discussions or to be party to impromptu meetings and telephone discussions. In addition, one PCT declined to take part in the research because the number of participants in their commissioning meetings was small and they were concerned that the presence of an observer would alter the dynamics. The fact that only the SaFF meetings were observed may mean that some important negotiations and methods of reaching agreements between organisations have been missed. However, in terms of making comparisons between the three case studies, my methods were

consistent. Each case study had their own style of agreeing the SaFF, but part of the reason for employing a case study design was to allow the testing of ideas relating to the same process in different settings.

A further limitation of the research is that only two consultants and two GPs were interviewed in each case study. The aim of the research was to concentrate on principal-agent relations between PCTs and NHS Trusts, not between managers and clinicians. Clinicians were chosen for interview to illustrate any similarity in or contrasting of views compared to management views. Clinicians did have different views to management and in this respect the decision to interview them was successful. However, the clinicians, and consultants in particular, also had views different to each other. Saturation point was reached for the management data, that is, no new themes were arising from the final management interviews, but the clinicians' views were not always consistent with each other and each provided some new themes. Saturation point was not reached for the clinicians. However, data gathered in the interviews showed that relations between NHS Trust management and consultants were an important step in the commissioning process. For this reason, the results chapter presented an analysis of "tier 3" in the principal-agent chain for commissioning. If the research had been designed specifically to concentrate on the principal-agent relations between NHS Trust managers and clinicians, a different design would have been adopted that included a wider range of consultant types with a wider range of experiences of commissioning. As a result, although the findings have discussed principal-agent relations between managers and clinicians in the NHS Trusts, this has been in an attempt to shed light on how these relations impact on the commissioning relationships and decisions between the PCTs and NHS Trusts. To gain a greater understanding of management control and the use of incentives in "tier 3" would need further research designed specifically for that purpose. Likewise, the research has not attempted to evaluate internal PCT relations between managers and GPs, although these also affect commissioning. The research has concentrated on one set of principal-agent relations in a complex web of such interactions.

This research has taken a case study approach and used qualitative techniques for data collection and analysis. These findings are therefore not generalisable in the sense that a quantitative evaluation based on a random sample of the whole

population of PCTs would be generalisable. Other evaluators have taken such approaches (Regen *et al.*, 2001; Wilkin *et al.*, 2002). The combination of characteristics of the three case study PCTs and their commissioning environments are unique to them. Other PCTs and the circumstances of their local commissioning will be very different. However, the case study PCTs were selected so that each characteristic individually would be apparent in other PCTs. The purpose of using a case study approach is to test theories in different situations in order to search for results that are meaningful and true in each situation. The findings of this research should therefore be recognisable not only to the case study PCTs but to other PCTs in England. This research generates a level of understanding that large scale quantitative evaluations are not able to generate.

Chapter Six: Conclusion

1) Introduction

Many studies have considered transaction costs, equity, efficiency, size, choice and accountability in the context of primary care organisations as purchasers, but no one to date has taken a principal-agent perspective of the commissioning relationships between PCTs and NHS Trusts. Little is known about the extent and nature of the relationships between PCTs as commissioners of secondary care services and their NHS Trust agents. This study has begun to fill this gap in knowledge by providing an in-depth analysis of the nature of these commissioning relationships.

The chosen research strategy has brought together case study research, qualitative methods and "realistic evaluation" (Pawson & Tilley, 1997). A case study approach has allowed the use of multiple sources of data to investigate contemporary phenomena in context, where the boundaries between the phenomenon and context are not clearly evident. The benefit of using qualitative research is that it is not necessary to specify a hypothesis at the outset (Silverman, 1993); instead, the method is interpretative, studies people in their natural settings, provides in-depth exploration of an issue, the understanding of processes, and seeks explanations of why and how phenomena occur. "Realistic evaluation" considers specific mechanisms and contexts in order to attempt to identify what works for whom under what circumstances.

Through the use of these methods I was able to carry out an in-depth evaluation of the commissioning relationships between primary care trusts and NHS Trusts in three case studies, using multiple levels of analysis (main PCTs, other PCTs, NHS Trusts, managers and clinicians). I used multiple sources of data (observations, interviews and documents) that were analysed using qualitative techniques to give insights into theory and policy.

2) Summary of study

This research explored the role of PCTs as commissioners of secondary care. Three case studies each comprising a main PCT and NHS Trust were selected using

information from nationally available databases. These were selected to vary in factors considered key to principal-agent relationships. These factors were PCT size, the urban/rural mix of its patients, the distance of the main PCT from its target allocation, whether or not the PCT had a choice of main provider and whether or not the PCT commissioned alone or with other PCTs. The case studies were recruited in the summer and autumn of 2001.

Data were collected from observations of meetings, interviews with managers and clinicians, and documentary evidence including copies of SaFFs and SLAs. The meetings that were observed were called commissioning meetings by the case study members; they were primarily to agree the Service and Financial Framework for 2002/3. Meetings were observed between November 2001 and March 2002. Interviews with managers that were key to this process were undertaken between April and September 2002. Primary and secondary care clinicians were interviewed about the commissioning process between August 2002 and January 2003. Interview and observation data were analysed using computer assisted qualitative data analysis software. Copies of SaFFs and SLAs were analysed in conjunction with the interview and observation data.

3) Summary of key findings

The key findings of this research are as follows:

1. PCTs do not always accept the legitimacy of their role as principal, that is, as commissioner of secondary care services. This is important as it undermines effective working even where NHS Trusts accept the PCTs legitimacy. Both principals and agents must accept the legitimacy of the principal.
2. Where principals do feel legitimate but where there are multiple principals, they need to have joint objectives or a mechanism for resolving such conflicts if they are to work together. Joint working is not appropriate where there are different objectives, where there is poor quality information, where there is a lack of trust between PCTs or where local capacity differs. Relationships between principals can be as problematic as those between principal and agent.

3. Relationships between NHS Trust management, and their directorates and clinicians may be as big a problem or more so than relationships between PCTs and NHS Trusts.
4. The dual nature of the principal's role affects directly the ability of the agent to achieve the principal's wishes. This arises because the PCTs do not act solely as principals; they have also an agent role. They are providers that provide services to the same populations as the NHS Trusts. Furthermore, PCTs control the funds that are allocated to each type of service provision. In this respect, PCTs are in direct competition for funds with NHS Trusts. These two roles can create a conflict of interests.
5. Too many conflicting pressures from national and local targets force organisations into prioritising the delivery of services that serve their own rather than the community's best interests. These pressures can undermine co-operation.
6. Multiple lines of accountability weaken the power of PCTs to ensure NHS Trusts meet commissioned agreements.
7. A public service ethos and awareness that the NHS is one large organisation can strengthen the joint interests of organisations, although the perceived best methods of achieving these joint interests may differ.
8. Local circumstances and history can dictate the degree and success of implementation of policy.

The policy recommendations are that:

1. there should be a greater use of incentives both as part of commissioning agreements between organisations and within organisations.
2. there should be clearer lines of accountability and responsibility.
3. there should be a greater openness by PCTs about their provider function and associated costs.
4. PCTs' roles as commissioners should be promoted in preference to their roles as champions of partnership working.

5. there should be further training to improve the appropriateness of workforce competence.
6. there should be encouragement of joint working between PCTs only where the conditions are appropriate. These conditions should be made explicit.
7. if the government is concerned about having a single system of commissioning throughout the NHS, organisations should be encouraged to implement policy according to guidance rather than adapting it to be a continuation of historical patterns of working.
8. StHAs should act as regulators and arbitrators.

4) Future research

This research has shed light on a number of important issues related to PCTs as commissioners of secondary care services. It has, however, illuminated also areas where further research would be of value.

The policy context within which the NHS works is changing frequently and, although the findings of this research will remain relevant to the general nature of commissioning, recent policy changes will affect specific areas. For example, the introduction of standard tariffs for the commissioning of key specialties as outlined in *Reforming NHS Financial Flows* (Department of Health, 2002c) will introduce financial incentives to the commissioning process and increase the level of monitoring of NHS Trusts' service delivery. The management costs associated with this monitoring may increase, and the co-operation and goodwill between organisations may decrease in response to contracts becoming more exacting. In addition, the commissioning decisions made by PCTs will need to be robust enough to withstand variations in demand and activity, and joint commissioning by PCTs may become more problematic as activity and finances must be disentangled. One of the limitations of the current research is that it was not able to consider commissioning or incentives related to individual specialties. This is now possible. Research to determine the best methods and outcomes of this new form of contracting is essential.

The current research has highlighted the fact that relationships between NHS Trust management and their clinical directorates and consultants may be as important for

commissioning and the implementation of decisions as those between PCT and NHS Trust management. Negotiations are taking place currently with regard to the new consultant contract. Whether or not a new contract is agreed in England, and whether it is implemented nationally or locally, research into the effectiveness of such internal control mechanisms and incentives is crucial. It is important also to understand how and why hospital doctors react to such measures. Of particular interest would be an understanding of how clinicians' motivations are affected by the use of incentives, financial or otherwise. Although consultants have to date rejected the new consultant contract in England, it may give them more freedoms for service development and local initiatives than the current system in which managers working within tight budgets are perceived as vetoing many proposals.

In a similar vein, this study did not consider the role of GPs as agents for PCTs. Compliance with commissioning decisions depends not only on the delivery of services by NHS Trusts but also on the management of demand by GPs. At the time the research began, few incentives were in place to encourage GPs to act in accordance with PCTs' commissioned activity. It would be interesting to see if this has changed and how well GPs are achieving these goals. In addition is the question of how active GPs are as principals, that is, how involved GPs are in deciding on the level of services to be commissioned.

Gender, leadership skills and historical patterns of working may all have played a role in the style of commissioning undertaken in these case studies. The interaction between and relative importance of these issues is not known. Given that respondents showed concern over the calibre of leaders and the government has created the Leadership Centre to resolve this issue, it is important to determine exactly what is required of PCT leaders and how training can best accomplish this.

This research has shown that there are multiple and conflicting lines of accountability and pressures to achieve targets, and that these weaken the ability of PCTs to ensure that NHS Trusts deliver commissioned services. *Improvement, expansion and reform* (Department of Health, 2002b) does not make the situation any clearer with respect to accountability. NHS Trusts are held to account by PCTs for the delivery of commissioned services and by StHAs for performance. It is not clear what levers PCTs have to hold NHS Trusts to account, nor how "commissioned services" differ from "performance". There is the added complication that PCTs'

star-ratings depend now in part on the performance (if performance includes the achievement of access targets) of NHS Trusts. NHS Trusts appear to be held to account by two organisations. The effect of this system, and the most appropriate organisation to which NHS Trusts should be locally and nationally responsible and answerable, needs to be determined.

Finally, with respect to principal-agent theory, the agent's ability to meet the principal's requirements is assumed usually to be affected by the agent's actions, the agent type and random, exogenous factors over which neither agent nor principal has control. The assumptions of principal-agent theory state that the agent knows the first two of these conditions and may know the third. The principal may not know any. This study has shown that when applied to health care organisations in the NHS, an additional factor can affect an agent's output. That factor is the behaviour of the principal, arising from the principal's additional role as agent. The actions of the principal affect the needs of the population to which the external agent must deliver care. Information asymmetry is reversed; the principal knows their own actions in advance but the agent may not. If the formal model of agency is to be applied to health care, this issue should be considered.

Appendix 1

Summary of postal survey of primary care groups and trusts

This appendix reports one part of the findings from a survey undertaken in 2001. The survey was designed to ascertain general information about principal-agent relationships associated with commissioning and detailed information about methods used by PCG/Ts to influence GPs. Findings relating to the devolution of budgets and responsibilities to PCG/Ts are reported in the Health Service Journal (Baxter *et al.*, 2002). The results reported here relate to the use of incentives within PCG/Ts. Further details are available in an unpublished project report (Baxter *et al.*, 2001).

Methods

This study was funded by the South and West NHS Executive region in England and focused on the PCG/Ts within that area.

Data were collected by postal questionnaires in February 2001, with a small number of interviews in October 2000 to help develop the questionnaire and in summer 2001 to shed light on issues arising from the questionnaire.

Initial interviews lasted between 45 and 90 minutes each and covered the following:

1. The context within which PCG/Ts were working, including the division of responsibilities between health authorities and PCG/Ts, the devolution of management responsibilities and budgets, and progress in the development of commissioning arrangements

2. The availability of routine data such as variations in referral rates and demographic information.

Pilot questionnaires were sent to four Chief Officers within and a GP Chair outside the southwest. Minor changes were made and the final version of the questionnaire was posted to all remaining PCG/Ts in the southwest on February 5th 2001, with a

postal reminder on February 22nd and a telephone reminder during the week beginning March 12th. The deadline for return of questionnaires was March 31st.

The final version of the questionnaire consisted of eight sides of A4 and was comprised of mainly closed questions, with a small number of open questions to allow respondents to explain some issues. The questionnaire had five sections: basic characteristics, the budget, perceptions of working together, hypothetical problem scenarios, and incentives and activity management.

A small number of GPs were interviewed as a follow up to the questionnaire: three who held official roles within their PCG/Ts and two with no official involvement. There were two aims to these GP interviews: first, to give a greater understanding of the use of incentives and other mechanisms designed to affect GP behaviour and second, to determine the feasibility of making comparisons between GPs and NHS Trusts as agents for PCTs.

Questionnaires were analysed using the statistical analysis software STATA. No comparisons were made between PCGs and PCTs due to the small number of PCTs (four).

Results

The postal questionnaire was sent to all 49 PCG/Ts in the South West region in February 2001. Twenty eight (57%) completed questionnaires were returned. Three were completed on behalf of two PCG/Ts jointly. Information was therefore received about 31 (63%) of a possible 49 PCG/Ts. Percentages are based on the number of valid responses (maximum 28) to individual questions. The majority (24, 86%) of respondents were level 2 PCGs. Four were PCTs; one of these was a level 3 trust, the remainder were level 4.

The results reported here relate to the section of the questionnaire on incentives and activity management. It asked about any incentive schemes or other methods used by the PCG/Ts to influence their patterns of activity use and to encourage GPs to be aware of the financial implications of their decisions. The questions were presented in four sub-sections relating to different types of incentives and controls. The first sub-section aimed to find out about the prevalence of financial incentives. The second considered the availability of other, practice-based, services as a way of

minimising the use of secondary care services. Third, controls were considered in the form of rules and regulations. Finally, the questionnaire asked about motivating GPs and practices.

Table 1 shows the use of financial incentives to manage activity and budgets.

Table 1 Financial incentives to help manage activity and budgets

	In place	Under consideration	Considered but rejected	Not yet considered	Total number of responses
National incentive scheme for prescribing and commissioning	13 (50%)	1 (4%)	4 (15%)	8 (31%)	26
Additional funds given if targets achieved	6 (27%)	4 (18%)	0	12 (55%)	22
Under spends can be carried across years	4 (19%)	3 (14%)	2 (10%)	12 (57%)	21
Practices have autonomy in deciding how under spends are used	4 (17%)	4 (17%)	2 (8%)	14 (58%)	24
Funds can be moved between budgets and services	3 (14%)	7 (33%)	1 (5%)	10 (48%)	21
Access to additional funds withdrawn if targets not reached	0	6 (27%)	4 (18%)	12 (55%)	22

A striking finding was that, except for the national prescribing and commissioning scheme, around half of the PCG/Ts had not considered the introduction of any form of financial incentive scheme. A possible reason for this is that PCG/Ts were at the time concentrating their efforts on other aspects of their large agenda. Indeed, the Tracker Survey of PCG/Ts reported that PCG/Ts were concentrating their efforts in the areas of organisational development, primary care development, clinical governance and relationships with other agencies (Wilkin *et al.*, 2001).

Half of all PCG/Ts stated that they were using the national incentive scheme for prescribing to include commissioning. Although the question asked specifically about commissioning, it is not possible to tell whether those stating that they were using the scheme were using it for commissioning as well as prescribing, or for prescribing alone. It seems unlikely that they were using the scheme for commissioning as only one had any practice level budgets. Three PCGs did state that their answers for the section on financial incentives referred solely or predominantly to prescribing; it is likely therefore that the results are an overestimate of the importance of financial incentives in managing commissioning activity and budgets.

Interview data appeared to support the findings, with a belief that financial incentives were the best way to engage GPs (*"money would incentivise me"*) but that they also stored up problems for the future (*"if you use the incentive to prime a service, the backlash when you remove that incentive is high"*).

Another reason why only half of the PCG/Ts were using financial incentives may be related to the view that driving change through financial incentives results in change for the wrong reasons, and perhaps the wrong kind of change. One PCT was *"actually creating a financial incentive for patients not to be referred ... but without there being an alternative"*.

To avoid some of these perceived problems, one view was that it was preferable to reward GPs and practices for setting up systems, reviewing patients, or learning the skills to undertake these activities, rather than paying for achieving specific outcomes or targets: *"We gave them money to start and then money to complete successfully."* Others mentioned "*cash for change*" policies and pump-priming money as incentives.

The interviews revealed that rewards were not always paid by, or initiated from, primary care. The pressure on NHS Trusts to meet access targets meant that they were asking GPs to help by reviewing waiting patients, and rewarding them for this: *"£10 to £15 for doing that and sending it back whether that took them off the list or not"*.

A limitation of financial schemes, particularly for prescribing, was the general lack of resources. A number of respondents complained that their health authority or

PCG/T was massively overspending on prescribing, resulting in payments to practices under the prescribing incentive scheme being unable to be made: "*[the] prescribing incentive scheme is a joke*" and *"we haven't got any money"*.

The second sub-section on incentives asked about the options available to practices as an alternative to referral to hospital services. These are shown in Table 2. Many practices would have had practice-based services (for example, outreach clinics) as a result of fund-holding.

Table 2 Availability of alternatives as a means of helping to manage activity and budgets

	In place	Under consideration	Considered but rejected	Not yet considered	Total number of responses
Individual practice based services (as a substitute for hospital services)	16 (62%)	7 (27%)	2 (8%)	1 (4%)	26
Shared practice based services (as a substitute for hospital services)	14 (52%)	13 (48%)	0	0	27
Inter-practice referrals	12 (46%)	9 (35%)	2 (8%)	3 (12%)	26

The interview data also suggested that creating alternative services, such as GP or nurse specialists, was important, either linked with financial incentives or as incentives in themselves.

The third section (see Table 3) showed that many rules and regulations were in place or yet to be considered; few had been considered and rejected. For those options that involve the authorisation of referrals, it is not known from the questionnaire who makes the authorisation - the practices, PCG/Ts or health authorities.

Table 3 Rules and regulations to help manage activity and budgets

	In place	Under consideration	Considered but rejected	Not yet considered	Total number of responses
Authorisation of referrals outside main SLAs	19 (73%)	2 (8%)	2 (8%)	3 (12%)	26
Adherence to guidelines and protocols	14 (54%)	10 (38%)	0	2 (8%)	26
Authorisation of expensive referrals	12 (48%)	1 (4%)	3 (12%)	9 (36%)	25
Authorisation of tertiary referrals	11 (46%)	3 (13%)	2 (8%)	8 (33%)	24
PCG/T manages waiting times	5 (22%)	5 (26%)	1 (4%)	11 (48%)	23
Limits on numbers of outpatient follow up visits	3 (13%)	8 (35%)	1 (4%)	11 (48%)	23
Restrictions on quantity of referrals (ceilings)	2 (9%)	4 (18%)	3 (14%)	13 (59%)	22
Authorisation of referrals made by locums	0	2 (8%)	0	22 (92%)	24

The interview data suggested that GPs and managers within the PCT made some decisions internally, for example in out-of-area treatment groups; other decisions were imposed by the local health authority.

The final sub-section asked about motivating GPs and practices to manage their referral activity, predominantly through the provision of information. The results are shown in Table 4. Peer pressure, informal feedback on practice and GP activity, and written feedback on practice activity were most common. Few PCG/Ts were providing written feedback on GPs' activity. The majority (64%) had not yet considered supplying information about the cost of activity in secondary care, rather than supplying information on activity alone.

Table 4 Motivations used to help manage activity and budgets

	In place	Under consideration	Considered but rejected	Not yet considered	Total number of responses
Education of GPs	18 (72%)	5 (20%)	0	2 (8%)	25
Peer pressure	12 (52%)	6 (26%)	0	5 (22%)	23
Informal feedback on practice activity	12 (52%)	5 (22%)	0	6 (26%)	23
Written feedback on practice activity	11 (46%)	5 (21%)	1 (4%)	7 (29%)	24
Informal feedback on GPs' activity	10 (43%)	7 (30%)	0	6 (26%)	23
Written feedback on GPs' activity	4 (17%)	8 (35%)	1 (4%)	10 (43%)	23
Provision of information on cost of secondary care	3 (14%)	5 (23%)	0	14 (64%)	22
Education of patients	2 (9%)	7 (30%)	0	14 (61%)	23

The interview data suggest that the use of the word "incentive" tends to lead people into thinking about financial incentives, but, consistent with the survey finding that non-financial schemes were common, respondents emphasised the benefits of non-financial schemes: "*The reward doesn't have to be money*" and incentives can be "*peer pressure, don't have to be financial*". GPs stressed the importance of improving the care (and speed of care) for their patients, and of improving their own working environments: *"We [are] quite often incentivised in 'your patient will get seen sooner' terms"* and also through "*an improvement in your working environment*".

On the whole, the interviews supported the findings from the questionnaire: incentives are helpful in encouraging change, although organisations should be wary of relying on purely financial incentives.

Conclusion

It was not clear that GPs were acting as agents for PCG/Ts. Incentives for their control were not widespread. The range of incentives and other methods of control to encourage GPs to use HCHS activity in line with the PCG/Ts' wishes was not well developed. The use of financial or other formal incentives was particularly uncommon. Half the PCG/Ts stated that they were using the national incentive scheme for prescribing extended to commissioning. This is probably an over estimate; only one had the indicative practice-level budgets necessary to run the scheme. Non-financial incentives were used more commonly than financial ones. Education, peer pressure and feedback on activity were common methods to try to influence GP behaviour.

Appendix 2

This is an example of a topic guide. It is designed for interviewing PCT managers. The topic guides for managers from other organisations and for clinicians differed only slightly.

Topic guide for interviews

Commissioning process: PCT perceptions

This is a PhD research study funded to explore the commissioning process in the NHS.

The aim of the research is to provide information that will help to improve the understanding and operation of the commissioning process.

Specific objectives of the research are to:

- *consider the effect on commissioning of organisations' objectives (including whether they are always self-interested) and the way these are met*
- *assess the effect on the process of information availability and asymmetry*
- *examine the roles of the organisations – particularly perceptions of power, legitimacy, mutual dependency and third parties*
- *consider the impact of targets and monitoring (including incentives) of, or by, other organisations.*

Study design

The study has already included observations of meetings between PCTs and NHS Trusts, and will involve in-depth interviews with some participants of those meetings and, later, with clinicians. Three PCTs were chosen as case studies. Interviews will be with members of these PCTs, their main acute NHS Trust providers, and other organisations that have been involved in commissioning issues. These respondents should provide a broad range of views and information about the process.

April 2002

Commissioning process: PCT perceptions

1. Background/experience [BRIEF – 5 minutes]

- Respondent's position and responsibilities
- Involvement in commissioning
- Previous posts – what and which organisation type
- Views of SaFF process/meetings – general, how they went
- Distinctions between the SaFF and the SLA – their own views/definitions

2. Objectives and meeting those objectives [10 minutes]

- What are their objectives? Why?

  PROBE: financial break even, monitoring & targets, government influence, high/best quality services, reputation/centre of excellence/expansion
  PROMPT: minimum requirement of PCT (reservation utility)

- What do they think the objectives of the NHS Trust are?

  PROBE: joint/whole community objectives v. self-interested
  PROMPT: minimum requirement of NHS Trust (reservation utility)

- How are their objectives determined and then discussed? Why this way?

  PROMPT: within own organisation, with other organisations

- How do they try to make sure their objectives are met? (LINKS WITH MONITORING)

  PROBE: whose objectives are most important to meet – own, other, govt?
  how are any risks shared? (financial or not meeting objectives)

- Do they think, on the whole, that their objectives are met, or that, on the whole, the other party's objectives are met? (Who wins?)

  PROMPT: Do they see a conflict between the objectives of the PCT and the NHS Trust?
  How are any conflicts resolved?

3. Information asymmetry and availability [10 minutes]

- What kinds of information do they feel they need for the commissioning process? How accessible/available is this?

  PROBE: own, others', activity, finance, quality, plans, risks, modelling assumptions, previous year's achievements, effort/action

  PROMPT: modelling assumptions (knowledge of relationship between effort/exogenous to output)

- In what circumstances do they share all information with the NHS Trust, and when are they tempted to keep some back? (A to P sharing?) Why these circumstances?

  PROMPT: for examples of circumstances changing to benefit themselves, but where they did not feel the need to tell the NHS Trust?

  e.g. (exogenous change) mid-year change, policy or target change, staff changes, donations, other purchasers/providers, purchasing private care

  - What if the change was to their detriment, not benefit?

  - How easy or difficult would it be to keep information quiet, if desired?

- What examples are there of the NHS Trust planning/implementing a change that the respondent was not aware of at the time?

  - how did they feel about this?

4. Roles –power, legitimacy and mutual dependency [10 minutes]

- How do they feel about discussing the NHS Trust's provision of services & finances with them?

  PROBE: internal management, directorate or practice (agent) compliance, financial, service delivery

  Does they think they (the PCT) have a right to do this? Also a right to monitor performance?

- If they have no alternative/one main provider, do they think this changes they way they work together? Vice versa. Why?

  PROBE: impact of single/choice of provider/PCT (multiple principal/agents)
  PROMPT: does it make them more or less willing to solve difficult issues, be the first to offer solutions?

- How willing do they think the NHS Trust is to accept help from them? (shared responsibility). How willing is the PCT to give help?

  PROMPT: to achieve targets, financial balance

- Who leads in the design of SLAs? Does that feel right? Why/why not?

PROMPT: what if Trust not happy with it? (passive or active agent)
- Who generally dominates commissioning discussions?
- Who generally dominates development of SLAs?

- If there is a hierarchy of organisations, where do they see themselves?

  PROMPT: above or below NHS Trusts?

  If <u>not</u> a hierarchy, what is the current set up? Is it right? Why/why not?

- Is the current set up in the NHS the best way to meet their objectives?

  PROBE: perceptions of the NHS Trust's feelings on being led by GPs, immature/small/new organisations, is it a 'primary care led' NHS?

5. Targets and monitoring of, or by, other organisations [10 minutes]

FINAL SECTION -

- How does the PCT try to stay aware of what the Trust is doing and how close they are to meeting the PCT's requirements?

  PROBE: what do they monitor (effort/action), how often, how easy?
  How this monitoring makes them feel - powerful, uncomfortable?

- How does monitoring help the achievement of objectives?

  PROMPT: PCT's own and NHS Trust's

- Do they think should be monitoring the NHS Trusts? Why?

- How do national targets & guidance affect the commissioning process?

  PROBE: effect of external pressures on ability to commission, constraints on the right to commission/make choices
  PROMPT: local and media pressures, reference costs & benchmarking

- In conclusion, any other points they would like to make?

Thank the respondent
Re-affirm confidentiality and anonymous reporting
Explain again how the data will be used

Appendix 3

List of codes used for analysis of data

This appendix gives a comprehensive list of the codes with which text from the observation and interview transcripts was labelled.

The following codes were developed from "free codes", created, in the first instance, prior to analysis and based on the key elements and assumptions of principal-agent theory. Many of the original codes were modified, merged or expanded as the analysis progressed.

agent - active
agent – passive

behaviour - output relevant/process irrelevant
behaviour - shared decisions
behaviour - shared information
behaviour - unshared decisions
behaviour - unshared information

contracts do matter
contracts don't matter

dependency

effort - reason for
effort - assumptions about
effort - type of
effort/outcome relationship

external/third parties

incentives -
incentives/levers/sanctions
incentives - threats from above

information asymmetry - agent effort
information asymmetry - agent type/adverse selection
information asymmetry - uncertainty/state of the world

legitimacy

multiple principles
multiple/choice of agents

objectives - clinicians
objectives - government/must do's
objectives - HA
objectives - NHS Trust
objectives – PCT

power - agent
power - other
power - principal
power – professional

risk

These codes were created as it became apparent from the data that these issues were important.

agenda - joint
agenda - self-interest/own
agenda - tertiary services

agent's agents

attitude - 'us and them' mentality
attitude - frustration with partners

attitude - gap in understanding
attitude - it's not my fault
attitude - trust
attitude – willingness

barriers to sharing

behaviour - avoiding decision-making
behaviour - clinical relationships
behaviour - communication
behaviour - creeping commissioning
behaviour - inactive principal
behaviour - micro-management
behaviour - monitoring

benchmarking

capacity/referral modelling
catalysts to sharing
clinical roles

conflict - commissioner/provider conflict
conflict - competing pressures
conflict - recovery and modernisation
conflict – resolution

context - context
context - past experiences
context – tradition

definition - commissioning
definition - SaFF
definition – SLA

feeling - de-motivation
feeling - disempowered
feeling - empowerment
feeling - engagement
feeling - mission impossible
feeling – ownership

finances - cost pressures
finances - deficit
finances - funding constraints
finances - general
finances - ring fenced
finances - sources of funding

immature organisations
in the driving seat

information - desired
information - good standard
information - poor standard
information - rejection of
information - use of
information overload
information vacuum

left hand doesn't know...

managing expectation

organisational sophistication
own preconceptions

PA role reversal
patient pathways/networks
PCT's own agents
PCT's own services

people - leadership style/personality
people - personal relationships
people - treacle layer
people - workforce calibre

power - games
power – vacuum

prioritising
private sector

reference costs
responsibility - collective
responsibility - confused
responsibility – single

setting the ground rules
single agent - effect of
status/hierarchy

system - accountability/performance management
system - conflicting messages
system - cross boundary decisions
system - organisational boundaries
system - partnership
system - policy commitments
system - views of the system

time pressures

targets - clarity
targets - feeling trapped

These codes were applied to observational data only and were designed to mark examples of specific events or participants in SaFF meetings. These codes were applied in addition to those given above.

meeting - lack of preparation
meeting - agreement
meeting - casual
meeting - clinician agent
meeting - clinician principal
meeting - conciliation
meeting - defensive
meeting - disagreement
meeting - disarray
meeting - HA principal (A only)
meeting - inpatients
meeting - manager agent
meeting - manager principal
meeting - outpatients
meeting - principal's principals
meeting – tension

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