Development and Organizational Change in Primary Care:
A Study of Local Health Groups in Wales 1999-2001

Stephanie Ross Williams
School of Social Sciences
Cardiff University

Thesis submitted in fulfilment of the requirement for the degree of Doctor or Philosophy

June 2008
Declaration

This work has not previously been accepted in substance for any degree and is not concurrently being submitted for any degree.
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ACKNOWLEDGEMENTS

The environment in which this study was conducted was a turbulent one in Wales: politically, professionally and personally. A new devolved Assembly government brought organizational changes which directly affected the research, the researcher and the researched. The study commenced under the auspices of the Medical School, within a Department that prided itself on excellence in teaching quality. Nonetheless being sited there was an enormous asset in terms of enlisting participants in to the study. I am grateful to Professor Tom Hayes for his encouragement, and Professor Roisin Pill for providing advice, too. Halfway through the study, the Medical School and the University merged, affording me the opportunity to acquire more formal supervision arrangements. The contrast was marked: the experience of working with Professor Gareth Williams emphasized the crucial role that a good supervisor plays throughout the process of designing a study, and undertaking the analysis. Perhaps even more important, for me, though, was the continued support through a long series of adverse personal events which occurred between 2000 and 2007. My husband deserves much of the credit for the fact that this piece of work has emerged at last: he has lived with it and remained supportive and encouraging through nearly a decade of hearing about it. My lovely family, too, have been unfailingly supportive, if a bit puzzled about the why of it all. But special thanks are also due to the Chairmen themselves: their willingness to participate in this study, and to stay the course throughout the more pressing concerns of their professional lives, was humbling, and earned my enduring gratitude, admiration and respect.
This study was designed to explore organizational change in primary health care, specifically the introduction of Local Health Groups which were meant to create radical change at local level across Wales. The aim was to gain a better understanding of the factors that influence the formation and development of organizations receptive to change. The specific questions included: firstly, what structural and organizational changes were made for the promotion and development of Local Health Groups? Secondly, what leadership behaviours did the selected health professionals apply to their roles as Chairmen, in terms of building organizations capable of change and development? And thirdly, what lessons can be learned for leadership and organisational reform, and policy implementation at local level for the future?

The policy decision to devolve decision-making in health care to primary care professionals at local level provided the opportunity to conduct a prospective study. A case study approach was selected to explore the experiences of all 22 Local Health Groups, through the reported experiences of the Chairmen as the lead figures responsible for forming and developing the new organizations. Data were collected using three waves of face-to-face interviews, supplemented with Minutes of Board Meetings tracing the study period: April 1999 to October 2001. Some limited observation of key events was also carried out.

The study was conducted at a time of considerable turbulence in the health system in Wales. Firstly, it appears from this study that the structural changes made to implement the new policy were inadequate to that task. But some Chairmen appeared to exercise specific skills that enabled them to manage the consequent uncertainty in the system more comfortably than others. In addition, key leadership behaviours appeared to influence the development of change promoting organizations. These included strategic vision: the ability of the lead figures to articulate an attractive vision of the future, and persuade others to pursue it. Secondly, the ability to forge constructive working relationships with a wide variety of stakeholder organizations proved to be pivotal. Thirdly, the ability to identify key features of the organization and build on them to create unique organizational identities and services emerged as a key leadership behaviour in this context.
"I am not a cynic but I do know that history is the propaganda of the victors....I know that the Duce has made it clear that the Greek campaign was a resounding victory for Italy. But he was not there. He does not know what happened. He does not know that the ultimate truth is that history ought to consist only of the anecdotes of the little people who are caught up in it."

Carlo Piero Guercio, p 33, de Bernieres, Louis, 1995 *Captain Corelli's Mandolin*, London: Minerva (Martin Secker & Warburg)
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### Glossary

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<tr>
<td>CDM</td>
<td>Chronic Disease Management</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Council</td>
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<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
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<tr>
<td>FHSA</td>
<td>Family Health Services Authority</td>
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<tr>
<td>GM</td>
<td>General Manager: LHG's Chief Officer</td>
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<td>GMP</td>
<td>General Medical Practitioner</td>
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<tr>
<td>GP</td>
<td></td>
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<tr>
<td>HA</td>
<td>Health Authority: there were 5 in Wales in 1999</td>
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<tr>
<td>HIPs</td>
<td>Health Improvement Plans</td>
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<tr>
<td>LA</td>
<td>Local Authority</td>
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<td>LHA</td>
<td>Local Health Alliance</td>
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<td>LHG</td>
<td>Local Health Group</td>
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<tr>
<td>LMC</td>
<td>Local Medical Committee</td>
</tr>
<tr>
<td>NAW</td>
<td>National Assembly for Wales*</td>
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<tr>
<td>NSF</td>
<td>National Service Framework</td>
</tr>
<tr>
<td>OOH</td>
<td>Out of Hours Co-operative arrangement</td>
</tr>
<tr>
<td>PCO</td>
<td>Primary Care Organization, later Primary Care Trust (English model)</td>
</tr>
<tr>
<td>WAG</td>
<td>*Welsh Assembly Government referred to as NAW until 2003</td>
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Map of LHGs in Wales: LHG and LA boundaries within Health Authority Areas 1999-2003

Wales

Health Authorities
Chapter 1  Introduction

1.1  Context

Primary Care is the cornerstone, indeed the flagship, of the UK health care system (Starfield et al 2005). For most people, in Britain, primary care embodies the health care system, comprising the totality of their personal experience of health care throughout their lives (Williams et al 1997). Despite this centrality, primary care has traditionally been viewed as the ‘country cousin’ to sophisticated high technology acute specialist hospital care. But, since the 1980s, when inflation began to rise rapidly in the health sector, compared to other sectors of the economy, policy makers have become increasingly focussed on the potential roles that primary care could make to improving the quality and the efficiency, as well as the effectiveness, of the overall health care delivery system.

These inflationary pressures, sparked partly by the rapid rise in expensive new health technologies, added to the existing imbalance between demand and supply that had bedevilled the NHS since 1947, despite the best intentions of Aneurin Bevan. Changing demographic patterns towards a higher proportion of older people living longer, producing, arguably, higher dependency ratios have also contributed to increased demands for health services. In addition, health care policies across the UK, since the 1990s, have been designed to strengthen public involvement in
service delivery and quality monitoring by promoting consumerist behaviour. One effect of this approach had been to raise public expectations of health service treatments higher than available resources could deliver. In Wales, this imbalance between supply and demand was exaggerated further by historical patterns of relatively high demand for acute services (Drakeford 2006).

In response, in the early 1990s, and in common with governments throughout the developed world, UK government health policies began to shift towards emphasising prevention of ill health, as a means of reducing demand in the longer term by 'intervening further upstream' (Welsh Assembly Government 2003, p.6). This attempt to intervene earlier met with mixed reactions from health service providers. Nonetheless it is still a predominant strand of health policy across the UK today (Smith and Goodwin 2006; Ham 2007).

In addition, health policy in Wales had another, and perhaps stronger, driver in the form of high levels of deficits incurred by the acute sector (Welsh Assembly Government 2003; Drakeford 2006). In some ways, the UK's experiment with delegating budgets to GPs (GP Fundholding) could be seen to have been an attempt to curb demand for secondary sector services by empowering GPs, as referrers, to provide more services from within the primary and community sectors. Starfield et al's (2005,
(p.457) studies correlated health systems with strong primary care elements with lower costs and better performance. A key weakness which emerged from the GPFH model, however, was the inability to impact significantly on acute sector spending, or, for that matter, accountability (Le Grand et al 1998). In this sense, then, setting up primary care organisations with responsibility for reconfiguring local services to meet local needs (rather than replicating historical spending patterns) could be seen as an appropriate policy response to curb acute sector spending. Since primary care was traditionally perceived as the weaker player in the system, attempts to strengthen it might have been expected to do the trick.

In line with such thinking, a series of major policy initiatives have been introduced, aimed at capturing and exploiting the "entrepreneurialism" of General Medical Practitioners (GPs) as independent contractors (eg through GP Fundholding) while, at the same time, increasing the public health and community orientation of primary care services, and the emphasis on prevention of disease and the promotion of wellbeing (Williams et al 1997; Department of Health 1997; NAW 2001; NAW 2002; Welsh Assembly Government 2003).

Despite this trend, the policy decision, taken by the then new Labour Government in 1998, to establish local primary care
organisations, represented a major change in the organisational landscape of health provider organisations across the UK. In parallel with the rest of the UK, in 1999, primary care organizations were created, in Wales, to take on responsibility for commissioning health services to better address local needs (Welsh Office 1998a and b; Department of Health 1997).

But, within this overall UK policy drive, the devolved Assembly government in Wales has increasingly been carving out its own distinctive agenda (Drakeford 2006) in relation to health services organization and delivery. The Welsh model of primary care organization (Local Health Group) put GPs in the driving seat, as Chairmen of the new organizations, and, more radically, formalised links with local authorities through coterminosity of boundaries and representation on the LHG Boards. Public involvement and responsiveness were formally encouraged through lay representation on these Boards too.

Against this backdrop, this study arose from the researcher's fascination with general practices as organizations. As a primary care development facilitator, and academic, issues about policy implementation at local level had been part of her portfolio for a decade, working with practices in the deprived post industrial areas of south Wales, supporting practitioner and practice development and innovation “on the ground” through, largely,
educational initiatives. Such initiatives were, in the main, aimed at improving the quality of individual practitioners' services. The implementation of the "new" Contract for GPs in 1990 had heralded a shift, in policy interest, towards practices as organizations. Thus the decision to set up LHGs in 1999 was welcomed as an excellent opportunity to study the ways in which these new, larger, organizations developed and grew, as change promoting agencies locally.

But the setting up of LHGs raised a plethora of issues, about ways in which local organizations implement policy directives, the variations that occur and why. These questions had always hovered in the background of my work, as various monitoring agencies complained about the extent to which their initiatives "failed" due to lack of application, determination, or other weakness of those at the grassroots. This study provided the opportunity to explore policy implementation at local level through the eyes of those responsible for leading the new organizations. The researcher wanted to know what they experienced, what problems they met in trying to change services locally, and why. How did they tackle any implementation challenges? And more, importantly, why did they make the choices they did? What approaches worked and what was less effective, in terms of strategies and tactics?
1.2 Selection of Research Problem

Just as the researcher's employment as a primary care development facilitator in the south Wales valleys from 1990-1996, provided the opportunity to learn about factors driving the policy intentions to develop primary care in Wales, it also provided familiarity with the organisational development challenges faced by GPs as employers and service providers, in trying to act on new policy directives. The researcher wanted to understand more about these challenges, from the perspective of those responsible for meeting them. It was hoped that learning to understand the ways key participants tried to deal with the changing expectations on them would lead to improved understanding of the problems inherent in policy implementation at local level, more generally.

This practical stimulus was strengthened by the relative paucity of academic literature on primary care organizations, as organizations, at the time (January 1999). Margot Jeffreys and Hessie Sach's (1983) work was an important step towards reconsidering the organization of primary care, predating the Conservative government's 1990 reforms. The introduction of GP Fundholding had stimulated a fair degree of interest across the UK (e.g. Bain 1994; Dixon and Glennerster 1995; Gillam and Pencheon 1998; LeGrand et al 1998; Light 1998) but substantive studies of the effects of GPFH or of the other models (Total Purchasing Pilots; Locality Commissioning Groups, Multifunds,
etc) beginning to emerge alongside GPFH, emerged later. In Wales, little evaluative research on GP fundholding had been commissioned; at the same time policy in Wales favoured fundholding above other possible models of primary care service delivery and organization. And although the decision to establish primary care organizations across the UK sparked a great deal of new academic research interest, matched by funding from the Department of Health and the Scottish Executive, this was not the case in Wales. The Assembly subsequently commissioned a review of the literature on primary care organizations from Professor Clare Wilkinson, to inform the consultation process on structural change in 2001 (Wilkinson 2001). Nonetheless it was hoped that this study could go some way towards addressing that gap in the literature.

In order to get a clearer understanding of the factors that might potentially impact on the establishment of LHGs, the researcher conducted a short study, between January and May, 1999, to elicit Welsh GPs’ attitudes towards the new LHGs. The guidance establishing LHGs (Welsh Office 1998b) stipulated that GPs would hold 6 of the 18 places on LHG Boards. This weighting indicated that their views could therefore exert a strong influence on the ways in which LHGs developed locally. The findings bore out the initial hypothesis: GPs across Wales expressed strong misgivings about the nature and function of the new LHGs (Williams 2002).
Thus they indicated the scale of the challenge facing the new organizations, in terms of engagement of local practitioners, as reported.

1.3 Research Aim and Objectives

This backdrop of scepticism (only 1 of the 80 GPs polled reported a positive attitude towards the new LHGs: "...potentially the best idea since sliced bread, but I emphasize potentially..." (SH30I) confirmed the overall research aim: to identify the influences affecting the formation and development of the new LHGs as they went live on 1st April 1999. Specific research questions were whittled down to:

(1) what structural and organizational changes were made for the promotion and development of LHGs?

(2) what leadership behaviours did the selected health professionals apply to their roles as Chairmen, in terms of building organizations capable of change and development?

(3) what lessons can be learned for leadership development, organizational reform and policy implementation for the future?

1.4 Research Method

The study was designed to be exploratory and inductive, aimed at eliciting the perceptions and experiences of the key actors responsible for leading the new organizations. The study aimed to
capture their perceptions of the factors that helped, or hindered, their efforts to develop their organizations, in order to address research question 1, and subsequently research question 3.

The role of Chairman, the individual responsible for leading the formation and development of the new organizations, was identified as the most appropriate focal point for the study, enabling exploration of research questions 2 and 3. Individual interviews were selected as the data collection method most likely to enable a deep understanding of relevant issues to emerge. All 22 Chairmen agreed to participate; there was 100% compliance throughout the study. A longitudinal design was used for data collection: Chairmen were interviewed, face-to-face, at the beginning of the study (April-December 1999) and at the end of the study (April-October 2001). The interim tranche of interviews (Summer 2000) were conducted by telephone. An interview guide was devised based on issues identified in the literature review and from the author's own experience in the field. Subsequent interviews were based on issues arising from previous interviews, alongside questions about Chairmen's views of their own progress towards achieving their aims.

The researcher's position as an academic employed within a medical school, conferred a degree of both access and credibility which was instrumental in getting this study underway. And, as a
senior employee of Wales' national leadership development agency, the researcher was able to participate in a number of primary care development initiatives throughout the duration of the study. Of course this quasi-insider role had, potentially, both positive and negative implications for this study. Positive features included ease of access to key actors. Negative features included the danger of being too close to events to enable clarity of analysis, together with the possibility of a too-ready acceptance of prevailing shared assumptions across the management and policy-making communities.

1.5 Thesis Structure

Chapter 2 examines and critiques literature relevant to the specified research questions. The research design is explained in detail in Chapter 3. Chapters 4 and 5 use the data analysed to explore the policy context in which the study is situated, and analyses the influences that specific organizational and structural features had on the establishment of LHGs. These two chapters serve to locate decision-making within the health sector at the time of the study, and thus address the first research question. Chapter 6 addresses the second research question, examining the personal characteristics and career histories of the LHG Chairmen themselves, and the challenges and opportunities they saw themselves facing. Particularly important in this chapter is the nature of the "ideological vision" some Chairmen expressed and
developed to build their organizations and embed them locally. Chapters 7, 8 and 9 address the second and third research questions, examining the ways in which Chairmen were able to build organizational relationships, both vertically and horizontally, to support their new organizations. These three chapters show the ways in which different Chairmen played the 'institutional politics' within the health system and thus serve to explain the location of decision-making locally. Chapter 10 analyses the specific features that Chairmen identified within their nascent organizations, and how they exploited, or leveraged them, to create unique identities for their new LHGs, enabling them to grow and develop into change promoting organizations. The final chapter, chapter 11, discusses the implications of the findings in terms of the specific research questions articulated. It includes recommendations arising from the study and also provides pointers for further research.

This study, though devised and conducted just as new primary care organizations were created, has relevance for today's debates about the organization and delivery of health care. The Welsh Assembly Government (WAG 2008) is currently (April-June 2008) consulting the public on its proposals to restructure the health service in Wales, so the issues raised in this study are pertinent to the decisions being taken now. And, in England, although the importance of the gatekeeper function is recognised as
contributing to efficiency of care and reduced costs (Starfield et al 2005), attention is also turning to promoting diversity of provision (DOH 2008). The findings of this study have implications for the roles of clinicians as leaders, the development strategies needed, and the issues impacting on local implementation of policy.
Chapter 2: Development & Organizational Change in Primary Care: Literature Review

2.1 Introduction  This chapter examines the literature relevant to public policy making, power and politics, organizational behaviour and change management in the field of health service organization and delivery. It also encompasses research relevant to facilitating innovation in organizations, including leadership behaviour and leadership development, in order to explore the theoretical background to the present study, and to identify any gaps in the existing literature.

This study examines a particular example of attempts to create changes in service delivery patterns within the public sector, in a specific geographical location, over a finite period of time. Literature relevant to this study crosses a number of disciplinary boundaries, however. Therefore, prevailing theories about policy making and implementation are analysed for their relevance and ability to illuminate the present study. Clearly this implies an understanding of the socio-economic factors which have combined to produce the context in which the study takes place. Theories relevant to the ways in which organizations behave in times of turbulence, and implementing organizational change relate to key aspects of the study and so are included in this review. Changes in organizational forms and structures in response to this turbulence are examined. Since innovation was a policy aim in the
context of this study, literature relevant to conditions needed to create innovation within organizations and, more specifically, across a health provider system, is also included. Leadership styles appropriate for fostering innovation and creativity in organizations, and the strategies appropriate to developing those sorts of leadership behaviours are examined. The aim of the researcher has been to synthesise the findings, using what Mays et al (2005, p.S1:6) have termed an “aggregative approach, focused on the cumulation and generalizability of evidence” to build a strong foundation of knowledge to support the proposed study and its design. This chapter critiques the literature identified as relevant to the study aim in order to identify current thinking and thus provide a strong foundation, and springboard for the present study’s focus, design and conduct. An important caveat should be noted here. In developing the initial search strategy, the decision was taken to limit the literature search to material relevant to the period directly under study (1999-2001). Clearly, during the seven years that have elapsed since the data was collected, events have moved swiftly, especially in the fields of public sector reform, associated organizational studies and leadership. The final chapter of the thesis, therefore, links the findings from this study to the more recent work in these areas, and examines their implications for policy and practice.
2.2 Search Strategy

In setting out to explore the issues noted above, it was necessary
to access a wide range of literature from different, and sometimes
overlapping, disciplines. In order to manage this diversity
effectively, an attempt was made to search systematically, using
MeSH terms to steer electronic searches of appropriate databases.
Search terms used included: 'health sector reform AND
innovation'; 'organizational change AND public sector reform';
'decentralization of health services'; 'organizational structure
AND innovation'; 'organizational structure AND UK health sector
reform'; 'organizational structures AND UK health service reform
AND Primary Care'; 'human services organizations AND
entrepreneurship'; 'Leadership AND innovation AND NHS';
'health policy' AND 'NHS' AND 'UK' AND 'primary care'. In
addition, key authors, already known to the researcher as credible
and important commentators, were searched using a combination
of Google Scholar and University web pages, to identify any works
that might have been missed by the database searches. Relevant
journals were routinely hand searched, throughout the last nine
years. Finally, recent work, particularly topic-based Literature
Reviews commissioned by the National Coordinating Centre for
Service Delivery and Organization related research, were
downloaded and critiqued for their relevance to aspects of this
study. The references included in these sources also provided an
additional check on sources that might have been missed by the researcher's electronic and manual searches.

2.3 The Public Policy Context

The decision, taken at the end of 1998, to create new organizations to oversee the delivery of primary health care services to local populations across Wales was not taken in isolation. It was, rather, the outcome of a long series of policy developments rooted in the changing economic and social patterns emerging in Britain since the 1970s. This section of the review sets out to explain the multiple drivers that worked together to create the context in which that policy decision was taken, and the reasons underpinning them.

By the end of the twentieth century, it had become evident that changes in both the social and economic conditions across the UK, perhaps exacerbated, but certainly affected, by changing demographic patterns, had worked together to unravel what has come to be termed the 'welfare consensus' that prevailed across Britain in the years following the end of the Second World War (Hutton, 1996; Clarke and Newman, 1997; Exworthy and Halford, 1999; Lister, 2005). In public policy terms, at least, the years immediately following the end of World War II had been characterised by general agreement that welfare was a public good and that the State had a legitimate role in ensuring the delivery of
welfare services in a fair and equitable manner (Timmins 2001).
The provision of welfare benefits and services was overseen by
welfare institutions created, as instruments of the State, to reflect
these values, as they were articulated at the time. Welfare was
seen to be an effective means of supporting the prevailing social
order and value system of Britain (Clarke and Newman, 1997).
Thus, bureaucratic welfare organizations were intended to be
large, so that they could take both a wide and a long view of social
need, and interpret such need uniformly across the UK. This
uniformity would ensure equal distribution of resources across
groups pre-defined – and generally agreed – as needy. Their rules
and procedures would ensure that services were allocated and
delivered without consideration of the personal characteristics of
the intended recipients, or the potential biases of service providers
(Clarke and Newman 1997). Until the 1970s, political discourse
largely revolved around questions of how much resource should
go to specific areas of welfare provision, rather than around
whether or not any allocation was appropriate (Exworthy and
Halford 1999; Minogue, 1998; Clarke and Newman 1997). In
retrospect, during these post-war years, the government could be
seen to have relied on an allocative planning, and, largely,
incremental model of funding public service delivery organizations
(Saltman and von Otter, 1992, p9).
The global economic crisis of the 1970s is considered by many to have been the proximate cause of the dissolution of this consensus, and the period of growing political discord that ensued (Giddens 1998; Saltman and von Otter, 1992). The onset of the economic crisis coincided with the emergence of a host of other social tensions. New social groupings were forming, whose interests had previously been excluded from those defined as "needy" in terms of welfare provision. Women's interests, as a distinct group, in particular helped to stimulate criticism against what came to be seen as 'paternalistic' aspects of bureaucratic organisations and policies (Fiona Williams cited in Clarke and Newman, 1997, p.10). Rising numbers of immigrants, with their specific needs, often fell outside the existing rules on entitlements, based as they were on the concerns of a more homogeneous population. The composition of households changed, and the need for more single occupancy homes began to grow. For the first time, too, population projections began to point towards growth in the proportion of older people living longer lives. Against this background of increasing diversity, what had previously been seen as a strength, the impersonality of the bureaucratic model, soon began to be perceived as a weakness (Clarke and Newman, 1997). At about the same time, the unit of social concern began to move away from the family as the predominant social grouping and, thus, focus of attention, in welfare policy terms, and more towards the individual (Ham, 2004, p. 236). The combination of
economic pressure and perceived scarcity, in the face of a plethora of "new" demands, combined to destroy the last shreds of consensus about what constituted social need, welfare, and the role of the state in meeting it.

Not surprisingly, in the face of these tensions, political discourse changed significantly, too. Interestingly, this change in discourse was not unique to Britain but was paralleled - or perhaps fuelled - by similar changes in the US. In both countries, neo-liberal philosophies began to gain prominence, at first in response to the critical economic conditions presenting globally. But the prescriptions of the New Right soon spread more widely across social and political arenas. Their focus on the individual may have struck a chord with prevailing social and demographic trends. But placing the individual at the centre of thinking, at the expense of the social group, had wide ranging repercussions, in both philosophical and public policy terms (Ellison and Pierson 2003).

The tenets of the New Right emphasized the rights of individuals, not the responsibilities of groups (or the State). Thus "rights" soon became equated with "freedoms", and therefore any structures or rules that encroached on these rights and freedoms was seen as an infringement of individual liberty. Thus, the role of the state was increasingly curtailed, so that individual effort
could be liberated. In economic terms, this inferred that jobs could be created not by State intervention but by individual entrepreneurship and hard work. The realm of welfare was consequently re-cast, not as a public good, but as a drain on public resources and assets (Clarke and Newman, 1997). This, in turn, affected the definition of what constituted a social need. At times in the ensuing decades, it seemed as though there had been a return to Victorian definitions of welfare 'worth', as, increasingly, responsibility for meeting need was placed at the foot of the individual (as carer or supplicant) and increasingly away from the responsibility of the State (Lister 2005, p.34). In discussions about resource allocation, individual responsibility for health and welfare sometimes became entwined with notions of worth, and blame, deserving and undeserving of State help or intervention. This changing discourse had a profound effect on health policy and delivery, as the following sections will show.

2.4 The Health Policy Context

In common with governments across the developed world, the UK government faced significant challenges in the health sector. By the 1980s, inflation in this sector was increasing faster than in other areas of public expenditure. This was partly due to the rapid pace of technological development in healthcare interventions (Smith and Goodwin 2006; Ham 2004; Welsh Assembly...
Demographic changes added to these cost pressures, and, as demand continued to outstrip supply, disillusionment with the Bevanite dream of conquering ill health among the population gradually began to set in amongst policymakers and the public alike. By 1990, cost control had become the dominant aim of policymakers in the health sector (Lister, 2005, p.35; Ham, 2004, p.236; Saltman and von Otter 1992, p.12). In common with governments across northern Europe, and the USA, the British government began exploring alternative models for funding increases in the delivery of public services.

The concept of “planned markets” as a means of increasing the productivity, or value for money, of public services gained prominence. Such an approach aimed to harness the competitiveness inherent in markets, through decentralisation of decision-making and the introduction of incentives to stimulate provider behaviour change (Saltman and von Otter, 1992), but within the overall confines of public ownership and direction. This focus on influencing the supply side of the economic equation meant that, although a variety of policy instruments were adopted, throughout the 1980s through to the present day, the underlying paradigm informing them was consistent with New Right ideology generally, and managerialism in particular.

Managerialism, as a way of thinking about organisations, is rooted in New Right philosophies about the role of governments in
promoting economic growth (Lister 2005). The New Right’s thinking about economic development springs from liberal philosophies about the benefits of the market as the preferred mechanism for allocating resources. Thus de-regulation of trade, and reduction of constraints on market forces, coupled with decreases in public spending are viewed as necessary pre-conditions for effective market operation which will, in turn, lead to higher economic growth and thus increased social gain. The individual, as purchaser, is viewed as the main agent, influencing the provision of goods for sale by the choices they make as consumers.

The prevalence of New Right thinkers in the debate about stimulating economic growth in response to the economic crisis of the 1970s, at the macro level of analysis, led to the adoption of a parallel philosophy at the micro level of public sector organisations in Britain. By 2007, in Britain, managerialism could be seen to have become the dominant approach to creating effective health care organizations. This represents a significant change in philosophy since the agreement to create the NHS in 1948 put medical professionals firmly in the driving seat. So, why did such a significant change come about?

Part of the answer may lie in the increasingly frenzied attempts by the Conservative government, from 1979, to control public
expenditure generally, and health spending in particular. Using the rhetoric of quality improvement through increased diversity of provision and greater consumer choice (Welsh Office 1988) opened the door to let a new class rise to ascendancy: managers (Wilsford 1994, p.269). Managers would be the channels through which public policy would be most effectively implemented. They would, through their emphasis on, initially, efficiency and cost control techniques, bring recalcitrant professionals to heel. Sir Roy Griffiths’ 1983 (DHSS 1983) report marked a seminal change in the philosophy underpinning health policy in the UK. With the benefit of hindsight, Griffiths’ comment about the difficulty Florence Nightingale might have, should she return from the grave, in finding anyone “in charge” marked the end of the ‘messy’, compromise system of consensus management that had prevailed across the NHS since 1974. Introducing a tight system of performance management and accountability would enhance the system further by introducing clarity and speed of decision-making.

Pollitt (1997, cited by Clarke and Newman, p 34) quotes Michael Heseltine, Secretary of State for Industry in 1980, indicating the centrality of management in accomplishing the new national project of transformation:

Efficient management is the key to the [national] revival...and the management ethos must run right through our national life...
To this end, General Managers were created to replace Hospital Management Teams. Private sector-style "Boards" were created to support, and hold to account, the new General Managers who held personal responsibility for decision-making. These Boards performed another function, too: they would help to embed the newly-termed District General Hospitals in the community – and thus distance them from central government responsibility.

These structural and titular changes signified huge cultural changes across the NHS. Until this time doctors – and, to a lesser extent, professionals generally – by virtue of their position and public esteem, held sole responsibility for resource allocation. Every clinical decision made, at each patient encounter across the health system, day in and day out, had a resource implication. And the only limitation on this power to commit resources was the individual clinician's conscience and professional judgement (Harrison et al 1992, p, 18). Under the terms of the agreement founding the NHS, this clinical freedom was enshrined as sacrosanct: a basic principle. So, the introduction of managerialism also marked a significant shift in the perception of professionals and their roles in the health care system. For the first time since 1948, professionals were cast as part of the problem to be resolved (Harrison et al 1992). And it was the managerial class, formerly mere administrators and implementers of clinician-led resource allocation decisions, who would rescue
the nation from the consequences of such 'irresponsible' decision-making by their focus on the corporate good, rather than on the single individual patient in isolation.

Clearly, accomplishing such a major cultural change in thinking and in practice would require a powerful legitimising philosophy. The discourse of the New Right provided just that. The language of the market: efficiency, quality, competition through diversity of products and services, levered by the power of the individual’s choices, promised to cater for the diversity of interests proliferating in a now more heterogeneous Britain. The newly-empowered individual would thus be freed from the stultifying, blunter instrument of State controlled welfare services, to secure more tailored-made options (DoH 1997, paragraph 1.4). It would appear therefore that the fostering of consumerism at the individual level across Britain was a necessary adjunct to the language of the market at organizational levels. Charters embodying patients’ rights heightened citizens’ expectations of the fruits of this new approach to public service provision (DoH 1997).

Thus the very language proved to be strangely seductive, at both organizational and individual levels, partly because it provided a unifying narrative thread for a wide variety of potentially competing interests. The concept of the market place gave voice and legitimacy to previously disenfranchised and overlooked social
groups, offering them a way to get their needs heard within the
system. Managerial control would offset the spending excesses of
unfettered clinical freedom. Individuals were to be further
empowered through representation on health service decision-
making bodies. This would serve to localise decision-making and
improve responsiveness to community interests. This focus on
responsiveness to individuals was later further enhanced by the
development of patient’s charters, under the Major government,
codifying and legitimating patients’ rising expectations of public
services. Such steps to strengthen demand were intended to
counter-balance what had come to be seen as the excessive
powers of professional providers over the supply of medical
services (Elston, 1991, p.68).

This potential to transform, offered by the language of the New
Right, at both individual and organizational level, may have held
the key to its attractiveness and thus to its tremendous cultural
the shift in language within the discourse on public services, from
an initial emphasis on efficiency in the early 1980s, fairly quickly
moving on to effectiveness, which, as a concept, could capture the
values of both professionals and managers. Professional buy-in to
the concept of effectiveness as a dominant quality dimension
significantly strengthened their power base at a time when it was
increasingly under threat. It was a bitter pill to swallow, but
agreement to allocating public resources on the basis of what worked was almost impossible to argue against. And it did give professionals the upper hand in the determination of what treatments could be deemed effective. Whilst managers might insist on “audit” regimes and trails, the clinical nature of audits was protected throughout the 1990s. Arguably it is only more recently, with the introduction of the National Institute for Clinical Effectiveness (NICE), that cost has become a more overtly dominant element of the effectiveness measurement process. And, the strong role which cost factors now have in NICE’s decisions has only emerged through more recent reviews (Williams et al 2007). Thus, the concept of effectiveness proved to be a successful tool in the discourse, helping simultaneously to legitimate actions taken to curb the power of professionals, and to give managers more credibility in the eyes of the public.

At the same time, responsiveness was also mooted as an important dimension of quality (Le Grand et al 1998). This idea that health services would be tailored to local needs and circumstances was an important plank in the proffering of increased individual choice to the British public. Again it also offered empowerment to previously disadvantaged groups. But, significantly, it also strengthened the importance of the effectiveness criteria, and helped to demonstrate the efficiency of
resource allocation decisions, based on what was needed (DoH 1997, paragraph 1.5) and what worked.

The linking of the two concepts of effectiveness and need gave an additional degree of clarity to the narrative thread of the New Right ideology. This in turn was further bolstered by the simplicity of the language used to sell the ideology to the public at large. More potently, perhaps, the linking of effectiveness and need helped to build a bridge between managers and professionals, one that could act as a unifier between these previously competing groups (Harrison et al 1992). It enabled both camps to claim to be acting altruistically, in the public interest, when making potentially unpopular resource allocation decisions, based, as they were able to claim, on higher criteria than mere penny-pinching. In this way, such concepts helped to define the territory of the larger debate. Clarke and Newman (1997) argue that this effectively limited the scope of the debate too, ensuring that wider questions about the role of the State and the nature of welfare as a public good stayed off the agenda.

But perhaps the real skill of the New Right apologists lay in their ability to alter the language of the prevailing political discourse to emphasise the power of individuals in the decision-making process, whether as citizens or within organizations (McDonald 2004). The rhetoric lent an almost missionary zeal, endowing
individuals with a sense of social purpose while at the same time encouraging them to act in their own self interest. The language of organizational transformation aligned self interest with social welfare and as such was almost universally seductive. As Clarke and Newman (1997, p. 52) attest:

"the visionary language of both the new managerialism and the New Right has tapped into much more potent vocabularies of motive"

and thus helped to create "an illusion of unity of purpose and reform". The promise of such transformative power may help to explain the widespread appeal of both philosophies, the New Right at the macro level of policy making, and managerialism as the tool for effecting these transformations, at the organizational level (Clarke and Newman 1997, p.34).

2.5 Organizational Change at the Micro Level

Clarke and Newman (1997) point out the "normalising narratives" which not only served to make organizational change the norm rather than the exception, but also helped to place those who resisted such change as obstructive and old-fashioned: labels such as ‘dinosaurs’, for example, were commonly applied by managers to recalcitrant professionals who objected to the scale and pace of change. These normalising narratives provided a crucial link between social change at the macro level and organizational change at the micro level. McDonald (2004), for example, illustrated the extent to which the vocabulary of staff
empowerment was used as an instrument of organizational control, delineating the boundaries between acceptable and unacceptable behaviour within the organization (e.g., self-directed, positive) in her study of a new staff development programme within a Primary Care Trust (PCT). This language emphasized the shift away from the responsiveness and reactive approach characteristic of health service administrators in the 1970s, promoting the adoption of the more 'managerial' qualities of leadership, individual initiative, and employee empowerment in effecting change (DoH 2001 cited in McDonald 2004, p. 925-6). Inevitably such changes in language would have to be paralleled by changes in the ways in which organizations were structured.

2.5.1 Structural Implications at the Organizational Level

Organizational theorists have struggled to make sense of the ways in which corporations, public and private, have reacted to the changing social and economic trends illustrated above.

Responding to the global economic crisis of the 1970s, and in line with the rhetorical solutions of the New Right, organizations decentralised, downsized, diversified, and in so doing, fragmented. The old hierarchical structures of "Fordist" organizations, geared to mass production for stable markets, gave way to "permanently innovating" (Exworthy and Halford, 1999) organizational models. In an effort to secure market share, organizations focussed more on their "core" business, enabling them to slim down their
workforces as they "outsourced" work to cheaper suppliers and producers across an increasingly global territory. The previously predominant model of the paternalistic organization, prepared to provide employees with benefits throughout their changing life stages (eg in the USA, health insurance, college fee payment plans), was replaced by calls for employee flexibility and part-time contracts. Perhaps most crucially, at least as far as the public sector was concerned, hierarchical forms of control were gradually replaced by contractual relations (Exworthy and Halford 1999; Flynn et al, 1996). Vertically integrated organizations tended to become flatter, too, with a consequent growth in the number of horizontal links. And, perhaps mirroring changes in social values, emphasis within organizations tended to be more and more on individual performance (Minogue et al, 1998) and on the difference that individual effort could make to overall organizational performance. This emphasis on individuals and empowerment, in turn, however, sparked a search for different mechanisms to ensure employee and organizational accountability (Ferlie et al 1996, p 235-7 cited in Blackler et al 1999, p224). The emphasis, in government white papers under the Labour government of 1997 onwards, was on individual empowerment and decentralized decision-making, within an over-arching framework of centrally determined standards (DoH 1997). Ferlie et al (1996) point to the emergence, in response to these pressures, of hybrid organizational forms within the NHS which, paradoxically, tended
to make service integration, a key policy aim, more difficult to achieve (Blackler et al 1999, p 226).

During this increasingly turbulent social and economic period, the drive to innovate became an over-riding organisational imperative. This focus on continuous innovation sparked an era of further structural experimentation and change (Pettigrew and Fenton 2000) as organisations struggled to find more effective ways to communicate internally in an increasingly more globalised, yet fragmented, marketplace. Pettigrew and Fenton (2000) point to the increasing pace of organizational change throughout the 1990s due to the influence of new technologies and the faster diffusion of innovations, increasing the competitive aspects of the environment, that were, in turn, further exacerbated by increasingly volatile consumer buying patterns. Organisations struggled to respond to less regulated environments by fragmenting and decentralising, shedding "excess capacity". At the same time there was a noticeable increase in merger and acquisition activity (Pettigrew and Fenton 2000, p. 22). This increased sensitivity to the external environment was paralleled by increased focus on the relationship between organizational strategy, structure and performance.

2.5.2 Structural Implications at the Level of the Individual Employee

One of the main implications of these structural changes at the organizational level was a new emphasis on employee flexibility.
At an individual employee level, employment security was replaced by an increase in the number of temporary contracts and part time working (Whittaker 1992), intended to reduce production costs in the drive to compete in the global marketplace with countries whose labour costs were considerably lower than in Britain. And these short term contracts, particularly at the senior management echelons of health organizations, were increasingly tied to specific performance goals. These goals tended to be couched in transformative terms (Clarke and Newman 1997, p.42), contributing to the idea that individual effort, initiative and ability could accomplish organizational regeneration – and that such whole scale change could be effected within a short time span. It proved to be only a matter of time before this emphasis on positive potential became imbued with the logical negative consequences. As public accountability arrangements tightened, clinical governance arrangements included personal accountability elements, and individual chief executives were increasingly dismissed in the wake of organisational failures identified by public scrutiny arrangements (Sausman 2001, p ii17). Thus the language of empowerment, organizationally and individually seductive as it was, also carried a sharp edge of personal cost at the individual level. This was particularly true for the newly empowered managerial class, but health professionals were not exempt from similar scrutiny. Clinical governance arrangements became increasingly formalised, through clinical
management structures throughout the 1990s (Ayres et al 1998). By 2000, these arrangements had come together to put responsibility for both clinical and managerial failings at the door of hospital Chief Executives (Marnoch et al 2000).

2.6 Innovation as a Key Organizational Goal

The increased focus on individual effort and performance had another important, if unexpected, outcome, relevant to the focus of this research study. In this increasingly competitive environment, organizations began to emphasise organizational learning as a core competence (Senge 1990, quoting Walter Wriston then CEO of Citibank) and to look for structural arrangements to facilitate learning at all levels of the firm.

Pettigrew's & Fenton's (2000) review discerned three types of organizational form emerging in response to this quest. The first, the "globalising firm" is characterised by its changing geographical boundaries and use of IT as the chief integrative mechanism. Structurally this type may be closely related, at least externally, to the multidivisional organizational type emerging from the 1960s. But it differs significantly from this more classic model in the emphasis put on business processes, not functions. A second type refers to what they call "the knowledge firm" which emphasises the value of knowledge creation and transfer as its core activity. In this type of organization lateral communication channels become important, and organizational capability depends on the ways in
which the firm is able to capture individuals’ specialist knowledge. The role of top management in this type of firm is to design and build the structures to enable and facilitate this knowledge creation and transfer activity. In this type of firm, the organization’s role, and thus its structures and processes, is to facilitate individuals’ creativity and learning. Pettigrew and Fenton’s third organizational type is the socially embedded network. Strategic relationships held together by extensive subcontracting arrangements within geographical areas characterised this model, to create intellectual and social capital, enabling the partners to ‘punch above their weight’ in increasingly globalised and highly competitive markets. These three organizational typologies have emerged in response to the perception that changing markets required increasingly tailored products and services, and thus that organizational structures that enable increased flexibility and responsiveness are required. Again, in all of these three typologies it is worth noting the emphasis – and value – placed on individual effort and creativity in building added value at the organizational level.

The emergence of these three organizational types is not the end of the story of organizational restructuring. Pettigrew & Fenton (2000) point to the on-going challenges to strike the right balance between the dualities that have surfaced in the wake of efforts to find optimal organizational structures. Tensions between
centralism and localism, standardisation and customisation, managing networks and maintaining horizontal accountability, and optimising individual and corporate performance are challenges which require continual re-balancing efforts. Blackler et al (1999, p.240) point to the anxieties created amongst workers, managers and professionals trying to make sense of, and implement, directives which they often perceive as conflicting. They concluded that organizations and individuals working within them could not be sheltered from such tensions, but that they could indeed be better supported through them using collective learning approaches.

2.7 Changing Leadership Styles

This, of course, has critical implications for the role of leadership in these emerging organizational forms, also of relevance to the NHS and to the focus of this research study. Moving away from command and control approaches requires leadership that is strategic and conceptual (Fenton and Pettigrew 2000). Leaders need to be able to make sense out of the environmental complexities surrounding the organization, and the often competing demands arising from them. Pettigrew's and Fenton's case studies point to the ability to deliver "clear, simple and evocative messages which balance future goals with present needs...to communicate purpose and priority" (p 299) as a critical leader competence in organizational performance, particularly in
terms of steering organizations through times of crisis. This implies a strong analytical ability together with sophisticated skills in communicating complex messages in simple terms. In addition, all three emerging organizational forms placed a high premium on organizational learning, at all levels of the firm, confirming Blackler et al's (1999) views, based on their case studies in NHS organizations.

The same environmental forces that impacted so strongly on organizations in the global market place had similarly significant effects on health and social policy, and thus on the shape of public sector organizations across Britain, as the following sections illustrate.

2.8 Structural Implications for Public Service Delivery

Organizations

The strength of the rapidly changing social, economic and demographic trends roiling across the UK throughout the last thirty years of the twentieth century prompted similar demands for organizational redesign in the public service delivery sector. The Blairite mantra of 'modernization' was seen by many to be echoing the New Right's prescriptions for slimmed-down, streamlined and thus more efficient organizational forms (Giddens 1998, p.166). In an effort to create more 'responsive' service delivery channels, the public sector was urged to adopt the same
structural principles that governed those of the free market. At the same time the welfare system was re-shaped in the mode of the ‘flexible’ labour force. Giddens argues that, in order to meet the welfare challenges facing Britain at the close of the twentieth century, especially in terms of tackling inequality and social exclusion, the instruments of the state needed reshaping on the basis of a new mixed economy (p.69). Such a model would require more devolution and decentralised decision-making, accompanied by more accountability and transparency. The role of government would be to manage risks (Giddens p.77). Giddens emphasizes the difficulties to be overcome in trying to strike the right balance between the contradictory tensions inherent in this approach to public policy. It may be that, in the face of this complexity, the rhetoric of the New Public Management appeared to offer a relatively simplistic solution, at organizational level, to the challenges posed at the macro level of society.

Minogue (1998) asserts that the New Public Management apologists favoured structural reform as the preferred means to achieving more cost effective and appropriate public service delivery at the micro, or organizational, level. To this end, devolved responsibility could be matched with increased financial responsibility, giving increased “freedom to manage”. This would be tempered by tighter individual and corporate accountability through cost centre allocation, Rayner-type scrutinies, and
customer satisfaction indices (Minogue 1998, p.33). Separation of purchaser and provider, a mechanism borrowed from the market, would be tempered by more strategic controls at regional levels, that would "hold the ring", by "steering not rowing" (Barber, M. for McKinsey, undated). This separation of operational activity from more strategic direction was a common feature of both public and private sector organizational change throughout the 1990s. Barber cautioned against the idea that this might mean "letting go" by government, emphasizing the need for strength and clarity at strategic level, as well as for a long-enough timeframe to ensure sustainability (p.9). These structural changes, devolving responsibility downwards and increasing performance management upwards, were intended to be implemented against a backdrop of increased capacity and capability underpinned by cultural change across the health system (p.7). But the extent to which the narratives of the New Public Management are consistent with, or conflict with, those of the Governance literature has been raised by Ferlie (2002). He notes that the governance models being proposed were predicated on concepts of partnership, interagency working and networks, requiring a different set of leadership skills capable of influencing and steering rather than the directing, commanding and controlling modes pertinent to hierarchical organisational forms. Ferlie (2002, p.4) viewed the New Public Management approach as being essentially centralist, emphasizing target setting, and measuring
local adherence through audit and performance management systems.

The engagement of health professionals, especially the medical profession, soon began to be seen as a critical element for effecting systemic cultural change. By the second half of the 1990s, systematic efforts were being made to capture professional interests in the pursuit of health sector reform. Systemic approaches to issues of service quality promulgated by Berwick and the Institute for Health Improvement in the US were increasingly promoted, amidst efforts to steer debate around issues of service “quality” and, latterly, “patient safety”.

Mechanisms to effect changes in physician behaviour became the object of academic study and policy discussions (see, for example, the Recommendations emerging from the Kennedy Report into Heart Surgery at the Bristol Royal Infirmary, 2001; King’s Fund Conference, June, 2007) and ranged from individual incentives, professional recognition and reward mechanisms, to encouragement to take on full scale management roles. Clinical Directorates were created in most acute Trusts, headed by the Medical Director. In addition, experiments in using networks (‘managed clinical networks’) as mechanisms for engaging clinicians were started. The Modernization Agency was set up, in England, to promote clinical engagement with the change agenda promulgated by the NHS Plan in 2000, using demonstration
projects, and "clinicians to persuade clinicians...[in an effort to win] hearts and minds by acknowledging professional sensitivities and potential resistance" (Davies et al, 2005, p. 119). These approaches, then, were aimed at reducing expected resistance to change and to harnessing clinical motivation and commitment to further organizational change initiatives (Marnoch et al 2000).

However the use of such networks quickly exposed the underlying tensions between the centralised managerial control systems in place in vertically managed NHS organizations, and the more horizontally linked network structures (Ferlie, 2002), which potentially threatened to remain as separate, but highly influential, and, perhaps potentially destructive, forces in the system.

As the twenty-first century opened, health policy reform efforts accelerated, according to Ferlie (2002, p.2) with two effects. The first was to change the nature of the role of local organizations to one of "influencing" rather than directing, change; this changed emphasis required further reforms in terms of organizational structures, roles and responsibilities. At the same time, attention increasingly turned towards the concept of innovation as an indicator of the success of structural and systemic changes for health service delivery organizations (Welsh Assembly Government 2005a; Welsh Assembly Government 2005b; Welsh Assembly Government 2003; National Assembly for Wales 2001a).
2.9 Health Policy Implementation Strategies

In pursuit of these changed policy goals, the Innovations in Care team in Wales, set up as a Task Force under the *Improving Health in Wales* (NAW 2001a) banner, acted as a catalyst for largely clinical innovations across Wales. And, in England, the National Coordinating Centre was set up to commission service-delivery and organization-related research relevant to stimulating, embedding and sustaining innovation in health service delivery across the health care system.

In terms of policy implementation strategies and their effects, Harrison et al (1990) concluded that successful policy implementation required a high degree of shared ownership of the aims and agenda across constituent agencies. It also required top level commitment and engagement to the policy aims. Thirdly, including relevant indicators in the performance management framework would facilitate implementation. Harrison et al also caution that competing policy aims inhibit implementation. Exworthy et al (2001) support these findings, pointing to policy implementation barriers raised by what Ferlie (2002) terms "initiative overload".
2.10 'Managing Change': Approaches to Effecting Change at Organizational (Micro) Level

The literature on change management, though largely drawn from private sector organizations, has more recently been trawled by several writers (e.g. Iles and Sutherland 2001; Bate et al 2004; Greenhalgh et al 2004) for lessons which might be applicable to the NHS in its efforts to implement whole scale change at both system and organizational levels. Greenhalgh et al's (2004) recent work on organizational factors stimulating innovation notes the importance of structure, capacity and context. The concept of receptive contexts for change was first proposed by Pettigrew, Ferlie and McKee (1992) based on their empirical study of policy implementation in NHS organizations. They identified a series of factors that were associated with forward movement. These included the quality and coherence of the policy to be implemented, together with goals and priorities that were clear and simple. The existence of key people capable of leading the proposed change; environmental pressures, including the nature of the change agenda and its location, favouring the particular change proposed; a supportive organizational culture; good managerial-clinician relationships; and co-operative inter-organizational networks were also noted as playing a determining role in the uptake of change. Whilst not terming these factors 'necessary preconditions' for effecting change, in terms of implementing policy at local level, together these factors were
identified as playing an important role in creating contexts in which change could be effected. Crucially, Pettigrew, Ferlie and McKee (1992) point to the transient nature of these factors, emphasising the dynamic nature of the concept of receptivity, and noting that whilst receptivity can be built through cumulative development processes, equally it can be destroyed by changes in any one of the eight factors. Butler's (2003) empirical study of implementing policy within two local authorities subsumes these eight factors down to four: 'ideological vision' denoting the existence of coherent policy, clearly communicated; 'leading change' denoting the locus of decision-making within a system; 'institutional politics' as indicative of the inter-play of relationships within a system; and 'implementation capacity' to indicate the extent to which organizations can be seen to have created unique identities and capacities by 'leveraging their asymmetries': in other words, by identifying and then exploiting their unique (and often tacit) assets (Miller et al 2002). Butler's study seeks to integrate the environmental, public service and organizational levels of change into a coherent theory, but he stresses the contextual specificity of the receptivity factors identified and calls for further testing to develop the theory beyond the cases he studied.

Greenhalgh et al (2004) also point out that characteristics of a proposed change itself can also affect uptake, depending on the
level of complexity involved, the "fit" with prevailing values and norms, and its perceived advantage relative to cost as being determinants of success. Their review emphasizes, above all, the complexity of the work involved in creating organizations receptive to change and in developing more creative ways of working in pursuit of innovations.

At the macro level, Bate et al (2004) reviewed literature relevant to social movements with a view to identifying any implications for service improvement within the NHS. They noted the importance of a rather different kind of leadership: that of the 'institutional entrepreneur' who facilitates radical change from within their institutions by enabling a new and different dialogue to take place:

"...leaders offer frames, tactics and organizational vehicles that allow participants to construct a [new] collective identity and participate in collective action at various levels..." (Bate, 2004)

which such leaders then weave into collective and unifying narratives to make meaning for others (Morgan and Smircick 1980, cited by Bate et al 2004, p.37). This form of leadership appears to work independently of position, status or charismatic traits, and thus perhaps provides a better fit for emerging network forms of organization. Bate et al highlight the importance of this type of leader's role in 'framing' dialogue so that common understanding is engendered across the organization or collective. This collective shaping of the sense-making process builds on earlier work by Weick (1995), and to some extent, Morgan (1997).
The leader's work in orchestrating this collective sense-making is referred to as an integral part of creating contexts receptive to change (Bate et al 2004, p 37).

### 2.11 Incentives and Change at the Individual Level

Grol's and Grimshaw's (2003) systematic review of effective ways of encouraging clinicians to change their behaviour echo these organizational findings at the individual level. They, too, cite the nature of the proposed innovation, in terms of its simplicity and clarity, as being important, alongside the perceived strength of the evidence base underpinning it. They also point to the importance of the match between the values underpinning the proposed change and those of the clinicians involved. This tallies with the importance of being value-driven, noted by the social movement theorists. In Grol's and Grimshaw's work, ownership was also deemed to be important, with more credence and commitment given to the adoption of changes that clinicians saw themselves as having stimulated, as opposed to those perceived as having been externally driven, regardless of the objective strength of the evidence base attached to proposed changes.

So, perceived ownership of proposed changes may be a determining factor in professionals' motivation to change. Several studies have sought to ascertain the extent to which this motivation was intrinsic, or could be affected by the presence of
incentives. Bosanquet's and Leese's (1989) study of the effects of incentives in the form of target payments for specific fees-for-items-of-service noted the mediating effect of local environmental factors on take up. For example, in more financially deprived areas, doctors trying to initiate changes to encourage uptake of preventive health measures had to take larger financial risks in order to innovate than did their colleagues in better-off areas. It was this study's findings that initially sparked the researcher's interest in exploring this area in more depth. Flynn, Williams and Pickard (1996, p.146) quote Hudson's caution that systems which promote individual reward (such as incentive payments) may well militate against the sorts of collaborative models of working appropriate to primary care. Since then, Davies et al (2005) have reported that there is a "risk of damaging intrinsic motivation [of health professionals] through the use of financial incentives", and that much more study is needed into the complexities surrounding models of organizations, and links between governance, incentives and individual performance.

2.12 Changing Models of Primary Care Organization

Against this background of continuing social fragmentation and political and organizational decentralization, over the last thirty years, the policy intention to devolve responsibility for overseeing delivery of primary care services to local levels across the UK, taken in 1999, was perhaps the logical next step in this trend
towards the development of market mechanisms to achieve public aims. The implementation of this policy decision across the UK sparked an explosion in academic interest (e.g. Le Grand et al. 1998; Regan et al. 1999; Regan 2002; Mays et al. 2001; Smith and Goodwin 2002; Williams 2002; Sheaf et al. 2003; Roland and Smith 2003), which has intensified as the distinctiveness of the new models has continued to develop across the four countries of the UK (Exworthy et al. 2001; Ham 2004; Smith et al. 2004; Exworthy and Peckham 2005; Smith and Goodwin 2006). The National Tracker Studies carried out by the King’s Fund and the National Primary Care Research and Development Centre collaboration charted the progress of these emerging forms, focusing largely on England’s model of primary care organization and its development into trusts (PCTs). The English policy drive has tended to focus on encouraging competition, and diversity of providers (Ham 2004; DOH 2008) as a spur to quality improvement and patient choice. The Welsh model, on the other hand, has promoted partnership and collaboration, particularly with local authorities (NAW 2001a; WAG 2005a). Smith and Goodwin (2006) note that the development of primary care organizations across the UK (and in common with approaches taken in the US and New Zealand) has been aimed at promoting more “managed care” within the primary health care sector, and point to the tensions this has created in terms of engaging health professionals. In contrast to the rest of the UK, Wales has not
seen a similar surge of interest in their own primary care models, until very recently. Indeed, within Wales, any attempts at evaluation of LHGs were strongly resisted by health authority chief executives¹. The Audit Commission did however conduct and report on an initial study of LHGs in 2000 (Audit Commission 2000). And a study carried out by the researcher (Williams 2002) to investigate GPs’ attitudes towards the proposed LHGs indicated widespread scepticism, ignorance about the roles and functions of the LHGs, and a marked lack of enthusiasm for the proposed changes.

These studies indicate that the story is not yet finished. Indeed, real questions remain about the policy aims themselves, the instruments chosen to implement them, and the way in which the policies were, or failed to be, implemented. In Wales, Health Authorities were abolished in 2003, and LHGs were made into statutory bodies (LHBs). Now the Welsh Assembly Government (WAG 2008) has invited consultation on proposals to further transform the organization of the NHS, by abolishing the internal market in Wales, establishing an independent Board to oversee planning and allocation of resources within the NHS, and reducing the number of LHBs from 22 to 8. Acute Trusts were rationalised from 1st April 2008, reducing the number from 16 to 8.

¹ Personal Communication, Bro Taf HA Chief Executive, summer 2002.
2.13 Analytical Approaches to Health Policy: Implications for the Present Study

Academic analysts of post war health care policy-making have tended to fall into three broad groupings: structuralist, Marxist, and pluralist, in trying to understand and explain the underlying forces driving politicians' and policy makers' decisions in the health care arena. Most commentators recognize that a plethora of competing interests are come together in different combinations to effect health policy decisions. Marxist theorists tend to identify the different groupings of interests along fairly entrenched economic, and therefore, class lines. Pluralists approach the topic somewhat less deterministically, perhaps, highlighting the rise and fall of different groups depending on the nature of the issue under discussion, and attributing fairly equal amounts of influence to the different constituent groups. Alford, in his seminal (1975) study, is often credited with first identifying and best describing the structuralist perspective, claiming that the ways in which health care was organised significantly affected the distribution of power and influence throughout the health system (cited in Ham 2004, p. 215). Alford pointed to three types of interest groups: dominant, challenging and repressed, and asserted that it was the interactions between these three groups that most accurately explained the way health care policy decisions were made. Alford's typology placed the medical profession and its powerful position in health care policy making in the 'dominant' group,
whose interests tended to control decision-making at both macro and micro levels. Alford noted that the interests of this dominant group were, however, under threat by the groups of interests that he termed 'corporate rationalisers': those responsible for health care administration and planning (Ham 2004, p.215). This review has argued that the rise of a new managerial class has been aimed at curbing the powers of the predominant medical profession, in terms of resource allocation. Harrison, Hunter and Pollitt (1990, p.113) point, however, to the limited impact that the Griffiths-initiated reforms actually had, in practice, on medical dominance in policy and decision-making.

Arguably, the present thrust to increase the role of doctors in decision-making, begun formally with the introduction of Medical and Clinical Directors as an essential prerequisite for gaining Trust status, is tacit recognition of the continuing centrality of the profession's role in terms of health care policy and decision-making. The Kennedy Report into the mistakes identified in the management of children's heart surgery at the Bristol Royal Infirmary (2001) highlighted the need for more involvement of, and more training of, doctors in management. Since 2003, UK health leaders have looked to the US for insights into managed care models and their operation. Ham et al (2003) compared the performance of Kaiser Permanente’s approach to chronic disease management with that of the NHS, noting the much larger role for
doctors in decision-making in the US model as a significant feature in its success.

Paradoxically, however, such moves to recognize an implicit reality in terms of power and influence, may also have served to further complicate the process of health care policy analysis. Since 1987, the Labour government has prioritised effectiveness as a policy and decision-making criterion. Setting up national bodies to agree (National Institute for Clinical Effectiveness) and set uniform standards of care and service delivery (National Service Frameworks) has been a key policy plank underpinning the modernization agenda in health care. Clinical and corporate governance arrangements at organizational level have been created to support the delivery and monitoring of more uniform standards of care across geographical boundaries. The determination to promote evidence-based medicine has subsequently been matched with calls for evidence based management (see, for example, Davies and Nutley, 2000; Crompton et al 2003; Shortell et al 2007) and in turn evidence based policy. But this focus on ‘what works’ may not be so appropriate in the policy making arena because it may give rise to an impression of linearity and causality that is at odds with the complex interactions of interests that combine to create policy decisions. Ham (2004, p.113) quotes Easton’s 1953 definition of policy as a “web of decisions and actions” driven by the allocation
of values. As such, it is the result of a complex mixture of social influences, with specific decisions often determined by a wide variety of factors, of which evidence may be only one, and not necessarily always the strongest. Russell et al (2008) point to the dangers inherent in the notion that policy can be, or should be, “driven by facts rather than values...or that ‘evidence’ is context-free” (p.40). Learmonth and Harding (2006) point to the disabling effects of the concept of evidence-based management “as it is currently constituted...[because] it describe[s] a world which does not exist in lived space” (p261). In their view, such conceptualization precludes consideration of forms of evidence other than those relevant to managerialism, which might help us to understand organizations and decision-making more fully.

This view has implications both for the analysis and understanding of health care policy making as well as for the development of leaders and organizations. It may have particular importance for the appropriate development of clinical leaders (Ham 2003; Grint 2001).

This study looks at the way in which a selected group of medical practitioners have worked to create and develop new organizations intended to transform health care delivery in specific geographical areas.
Ham (2004) and Harrison et al (1990) both point to the need for care in delineating the scope of policy analysis efforts, since what may be appropriate at the macro level may not be helpful in illuminating the micro level of activity. Ham (2004, p. 228) notes the need for more empirical studies in this arena, particularly “related to the action and inaction of structural interests and the changing role and functions of the state” in relation to specific policy issues. These findings point to the emerging need for this study, that attempts to look at the interaction of key actors and structures in an effort to shed light on the policy implementation process at a particular point in time: the creation and development of primary care organizations in Wales from 1999-2001.

2.14 Research Focus: The Present Study

Questions remain as to how appropriate the structural and organizational changes which took place actually were, in terms of the ways in which they helped or hindered the delivery of stated health care delivery objectives. How did the structural imperatives of decentralisation and devolution of responsibility to professionals at local level play out in practice? What organizational features were incorporated to foster changes in service delivery on the ground? This study examines these questions by looking at a specific policy initiative and its implementation through the eyes of the key actors responsible for
implementing it locally. The policy decision, taken in 1998, aimed to secure a better match between local service delivery patterns and local needs, in the NHS in Wales, between 1999 and 2002. The policy instruments devised were structural: the new primary care organizations set up on 1 April 1999, to oversee the operational delivery aspects of service provision, within a strategic framework to be set by five new health authorities across Wales. This study, therefore, set out to identify, empirically, factors that influenced the development of primary care organizations (LHG) in Wales between 1999 and 2001, in order to try to understand what happened in terms of policy implementation, and why.

Specific research questions to be addressed were:

(1) What structural and organizational changes were made for the promotion and development of Local Health Groups?

(2) Given that the new organizations were meant to create radical change at local level, what leadership behaviours did the selected health professionals apply to their roles as Chairmen, in terms of building organizations capable of change and development?

(3) What lessons can be learned for leadership and organisational reform, and policy implementation at local level for the future?
Chapter 3: Methodology

3.1 Introduction

This chapter outlines the research strategy and methods chosen to address the central aim of this study: an exploration of the factors that influenced the development of primary care organizations (LHGs) in Wales between 1999 and 2001. The chapter outlines the research design, and the specific ways in which it addresses each research question. The chapter consists of four main sections: section 3.2 explains the choice of the case study approach as the research method. Section 3.3 justifies the selection of the role of Chairman as the key actor and therefore focal point of the study. Section 3.4 argues the case for the choice of individual interviews as the method for collecting data. Validity issues are addressed in section 3.5. The conduct of the study is explained in section 3.6, while data analysis strategies are detailed in section 3.7. Section 3.8 summarises the chapter, and explains the ways in which ensuing chapters address each research question. These questions are repeated here for ease of reference:

(1) what structural and organizational changes were made for the promotion and development of LHGs?

(2) what leadership behaviours did the selected health professionals apply to their roles as Chairmen, in terms of building organizations capable of change and development?
(3) what lessons can be learned for leadership development, organizational reform and policy implementation at local level?

3.2 Research Design: The Case Study Approach

Twenty-two Local Health Groups, covering the whole of the principality, became operational on 1st April 1999 (see Map). Each consisted of a Board of eighteen members, some elected and some selected. The range of skills and familiarity with health service language, culture and procedure could be expected to vary enormously among the eighteen members, including as they did two lay representatives, a community nurse, a local authority officer, a dentist, pharmacist, optician and six GPs. The guidance (Welsh Office 1998b) stipulated that the Chairman should be a practising GP. So the challenge for the researcher was how best to capture their experiences and perceptions, as they unfolded.

The process of the formation and development of the new LHGs could be viewed as a naturally occurring phenomenon, capable of direct observation (Lofland and Lofland, 1995). An exploratory approach would enable the researcher to study participants within their natural settings as they came together to form the new groups (Bowling, 2004). The research aims implied a commitment to an ethnographic approach, focused on exploring the nature of the social phenomenon presenting, rather than on testing hypotheses about it (Denzin and Lincoln, 1998a). Moreover, the
researcher wished to focus on “participants’ methods, definitions of order, explanations and assessments” (Pollner and Emmerson in Atkinson et al 2007 p. 119) in order to develop a framework for understanding the phenomenon of Local Health Group formation and development. Thus ethnographic features would need to be incorporated into the study design (Atkinson and Hammersley in Denzin and Lincoln, 1998a).

These considerations pointed towards taking a case study approach (Bowling, 2004, p.404). The phenomenon to be studied: the emergence and development of these new organisations, formed a discrete whole (22 LHGs) within a bounded geographical and administrative area (Wales). This area also had a degree of policy autonomy (Drakeford, 2006) from the rest of the UK, as a new Assembly government had been elected in 1998. These features conferred a significant degree of distinctiveness to the LHGs. The “case” therefore would be the 22 LHGs themselves.

Because of the dynamic nature of the phenomenon to be studied, however, a method that would enable the researcher to capture both the longitudinal and “processual” aspects (Pettigrew 1973) of the change experience would be needed. Selecting all twenty two LHGs would enable a comparative approach to analysis to be taken, as it could be assumed that each LHG might respond
differently, in light of their own specific context and perceptions of need, to the policy challenge presented to them.

However, the issue of access still remained: how best to capture the experiences of this group given the practical limitations of time and resources available to conduct the study. In this respect, Rosemary Stewart's (1996) study of 20 newly appointed District General Managers (DGMs) across England and Wales, as part of a restructuring of the NHS in 1985, provided an important element of inspiration for the present study. Stewart selected 20 DGMs and interviewed them at regular intervals over the course of the next two years to elicit their views of their jobs and what they felt had gone well or badly. Stewart's aim was to develop a definition of leadership and subsequently to base management development activities around this definition. Stewart had a team of four researchers, and funding from the NHSTA for the study, which consisted of semi structured interviews, with lengthy initial and final interviews, averaging about 25 interviews per subject. The study resulted in a comprehensive analysis of the experience of the emergence of a new form of leadership within the NHS in the UK. It was one of the first studies of its kind, in the NHS, focussing as it did on the people responsible for policy implementation, and, in particular, on their experiences as they took on new roles. This work thus had a number of similarities with this researcher's aims, in that it studied the impact of the
creation of new roles as part of a major structural change; secondly, it explored individuals' experiences as they took up these new roles; thirdly, it focused on the individuals' experience as a way of learning about the social whole; and, finally, it identified implications for leadership development in the future. It was decided to construct a similar study, though on a much smaller scale, sufficient to address the research questions specified, and at the same time, commensurate with researcher time and available resources. The commitment to an exploratory inductive approach would be central to the research activity.

3.2.1 Time Frame and Perspective

Focussing on the experiences of the twenty two LHGs, from formation to development, would enable "emphasis on the organization as an ongoing system with a past, present, and a future" (Pettigrew, 1973, p. 268) to be built into the study design.

The study would be prospective, following the initial establishment and subsequent development of the LHGs over a period of time. This would enable the social process of change and development to be explored. The researcher aimed to get as close as possible to the LHGs in order to learn how they interpreted their remit and developed plans to operationalise it. Ideally, some form of direct observation would have been appropriate. However the logistical difficulties of systematically observing 22 groups across Wales over a period of time whilst working full time meant that a more
focused – and thus more limited - approach would have to be used. Furthermore the researcher, as a senior manager within the agency responsible for leadership development in the NHS in Wales, wanted to avoid any hints that the study was an evaluation of progress of the new organisations. The aim was to focus on participants’ own understanding, to learn as much as possible about their experiences of the development process and pathway itself.

Therefore the researcher’s key aim remained the identification of the challenges and opportunities perceived by key players themselves. Previous primary care development studies had tended to focus on evaluation of either the implementation of policy directives, or, less frequently, of their outcomes. Such studies tended to be conducted from a “top-down” perspective. In this situation, however, the researcher sought to identify development opportunities and implementation barriers from the perspective of those directly responsible for implementing the new policy, ‘on the ground’. By studying the implementation of the new policy as a process, by focussing on a major organisational change within a specific health system, the aim was to create a picture of the drivers promoting, or inhibiting change, over time. It was hoped that identifying issues faced by social actors, at field level, and in such a context, would contribute to improved understanding of the difficulties facing those responsible for
implementing policy at local level, and, ultimately help to inform the policy making process.

3.3 Selection of the Chairman as Key Actor and Focal Point of the Study

The role of LHG Chairman was selected as the eventual focal point for the study. This individual, elected by GP peers but directly accountable to the Secretary of State for Health & Social Care, held primary responsibility for the creation and development of the new organisations and, ultimately, for the delivery of the LHG’s remit (Welsh Office 1998b). The Chairman, as the first appointment and lead figure, would also have a role in selecting many of the new Board members, and in selecting his General Manager (the accountable officer of the LHG). The Chairman would, therefore, have a major role in shaping the new organisation.

The role of Chairman was unusual in another respect, namely its relative independence within the health care provider system. The Guidance Advice (Welsh Office 1998b) indicated that Chairmen – and independent contractor clinician Board members – should be professionals actively practising in the locality. Whilst Board members were to be paid honorariums as token recognition for the time they were devoting to the work, Chairmen were allocated designated sessions (2) for their duties. At the same time,
however, as practising GPs, they each held additional sources of income, independent from their roles as Chairmen. Their income as practising professionals far exceeded the honorarium paid to them as Chairmen. Moreover, as local GPs, they lived in the communities they were elected to represent, and thus knew their 'patches' well, with (on the whole) longstanding family ties to the area. They would be likely to be respected and recognisable local figures within their communities. And they would be unlikely to have been closely associated with the management community responsible for health policy and decision-making. This added to their independence of viewpoint.

LHG General Managers were also possible focal points for the study. The General Managers however had complex accountabilities. They were appointed by Health Authority Chief Executives, and remained accountable to those Chief Executives, for the work of the LHGs as sub committees of the Health Authorities. They were required to work closely with Chairmen to create and develop the new organisations, but their salary slips came directly from the health authorities, as they remained health authority employees. The General Managers were also career NHS managers, and as such, would be likely to see themselves as responsible for implementing, rather than changing, any central policy directives. In addition, any future career ambitions would be highly sensitive to perceived performance and loyalties in this
role. In the researcher's opinion, this ambiguous position incorporating potentially conflicting loyalties, might introduce an element of selective recall, and thus potential partiality into the study.

Mapping the development of the new organisations through the Chairman's eyes and ears would avoid any bias inherent in a more ambiguous role. However the Chairmen would also come into the role with a particular perspective and set of experiences. Because, however, so few of them had any prior management experience, they might bring a freshness of perspective to the work. Most would be expected to bring a high degree of local experience and sensitivity as well, which career managers, who by necessity need to move relatively rapidly across organisations in order to gain promotion, were unlikely to be able to match.

Other members of the LHG Boards represented a wide diversity of groups, with very few common features. Each of the other independent contractor professions was represented by only a single member in each locality. Nurses were represented by two representatives, drawn from an unspecified variety of different specialties within the profession (e.g. Health Visitors, District Nurses, Midwives) and, though each would have made a fascinating group to study, drawing any generalizable conclusions from their collective insights might have proven problematic.
Nurses did not have a leading role to play in the development of the LHG per se: rather, they were one among many, with the same status as other professionals on the Board. Given that a key research question was the identification of leadership behaviours, the decision was made to focus on the Chairmen as the key actors in this study.

3.4 Data Collection: The Semi-Structured Interview

Having selected Chairman as the focal point for the study, the issue of access largely determined the method of data gathering employed to carry out the research. The logistical problems involved in arranging access to 22 different groups across Wales, for the purpose of observation, have already been mentioned. Ideally, direct observation of LHG Board meetings might well have been the most desirable way to capture the experience of setting up and developing these new organisations. However, in the researcher's experience as a senior NHS manager, Board meetings tend to be rather formalised affairs, with much of the decision making agreed informally outside of the meeting. For this reason, direct observation of Board meetings did not appear to offer the best opportunity to collect the "richest possible data" (Lofland and Lofland 1995). The researcher would only have been able to attend those Board meetings open to the public anyway. It was decided instead to collect Minutes of Board meetings and use these as a means of triangulating data gathered from other sources.
3.4.1 Interviews as Data Collection Instrument

Meeting with, and talking about the challenges and opportunities presenting themselves to the Chairmen, would offer insights into their own understanding of their roles and the issues they were identifying as important in carrying out those roles (Taylor, 2005 p. 41). This in turn would shed light on the extent to which they saw themselves as agents for change, what their motivations were and where their loyalties lay. Thus the proposed schedule of “intensive interviewing” was meant to “discover the informant’s experience of a particular... situation” or experience (Lofland & Lofland, 1995). It would enable a relationship to be built up, over time, with each of the Chairmen that would draw out their own construction of their new worlds and the issues which struck them as important. The decision was therefore made to carry out one-to-one interviews with each of the Chairmen over the next two years.

Interviews were guided, rather than structured, allowing the social actors themselves to identify issues of importance to them (Marnoch et al 2000), thus enabling insights into both the process of development of the new organisations and the experience of developing them (Flynn et al, 1996). An interview guide was constructed, based on issues identified in the literature as likely to be pertinent, together with those issues identified by the researcher's previous study (Williams 2002). An Interview Guide
was devised for each tranche of interviews. Table 3.1 is the first one. Subsequently, efforts were made to incorporate issues raised by Chairmen themselves, to test the relevance of these more broadly. In addition, each Chairman was sent a summary of his previous interview, together with a broad list of topics to be covered in the ensuing interview. An exemplar is listed in Appendix A.
<table>
<thead>
<tr>
<th>Step 1: Establish Rapport</th>
<th>Explain my interest in study; Professional background &amp; current roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat study aims</td>
<td>Anticipated outcomes of study</td>
</tr>
<tr>
<td></td>
<td>Benefit to individual participant:</td>
</tr>
<tr>
<td></td>
<td>reflection/PPDP points if wished</td>
</tr>
<tr>
<td></td>
<td>Benefit to me: PhD</td>
</tr>
<tr>
<td>Agree process</td>
<td>Initial &amp; Final Interviews: face-to-face;</td>
</tr>
<tr>
<td>Get permission to record</td>
<td>Turn on Tape</td>
</tr>
<tr>
<td></td>
<td>Make sure tape is working</td>
</tr>
<tr>
<td>PROMPT:</td>
<td>check red light!</td>
</tr>
<tr>
<td>Step 2: Start Interview &quot;proper&quot;:</td>
<td>How did the interviewee approach the role of Chairman?</td>
</tr>
<tr>
<td>1. Role of Chairman (Run up)</td>
<td>Why ran for election?</td>
</tr>
<tr>
<td>2. How found role once elected?</td>
<td>What hoped to achieve?</td>
</tr>
<tr>
<td>3. Training &amp; Development Needs:</td>
<td>Did you ID any?</td>
</tr>
<tr>
<td>4. Setting up the LHG</td>
<td>How did you go about meeting these?</td>
</tr>
<tr>
<td>5. LHG Aims</td>
<td>Hopes for the next 3-6 months?</td>
</tr>
<tr>
<td>Stage 3: Summary &amp; Closure</td>
<td>Thanks for time</td>
</tr>
<tr>
<td></td>
<td>Promise to send summary for review</td>
</tr>
<tr>
<td></td>
<td>Remind will contact in 3 months for update</td>
</tr>
</tbody>
</table>
3.4.2 Problems of Access

The first interview would be conducted face-to-face, and would establish a form of baseline; subsequent interviews would explore Chairmen’s views of their own, and their organisations’ experiences over time. Interim interviews were intended to be conducted by telephone, with the final interview, again to be conducted face-to-face. The initial and final interviews were expected to take about one hour; interim interviews were designed to be shorter. Initially, the researcher planned to carry out a series of three interviews per year, with each Chairman, over the course of the two year study. In practice, however, the experience of carrying out the initial interviews, in terms of access and duration, to say nothing of travel time, made it necessary to curtail this ambitious programme considerably. In the event, the initial interviews took an average of one and a half hours – one took three hours – in addition to travel time. Because of the nature of the geography and transport links of Wales, travel time was often considerably out of proportion to distance, even though efforts were made to schedule interviews geographically: for example, undertaking all those based in North Wales over two days, but this still entailed an additional two days’ travelling time, all to fit with the demands of what were rapidly becoming the researcher’s two full-time jobs. In addition, the Chairmen’s additional commitments and the requirements of their ‘day jobs’ severely limited the opportunity to schedule interviews in
geographical groupings, or to suit the researcher's convenience.

Despite their willingness to participate in the study, the constraints on their time were many and the researcher was grateful to get into their diaries at all.

3.4.3 Enrolling study participants

The researcher had contributed to the design of the development programme created (under the auspices of the NHS Staff College Wales) to prepare the newly elected Chairmen for their new roles. As part of this process, the researcher attended the final two day study block for the Chairmen, on 1-2 July 1999. This study block provided an opportunity to speak with individual Chairmen and to invite them to participate in the study. It became clear at this meeting, however, that the Chairmen were interested in forming their own peer group by this time. Indeed one of the aims of the development programme had been to bring them together to begin sharing their learning as they took up their new responsibilities.

From the perspective of primary care development this was a very good thing, but from the perspective of the researcher it had a definite down side in that, as a group, they were becoming protective of their collective privacy. They decided, for example, to meet quarterly as an all Wales group. They did not agree to the presence of "outsiders" at these group meetings. Eventually, I was able to participate in, and observe, selected development activities;
nonetheless, the one-to-one interview process remained the principal data collection tool.

Following the Study Days held on 1st and 2nd July 1999, the researcher wrote individually to each Chairman, formally inviting him to participate in the study. The letters explained the purpose of the study, the research method and tools, and the efforts that would be made to safeguard each individual's confidentiality throughout the study (Appendix A). The letters included a tear off slip, to be signed in agreement to participate in the study, together with relevant contact details.

This study took place before current Medical Research Ethical Committee requirements had been designed or implemented. It should be noted that, remarkably, all twenty two Chairmen agreed to participate in the study. All 22 Chairmen remained enrolled in the study throughout its duration.

3.5 Validity Issues

The research method adopted was designed to elicit individual actors' subjective impressions, experiences and views in order to discover the meanings they attributed to their interactions with other key actors and agencies within the health and social care system in Wales. In order to aid critical reflection and analysis of these accounts, however, some mechanisms for validating the
data would be necessary. Three approaches to this problem were adopted: participant validation; triangulation; and inclusion of all possible cases in the study design.

The first mechanism for ensuring accuracy of interpretation was participant validation, gathered in two ways. Firstly, after each interview was transcribed, the researcher produced a summary of the issues raised by the individual. This summary (see Appendix B for an exemplar) was sent to each Chairman as an aide memoir, together with a list of topics to be raised in the subsequent interview, two weeks before it was scheduled to take place. At the beginning of each successive interview, the participant was asked to comment on the summary and the researcher’s understanding of the points noted. Secondly, as the study progressed, and to aid interpretation of the emerging analyses, the researcher devised two additional frameworks. The first framework was a diagrammatic representation of the organizational landscape through which LHGs were making their ways. Chairmen were invited to comment on the accuracy of this diagram as a map of their key stakeholders. This map was initially used to check the researcher’s understanding of the organizational context. As the analysis progressed, and the importance of relationship-building became clearer as central to the LHGs’ development as organizations, the researcher adapted the map as a tool for eliciting Chairmen’s perceptions of the relationships they were
The researcher subsequently added a rating scale to the diagram to enable discussion of the quality of the relationships that Chairmen felt were developing with each of the relevant organizations, over time.

Secondly, during the second tranche of interviews it became clear that a number of different forces were affecting LHG development. The researcher constructed a chart along the lines of Lewin's (1951) Force Field Analysis to try to capture the range of these forces and their impact. Lewin's diagrammatic tool was devised as a means of analysing organizational contexts in terms of the likelihood of a proposed change being adopted. Essentially, it enables mapping of factors promoting the adoption of a change on the left hand side, juxtaposed by factors likely to hinder adoption on the right hand side, with arrows of different sizes to denote differences in strength. Again, in this study, participants were asked to comment on the extent to which the researcher's analysis reflected their own understanding and interpretation of their world.

As interview prompts these two tools were valuable; they were useful means of checking the validity of the researcher's emerging interpretations (Miles and Huberman 1994). However the relationship indicator was not meant to be, and proved not to be, wholly successful as a measurement tool. Respondents varied in
their receptivity to, and use of, the tool, with some Chairmen expressing discomfort with using it. The researcher was also anxious to avoid leading the respondents too much in one direction, at the expense of providing space for them to raise their own issues, within the limited periods of time available for interviews. Nonetheless, both the organizational map and the Force Field diagram provided useful frameworks for the researcher, against which to test her own emerging understanding and interpretation of the data with participants.

3.5.1 Potential Threats to Validity Participant validation is recognised to be imperfect (Bloor, 1983 cited in Maxwell, 1996). Maxwell (1996, p. 94) cites Guba’s and Lincoln’s (1989) view that “systematically soliciting feedback from the people you are studying...is the single most important way of ruling out misinterpretation”. But Bloor is reported by Maxwell (1996) to counsel caution, noting that participants’ responses to the researcher’s analysis can only be taken as evidence regarding the validity of that account. In other words, the participants’ accounts are not, in themselves, necessarily valid; hence the need for corroboration from other sources.

Two points are important to note here. The first is the reminder that it is participants’ own experiences that are of prime interest in this study. The aim throughout has been to capture the
participants' own perceptions, values and meanings that they attribute to their actions and those of others: in other words, relative not absolute "truth". The aim is to build a picture of their world, in order to understand more fully the actions they took to develop their organizations and why (Miller and Glassner 2006, pp 126-7). It is only by getting closer to their understanding of the world in which they found themselves, as change agents, that we can hope to understand the reality of the policy implementation process on the ground.

Secondly, therefore, triangulating the interview data with documentary evidence from Minutes of LHG Boards, and policy documents, was an appropriate strategy for testing the validity of interview data. Denzin referred to this as validation by data source (Miles and Huberman 1994, p. 267). In line with this strategy, each LHG was written to, requesting a full set of the Minutes of all public Board meetings held between 1st April 1999 and 31st March 2003, i.e. covering the full time span of their existence. This combination of data collection methods: structured questionnaire and guided personal interviews, limited participant observation, and documentary analysis was intended to build a detailed understanding of the context as well as of the process of development, thus contributing to the growing body of policy ethnography in the NHS (Flynn et al, 1996).
Thirdly, the inclusion of all twenty two LHGs in the study was useful in reducing potential bias because it enabled constant, ongoing comparisons to be made. This enabled continuous testing and re-testing of emerging findings (Maxwell, 1996). Participants' own feedback served to provide an additional check on the validity of the researcher's emerging analyses.

3.5.2 Researcher Bias Commentators have, however, also noted the extent to which researchers can influence the research setting and its participants (Miles and Huberman 1994, p. 265). To minimise potential effects like this, and to prepare to introduce herself to the study participants, the researcher prepared a personal profile. This was also helpful in carrying out the interviews, because it enabled the researcher to think about how to develop an atmosphere of trust, to gain insight into her interactions with the study subjects, and, also, into her own interviewing techniques.

In addition, Miles and Huberman suggest a number of steps that can help to reduce researcher bias (1994, p. 266). In line with participants' time and space constraints, interviews were held in a wide variety of settings, including Chairmen's own surgeries, practice libraries and, in some cases, own homes. For example, at the beginning of the study, few LHGs had premises of their own, leaving Chairmen to identify and procure them as one of their first.
duties once appointed. Taking field notes from each setting helped to identify and 'ground' some of the challenges facing Chairmen in the early months of the study. Towards the end of the study, when most LHGs had acquired their own premises, meeting Chairmen there emphasized the development that had actually taken place in the intervening period of time. In addition, the researcher made specific, systematic and continuous efforts to clarify her own purpose in conducting the study, through initial letters of invitation, followed up by invitations to specific interviews, the interview schedule, and the summaries prepared for each Chairman following each interview (Appendix B: Exemplar).

Inevitably, too, the researcher can be a source of potential bias, in this type of research. Again, led by Miles’ and Huberman’s (1994) suggestions for reducing this, visits to the participants' work sites were spread out over six month periods over the course of the three years of the study, thus minimising her impact on the research sites. In addition, the researcher’s work brought her into contact with a number of policy makers and advisors throughout the period of the study. Naturally, these people made comments about the policy implementation process from their perspectives. Some of these yielded material directly relevant to the study. In such cases, the researcher was careful to make detailed notes. These provided a useful comparator for the researcher. In the
same way, observing a key meeting of the Assembly government's Health and Social Services Committee provided further opportunity to gain insight into the policy intentions being promulgated, and the forces driving them. Every effort was also made, throughout the study, to think conceptually (Miles and Huberman 1994, p.266). The analytical frameworks constructed to elicit participant feedback on emerging interpretations exemplify such efforts. Nonetheless, the researcher became increasingly aware of the potential biases inherent in her own position within the health system, and the potential impact that assumptions implicit in her own work role might have on the subsequent interpretation and analysis of data. To address this aspect of potential bias, the researcher has tried to make these as explicit as possible throughout the study, from design to analysis. In this way the researcher's own understanding of the context is made as transparent as possible.

The two development programmes that the researcher participated in and observed took place in 2000 and in 2001. The first focussed on developing the key relationship between Chairman and General Manager; the second looked at leadership styles and skills. The latter programme was designed to prepare Chairmen for what they perceived to be a stronger leadership role appropriate for the new organisations which it seemed likely would be created once health authorities were wound up. Both of
these two-day programmes provided insights into issues the Chairmen had identified as important to their own development and that of their organisations. As such they served again to help validate data collected from the interview process rather than to generate new data. In addition the researcher’s professional role required attendance at various LHG Conferences. Meetings with senior NHS Wales and Assembly officers were also part and parcel of the researcher’s working life. This created opportunities for observation that were valuable in terms of supporting or refuting emerging hypotheses. Relevant observations and comments are noted in the text in footnotes where referred to in ensuing chapters reporting on the results of the analysis.

3.6 Conduct of the study

All interviews were carried out on a one-to-one basis. Each Chairman was written to personally, inviting him to participate in the study, and enclosing written consent forms. Guarantees of confidentiality were also given. Care needed to be taken to ensure that no hint of information divulged by one Chairman was ever shared with another. The interviews took place at roughly 6-9 month intervals between August 1999 and December 2001, as the Table below shows (Table 3.2):
Table 3.2 Interview Schedule

<table>
<thead>
<tr>
<th>Initial Tranche</th>
<th>Interim Tranche</th>
<th>Final Tranche</th>
</tr>
</thead>
</table>

As noted above, all 22 Chairmen agreed to participate in the study; all 22 continued to participate throughout the course of the study, apart from three, who had resigned from the role during the course of the study. In all three of those cases, their replacements agreed to, and continued to, participate. This high level of participation over the course of a two year study was very rewarding. It may have been – and indeed several Chairmen commented that this was the case – that they found the interview process a useful opportunity for reflection. The researcher tried to develop a relationship of trust with each of the participants, and to maintain it by scrupulously respecting their confidentiality. Some of the emerging analyses were reported to two all Wales Primary Care Research seminars, and to two international conferences on strategic issues in healthcare management, but stringent efforts were made to ensure that no comments were attributable to individuals. This required special care as such a small group of high profile people could be easily identifiable within a community as small and relatively closed as NHS Wales. Nor was any data, or analysis, made available to the Welsh
Assembly Government at any stage, though some interest was expressed.

3.6.1. Timescale Finally the length of time needed to conduct, transcribe, summarise and feedback the interviews to the participants, and then to carry out the analyses, meant that the original intention to carry out interviews at quarterly intervals was wildly ambitious and impractical. The original interval schedule was thus pared down to three interviews per Chairman over the course of the three year study; this produced 67 interview transcripts in all (in one case both the retiring Chairmen and the new Chairmen gave interviews). Nonetheless, the study design and method adopted enabled the researcher to capture the processual nature of the organizational change in question, as recommended by Pettigrew (1996).

In the event, and this would have been impossible to have predicted at the outset of the study, the time period of the study matched the lifespan of the LHGs as organizations. The decision to abolish health authorities was announced in January 2001, with the publication of the NHS Plan for Wales, *Improving Health in Wales* (NAW 2001). From 1st April 2003, LHGs were transformed into statutory agencies, Local Health Boards, with responsibility for commissioning and providing primary care.
services to their local populations. The organizational boundaries, coterminous with local authorities, remained intact.

3.7 Data Analysis

Each interview was recorded by the researcher, whether it was undertaken face-to-face or by telephone, using electronic devices. In addition, the researcher took her own notes during each interview. Field notes were also made, after each interview, to record the researcher's initial impressions of the interview setting and the interview process. These served as useful checks on understanding throughout the study. For example, notes on the researcher’s impressions of the site at which each interview took place, and the potential impact the conditions noted had on the individual Chairman’s challenges in carrying out his new role (eg lack of personal space, or office support, or premises for the LHG and the impact on developing organizational identity) were captured. Subsequently these helped to inform analysis.

Each tape was checked by the researcher, immediately following the end of each interview. In one or two cases, perhaps inevitably, the tape had malfunctioned. In both of those cases, the researcher immediately checked her own notes and, by transcribing them virtually immediately, was able to reconstruct the main elements of the interview. The subject’s verification of the substance of the interview was invaluable in such cases too.
In all cases, interview transcripts were listened to, by the researcher, and transcribed within two days following the interview. As the interviews progressed and the transcriptions became more time consuming, an external resource was employed to assist the researcher with the mechanics of transcription. This ensured that all tapes were transcribed within a reasonably short timeframe following the interviews. In these cases the researcher again checked each transcription by following it line by line while listening to the tape. This ensured that nuances of speech were captured and aided understanding and interpretation. This approach helped to ensure that attention was paid to the details that contribute to understanding of the individual actor's meaning within the whole context (Potter and Weatherell, 2000).

3.7.1 Analytical Techniques Each individual transcript was coded, line by line, by hand, by the researcher. Because the interviews were often conducted in batches for geographical reasons, it was easier to find oneself immersed in the data, during analysis. This helped in “searching out patterns” and the identification of phenomena, “and being sensitive to inconsistencies” (Bryman and Burgess 2000, p. 6-7). Clearly, the interview guides themselves provided an initial and rudimentary indicative coding frame. After the first ten interviews were addressed this way, the researcher began using colour codes to identify emerging groupings of concepts across transcripts, using highlighters and
matching self-sticking plastic tabs. These groupings were tested, against each transcript, as possible themes. This process of referring back and forth between categories emerging and the data itself, enabled the researcher to make connections between the categories, in a form of 'axial coding' (Bryman and Burgess 2000, p. 5). This process was further aided by writing analytical memos throughout the process of analysis. This helped to capture insights generated and to access them again, at later stages in the study. Such memos proved to be invaluable throughout the (lengthy and frequently interrupted) period of analysis, theory generation, and writing up (Bryman and Burgess, 2000, p. 5).

Where relevant themes emerged from preliminary analysis, they were incorporated into the interview guide for inclusion in subsequent interviews, so that data analysis continually informed data collection (Charmaz and Mitchell, 2001, p. 161).

In late 1999, the researcher entered the first twenty transcripts into NU*DIST for electronic analysis. The researcher had attended a course on using NU*DIST and had hoped that using the package would be an aid to data analysis throughout the study. The researcher's experience of using the package, however, was not wholly positive. The researcher felt that a degree of distance from the data was created by using this approach. This distance had the effect of reducing researcher control and thus confidence in
understanding and interpretation. As Jennifer Mason (2000, p. 108) has noted:

"computers cannot perform the creative and intellectual task of devising categories, or of deciding which categories ... are relevant.... Or what is a meaningful comparison, or of generating appropriate research questions and propositions with which to interrogate the data...."

For this reason, the researcher discarded the electronic approach and returned to using a manual approach to coding and analysis throughout the study. Although the manual approach did not make it easy or quick to retrieve data, the researcher was able to maintain close contact with the data.

Each wave of interviews – initial, interim, and final – were analysed individually and then collectively within “waves”. In addition, vertical slices were taken to try to get a fuller understanding of the processes and context. During this process a parallel “time line” (Appendix C) was created by the researcher, noting significant policy events and announcements from the WAG, which would be expected to have an impact on the concerns of Chairmen during this period. The time-line was used to help further triangulate the interview data.

3.7.2 Analytical frameworks applied Throughout the analysis, special attention was paid to participants’ own words in an effort to understand the specific meanings they attached to their own actions, and those of other agencies. Weick’s (1995) work on the way individuals and groups make sense of their environments was
an important analytical aid to understanding meanings and concepts generated, prompting the researcher to look more deeply into the subtleties of Chairmen’s discourses.

In addition, the relationships the Chairmen formed and the value they placed on those relationships was particularly noteworthy and significant in the context of this study. During the course of writing up the data, a typology created by Schulter and Lee (1993) for the Tavistock Foundation and later adapted by Meads (2001) for use with primary care organizations in England (see Chapters 7-9) was especially helpful in organising the reporting of the relationships that were developing throughout the study. This typology was not used as a measuring tool in this study, but as a reporting device.

An additional theoretical framework was identified by the researcher towards the end of the period of data analysis and interpretation. The concept of organizational receptivity to change, was first written about in relation to public sector organizations, by Pettigrew, and later amplified by Pettigrew, Ferlie and McKee (1992). But Butler applied the framework to public sector organizations in 2003. Butler’s application was particularly helpful to the researcher in helping to build theory from the data gathered in this study. Butler defined receptivity as a series of features, or patterns of associations, which appear to contribute to
enabling an organisation to adapt and change. Receptivity factors are dynamic, and, therefore, indeterminate in outcome, so are best identified over time. They are also likely to be context-driven and specific. Butler's work was based on the study of existing and well established local authority organizations. The factors he identified emerged from a case study of the ways in which the two organizations responded to government-initiated policy directives on contracting out. This study on the other hand examines new emergent organizations. Nonetheless the concept proved useful to generating further understanding in this study.

3.8 Summary

As stated at the outset of this chapter, the research aim was to explore factors that influenced the development of LHGs in Wales between 1999 and 2001. The setting chosen was Wales, because it offered a discrete geographical and policy arena. The specific case to be studied consisted of the twenty-two Local Health Groups created on 1st April 1999. An exploratory inductive approach was the research method selected as most appropriate for addressing the research aim. The LHG Chairmen were selected as principal actors whose experiences would be captured, throughout the study period, using one-to-one semi structured interviews. Analysis was conducted according to principles of grounded theory.
The next chapters, 4 through 10, give the results of the study. Chapters 4 and 5 examine in detail the context in which the study took place, focussing on the different structural arrangements created, their intentions and their effects in practice, and thus address research question 1. Chapter 6 examines the characteristics that Chairmen, the key actors in this study, brought to their roles and their implications, thus addressing research question 2. Chapters 7, 8 and 9 examine the horizontal and vertical relationships formed by chairmen, and their importance in terms of the development of LHGs. These chapters address research question 2, identifying specific leadership behaviours relevant to Butler's 'institutional politics'. Chapter 10 examines the assets identified and applied by Chairmen to the task of building and developing their new organizations, thus addressing research question 2. Chapter 11 discusses the implications of the results and concludes the study with recommendations applicable to leadership and organizational development and policy implementation, along with suggestions for further research, addressing research question 3.
Chapter 4: Structural Influences on LHGs: Locating Decision-making in NHS Wales 1999-2002

4.1 Introduction

This chapter, and the next one, address the first research question: the nature of the structural influences on LHG development. This chapter examines the vertical, or hierarchical, linkages with LHGs, illustrated in Figure 4.1; chapter 5 analyses the horizontal connections with LHGs. Figure 4.1 shows the organizational landscape of NHS Wales during the period under study. The solid bold lines indicate existing connections between organizations; the larger bold arrows point to the hierarchical relationships; dotted lines indicate new connections needing to be created, to implement the policy directive to build partnerships to improve service integration. The wide variety of stakeholders arises from the policy directive to increase responsiveness to the local community. Section 4.2 explains the roles, terms of reference, and structure of LHGs arising out of the 1998 policy decision to create primary care organizations across the UK. Section 4.3 examines the structural links between the LHGs and the National Assembly for Wales (NAW). Section 4.4 examines the structural links between LHGs and the five health authorities across Wales. Section 4.5 summarises the chapter, and its relationship to the research questions posed at the beginning of the study.
Figure 4.1: Key LHG Stakeholders in Wales

National Assembly for Wales

Health Authority

Politicians: (AMs, MPs)
Local Authority
Local Health Alliances

22 LHGs

Press/Media
Voluntary Sector

NHS Trusts

Professional Communities
(Independent Contractors, Nurses, PAMs, etc) LMCs

General Public:
CHCs
Local community
Local politicians

Key:
Relationships already in existence: eg Trust<->HA: solid lines
Relationships to be forged by LHG: dotted lines

Bold type/larger font: more established players with statutory power and authority in the system
Plain type/smaller font sizes: advisory relationships and potential to influence rather than direct LHGs

Source: Developed by researcher in February 2000, following first tranche of interviews, in order to elicit participants' views of emerging analysis and interpretation in 2nd tranche of interviews during Summer 2000.
The study draws on interview data\textsuperscript{1}, supplemented with grey literature and Minutes of LHG Board meetings, to analyse the distribution of power and influence within NHS Wales in 1999, as a backdrop to locating the decision-making points within the health system, and illustrating the ways in which the new structures facilitated or impeded the development of LHGs, between April 1999 and October 2001.

The key stakeholder groups included in this discussion, and shown in Figure 4.1, comprise all those with whom LHG Chairmen were trying to build positive relationships: firstly, looking vertically, the newly-formed Welsh Assembly (NAW, later WAG), and within that the NHS Directorate; and the Health Authorities (HAs); then, looking horizontally, Local Government, including Social Services departments and Local Health Alliances (LHAs); NHS Trusts; Local Medical Committees (LMCs) - and to some extent other Local Professional Committees (LPCs) representing the remaining independent contractor groups; educationalists; Community Health Councils (CHCs) and voluntary organisations; and, of course, the media. Apart from the LHAs, these agencies pre-dated the establishment of LHGs. All of them, however, could be said to have had a strong interest in primary care development within their local communities. This

\footnotesize{\textsuperscript{1} Data excerpts used throughout the dissertation are taken from transcripts of interviews with Chairmen. Each Chairman was assigned a three digit code at the beginning of the study. The single digit suffix refers to the relevant interview tranche, followed by the date on which the interview took place. In addition selected sections of the excerpts are put in bold type to aid reader understanding.}
chapter, therefore, focuses on the impact that the new structural arrangements had on the vertical distribution of power and influence within NHS Wales.

Together chapters 4 and 5 explore the political and cultural context in which the specific case under study is situated, thereby addressing the first research question. In so doing, they set the stage to examine the notion of 'organizational receptivity' (Pettigrew et al 1992; Butler 2003) to change, as indicative of an organization's capacity to react positively and constructively to new government policy initiatives. The analysis suggests that, despite all the good intentions to strengthen primary care enshrined in policy and rhetoric, the structural changes made were inadequate to the task. The organizational restructuring effected, though extensive, appears to have had little impact on the dynamics operating within the health system in Wales, or on the distribution of power and influence within it, during the years under study.

LHGs 'went live' on 1st April 1999, officially charged with improving the health of their local populations (Welsh Office 1998b). How did other stakeholders react to this new organisation? These reactions can be analysed in terms of the structural changes introduced and the impact these changes had on the behaviours of the key actors involved. Specifically, it is
argued here that the structural changes themselves had a
determining effect on the location of decision-making throughout
the system. Analysis of the extent to which the newly appointed
Chairmen, as key actors within the system, were then able to
influence the subsequent development of the new LHGs forms the
subject of this thesis.

"....the Health Service conducts its business in this kind of fragmented
and sort of factional way, really. In a way it seems to be a system
where it arms the various groups, and then enables them to have a
sort of open house – not to say guerrilla warfare because that's too
negative – but...there seems to be a kind of thicket of different
groups with their interests, but making clear progress quite
difficult really...." (006.3: 16.07.01)

This LHG Chairman’s view of the LHGs’ development process,
after nearly three years in post, is salutary. His frustration with
the lack of “progress” was common across virtually all Chairmen,
and the frustration they experienced continued to grow over time,
from a feeling of impatience to get on with the job – and to be freed
up to do so – in early summer 1999, to a general perception of
being actively hindered from delivering the vision they felt
themselves to have been appointed to achieve, by summer 2001.

This analysis focuses on organizational re-structuring, and the
resulting interplay between agencies, context and actors (McNulty
and Ferlie 2004; McAuliffe and McKenzie 2007). It examines the
forces marshalled by different agencies, both individually and
collectively, to influence the actions of others. This microanalysis
thus traces the roles of interest groups and government in relation
to the specific policy of establishing a primary care focussed NHS
in Wales (Pollitt, Burchill and Putnam 1998), based on an examination of organisational structures and their impact on individual behaviours (Lipsky 1980). The assumption is that, in any organisation or system, a number of interests operate simultaneously, and often these interests conflict with each other. Organisational structures can enhance or decrease the potential for mutually advantageous adjustment of these conflicting interests. Examining the extent to which the new structures created helped to encourage – or worked to impede - implementation of this espoused policy will contribute to increased understanding of “the mechanisms by which essentially antagonistic or divergent interests are adjusted (Dahrendorf, cited in Lipsky 1980 p.17). The analysis proceeds to examine the extent to which any collective actions identified could be seen as significant “system realignments” (Hartley 2002).

As Figure 4.1 illustrates, LHG's could be said to have been created in the midst of a fairly crowded organizational landscape. The existing organizations could be categorized as key stakeholders, holding a strong interest in primary care activity. How did their roles and responsibilities complement or conflict with those of the new organizations?
Establishing LHGs: Structure, Membership, and Terms of Reference

*Putting Patients First* (Welsh Office 1998a, paragraph 4.19) specifically states that the rationale behind setting up the new Local Health Groups was “to ensure that primary care is empowered and supported to improve the health of their local population”. LHGs were constituted, therefore, so as:

> “to give GPs and other local stakeholders the opportunity to take increasing responsibility for shaping health services to meet local need and by taking responsibility for commissioning local health care” (Welsh Office 1998a).

The Guidance Advice (Welsh Office 1998b, p.1) emphasized the pivotal role that LHGs were expected to play, stressing that they “must be vehicles for decision-making not just maintaining the status quo”, and laid out the three core areas of responsibility, shown in Table 4.1.

It is also important to note, in light of subsequent events, two additional directives included in the document. Firstly, the Guidance Advice emphasised that, although LHGs were initially being established as sub committees of health authorities, they would “be encouraged to take on greater autonomy and responsibility”, that criteria for assessing this would be agreed early in 1999, and that LHGs would take on “direct responsibility for commissioning” from April 2000 (p3). Secondly, in addition to the roles, outlined in Table 4.1, the Guidance Advice specifically noted the need for LHG Board members “to act corporately” in
### Table 4.1: The Role of LHGs

<table>
<thead>
<tr>
<th>AIMS</th>
<th>OBJECTIVES</th>
</tr>
</thead>
</table>
| Development of local Health Improvement Plans: | 1. Proposing priorities and opportunities for the development of primary health care  
2. identifying local health needs  
3. focusing on the quality of services provided for local communities  
4. building effective links with local partners in health |

- “Implementing the HIP should be at the heart of the LHG agenda”

| Developing the principles of clinical governance to improve the quality of primary health care | 1. HAs and LHGs will agree quality markers and offer, where appropriate, expert support  
2. LHGs must demonstrate a systematic approach to developing and monitoring clinical standards  
3. Each LHG will elect a senior clinical professional to take the lead on clinical standards and professional development as part of the group’s overall responsibility to demonstrate that quality of care is a key value.  
4. LHGs will need to develop the support of other members of the LHG, perhaps through the formation of a multidisciplinary Quality sub group...link[ed]to other local national and international experts and appropriate networks...This group would be accountable to the Chair of the LHG.  
5. Individual health professional [members]...will be expected to develop the quality of services and to demonstrate that they are doing so through clear reporting arrangements.  
6. LHG performance will be monitored by the health authority. |

| Informing and developing the commissioning of hospital and community services | 1. LHGs will be encouraged to take on greater authority and responsibility  
2. LHGs will...take direct responsibility for commissioning a range of agreed local services from April 2000 |

Source: Adapted from *Working For Patients: Establishing Local Health Groups*  
Welsh Office 1998b
terms of securing local engagement and implementation of LHG decisions. It also noted the need for LHGs to "engage closely with local professional advisory machinery" (p.4).

In pursuit of these policy aims, LHGs were constituted as management boards of 18 people, as Table 4.2 shows. GP representatives were to be elected by ballot from amongst the local medical community, with elections run by the Local Medical Committee (LMC). Other professional representatives were selected by interview panels conducted by their relevant Local Professional Committees (LPCs). Local authorities were asked to nominate two senior officers; health authorities were also expected to do the same, and to specify an additional individual as Responsible Officer.

These designated representatives were intended to embed partnership working in the structure of the Boards themselves. Public involvement was fostered by the representation on the Board of two people nominated by the relevant umbrella organizations for the voluntary sector and the local community. Thus the composition of the new organizations matched the policy aims articulated in Putting Patients First (Welsh Office 1998a).
Responsiveness was further encouraged by the stipulation that LHGs would hold meetings in public, and would ensure that appropriate arrangements were in place to enable local people to attend LHG Board meetings. But how did the structural supports that were built in to the system help facilitate the effective implementation of the LHG’s new roles? What decisions, in what spheres of activity, were they free to take?

<table>
<thead>
<tr>
<th>Constituent Group</th>
<th>Representation</th>
<th>Selection Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>6: 1 of whom would be elected as Chairperson</td>
<td>Election via LMC</td>
</tr>
<tr>
<td>Dentists</td>
<td>1 nominated by local peers via LDC</td>
<td>Selection via Appointment Panel</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1 nominated by local peers via LPC</td>
<td>Selection via Appointment Panel</td>
</tr>
<tr>
<td>Opticians</td>
<td>1 nominated by local peers via LPC</td>
<td>Selection via Appointment Panel</td>
</tr>
<tr>
<td>Nurses</td>
<td>2 nominated by local peers</td>
<td>Selection via Appointment Panel</td>
</tr>
<tr>
<td>Health Authority</td>
<td>2</td>
<td>1 to be designated Responsible Officer (GM)</td>
</tr>
<tr>
<td>Local Authority</td>
<td>2 senior officers</td>
<td></td>
</tr>
<tr>
<td>Local Community</td>
<td>2</td>
<td>Proposed by local umbrella voluntary organisation and local community council respectively</td>
</tr>
</tbody>
</table>

Perhaps significantly, on 1st April 1999, the birth of the new organisations was a surprisingly quiet affair, with little in the way of ceremony or publicity. This lack of fanfare is an interesting juxtaposition with the espoused scale of the LHG’s remit. Despite such an inauspicious start, the LHGs had, potentially, strong support for their new roles. The policy intention was ostensibly clear, and aligned with UK policy to devolve decision-making to local level, as well as to empower clinicians to make improvements to their services in line with local needs. The newly elected Minister for Health & Social Care took a personal interest in LHGs, as her willingness to address the Chairmen at their induction training, and subsequent agreement to meet the Chairmen at quarterly intervals, testified. And legislation to enable pooled budgets and the UK government’s decision to pump more funds into the health care provision system, in line with Derek Wanless’s (DOH 2002) subsequent recommendations, were further concrete examples of direct interventions to support increased decision-making at local level. Table 4.3 illustrates the facilitating forces (on the left hand side) supporting LHG development. The right hand side shows the opposing forces, militating against the further development of LHGs. The Table, adapted from Lewin’s (1951) approach to mapping the interplay between opposing and resisting forces, uses bold type to indicate relative strength of the force in question. So, for example, in terms of the LHGs’ remit, the policy intention is clear, and thus helpful
to LHG development. This clarity was later offset however by the failure to articulate clear development stages or pathway throughout the lifespan of LHGs. The Table will be used in the following sections of this chapter and the next one to illustrate specific points.

Table 4.3: Force Field Analysis: Pressures Facilitating & Inhibiting LHG Development (Vertical Links) August 2000

<table>
<thead>
<tr>
<th>Facilitating forces</th>
<th>Inhibiting Forces</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Putting Patients First</strong>: LHG's remit</td>
<td>No defined developmental pathway for LHGs</td>
</tr>
<tr>
<td>LHGs’ statutory right to be consulted by Trusts</td>
<td>Trusts’ longer standing links direct to HA; Lack of LHG decision-making powers as HA sub-committees</td>
</tr>
<tr>
<td>NAW agenda: inequality &amp; access</td>
<td>National UK government agenda: waiting lists and winter pressures</td>
</tr>
<tr>
<td>Establishment of All Wales Chairs Group &amp; quarterly meetings with Health Minister</td>
<td>No statutory direct channel to NAW &amp; HA CEO presence at LHG Chair meetings Changes in Personnel at senior levels: eg NHS D Director, HA CEOs</td>
</tr>
<tr>
<td>Devolved budgets: GMS, PCD</td>
<td>Existing spends Proportion of monies already allocated leaving marginal scope for manoeuvre Skills deficit re preparation of effective Business Cases &amp; short timescales required for production</td>
</tr>
<tr>
<td>New monies from Centre (June 2000)</td>
<td>Proportion allocated for primary care</td>
</tr>
<tr>
<td>Local Health Alliances</td>
<td>Local Authority re-structuring</td>
</tr>
<tr>
<td>Chairs/GMs Futures Group</td>
<td>Organisational capacity</td>
</tr>
</tbody>
</table>

Key: The features in **bold type** indicate a more significant impact than its opposite force.
Source: derived by researcher using interview data, as a tool for checking accuracy of interpretation with participants. August 2000. See Methodology for further details.
Despite being a new organization, and partly because of their wide composition, LHGs had many potential allies locally. All 22 Chairmen had been directly elected to their positions on the Board by members of their local professional advisory committees (LMCs): this could have been seen as conferring a degree of credibility and authority within the local professional communities\(^1\). In some cases, the LHG Chairman was himself a member of the Local Medical Committee:

> "We have four LMC members on our [LHG] Board, but I think the relationship between the LMC and the Health Authority is [pause] has a history of being not too good, and I see no reason why the relationship shouldn't be stronger..." (010.2: 06.04.00)

This Chairman clearly saw the LMC as a potential ally and bridge to the rest of the GP community, and to the health authority. However the relationship was not straightforward. LMCs had a "history" as the previous quote indicates. Part of this history included the LMC's traditional role and focus on promoting the professional interests of GPs, as a local trades union, in effect. This focus may well have accounted for much of their credibility among local GPs, but did little to allay suspicions of GP dominance amongst other professional groups represented on the LHG Boards.

Another put the dilemma starkly:

> We've set up quarterly meetings now between the LHG Chairman and the executives of the LMC. I reckon, well, we all recognise I think but I specifically recognise that unless we were going to get the LMC on

\(^1\) Subsequently, individuals were elected to the posts of Chairmen by the whole of the LHG Board membership.
board, they could really make matters quite difficult because they would stop the devolution to your local health groups if they felt they are more likely to get a hearing from the health authority with their statutory link, if you like, than they would do through the LHGs.

In this case, an existing structural link between LMCs and their Health Authorities reinforced tendencies that might have been potentially conflicting with the needs of LHGs. Some LHG Chairmen addressed this constraint through diplomatic overtures. But the fact that such structural constraints were not addressed in setting up LHGs is significant: the new organisations were very much left to carve their own way through the thicket of existing agencies and their often overlapping functions.

However, the extent to which the LMC is representative of local medical opinion, or only of a select group, is of course debatable, but it has traditionally been considered an important force locally (which was further legitimised by giving the LMC authority to hold LHG Chairmen's elections in the first place), so steps taken to work alongside it could have been seen as an effective tool for securing the interest and engagement of local GPs.

The scale of this task should not be underestimated, however, as the strength of the negative responses to a survey carried out by the researcher in the run up to LHGs (Williams 2002) discovered. The GMP community across Wales reported widespread scepticism about the democratic nature of the electoral process, as well as of its outcomes:
"I feel very unhappy and demoralised at the way the elections went...since the old Mafia got voted in. It's the same boys on the LMC and the same on the MAAG. None of us newcomers can get a look in at all" (SH7)

Still others complained that the elections in their areas had been dominated by "politicos," rather than by "ordinary", GPs: "It's almost a problem of democracy: the GPs who've stood are acting politically, they're LMC-types...politics is the confounding factor" (FHGP 42I.) Survey respondents also reported information deficits and practice commitments as significant constraints on their ability to participate in the electoral process, whilst those that did make the effort complained that they were none the wiser for having done so: "I've never seen anything like this. I've been to all the meetings but am none the wiser. It's never gotten off the ground here" (NFH7I). Out of 80 GPs polled in that survey, across Wales, only one reported optimism: "Potentially the best reforming idea yet.. I emphasize 'potentially!'" (SH30I). The majority were unenthusiastic about the advent of LHGs. A significant proportion of those canvassed were angry about the loss of the benefits that they perceived GP Fundholding to have brought to their patients. Many others reported that they worried about becoming government scapegoats, having to implement a form of "backdoor rationing". Others spoke of concerns about the impact of proposed clinical governance arrangements on their clinical freedom: "It's affecting our liberty of making decisions and implementing plans" (SHGP51I).
While some initial scepticism would be expected to accompany any large scale organisational re-structuring such as the introduction of LHGs represented, the wide range of the negative responses was striking, and indicative of the scale of the challenge facing the new organisations in terms of engaging local GPs at the grassroots.

Figure 4.1 illustrates the range of relationships to be forged by the new primary care organisations. As noted in the key, the unbroken lines indicate existing statutory relationships; the broken lines illustrate the new relationships to be developed among agencies and groups already in existence. The lines are important because they indicate advisory relationships, and thus show clearly the structural limits on the LHGs' ability to influence decision-making across the geographical areas over which they were responsible. Chairmen reported varying degrees of success in building these new links, which will be explored in more depth in chapters 7, 8 and 9. For now the main focus is on the structural constraints inherent in the systems.

But both the size and composition of the LHG Board proved to be challenging to the Chairmen. Forming a corporate entity out of a disparate group of 18 people would be a challenge to any senior manager, and certainly taxed the skills of the newly elected GP Chairmen. In addition, the preponderance of GP Board members
was predicted to be problematic by many commentators, and proved to be perceived as such, as the following excerpts from three interviews indicate:

I think there is a certain amount of conflict in that there is occasionally the politics start to come in to it. ....I think that is the general practitioner members will sometimes slip into their mode of defending their professions' interests which they have been used to when they have sat on the LMC and so on. But I think that this isn't appropriate and when I recognise that I try to dampen that down. (010.1: 16.08.99)

I think if we can get ourselves actively involved in terms of our own project managements, and we're given the opportunity to do things, I think that the Board will remain on the boil. I think that the Board - my interpretation of my Board - is that they have felt not involved, I think that they certainly are disappointed that we're not as involved - I think they actually don't understand, one or two of them...well, certain Board members on occasion- its as if they haven't taken on board their corporate responsibility...I mean there are people there who would say that they are there to represent their individual profession..." (019.3: 18.07.01)

The doctors have been in charge of everything and actually I just realised that that is true but it is OK. We are getting on with that. We are. The structure that we developed got us over that because it gave everyone a forum to say something....(002.1: 28.09.99)

These comments illustrate the range of difficulties encountered in seeking to engage both local professionals and the local community. They also show that the sheer size of the Board and its multi-professional complexion made it difficult to build and to maintain collective corporate engagement and ownership. This presented continuing difficulties for the GP Chairmen trying to introduce service changes locally:

"Well, in the sense that if you have colleagues that will write letters which are materially incorrect, to all of your colleagues out there without consulting you, and there are major errors, then you have to, within two hours, compose a letter basically calling them liars and idiots, politely, and it does create certain tensions....I mean, sometimes I despair, you know. I will [work] out agreements for some policy
So, the need to build consensus among professional colleagues, without any clear levers of power, and a perceived lack of clear direction and commitment to the LHG’s progression, were sources of continuing challenge to LHG Chairmen. Some GP Chairmen commented on the unexpected alienation they experienced in this new role:

_Basically I feel like piggy-in-the-middle between the health authority and those bastards who used to be called my colleagues, but!...Honestly! You’ve never seen letters written like it sometimes! (005.2: 12.06.00)_

Such structural constraints affected the ability of LHGs to effectively engage their own professional communities.

In response to these challenges, the majority of LHG Chairmen narrowed the definition of their constituents to the local medical community: at the outset, only two articulated a more inclusive view, which went so far as to embrace the general public. However, where Chairmen did adopt a wider definition, they were able to build new alliances, which proved to be effective agents of change. But, as is explored in Chapter 6, most missed this opportunity. Each LHG Board had one member, meant to represent the public, and one member representing the voluntary sector. Although the potential existed for these two post-holders to build broader-based community alliances, their small number
was dominated by the other 16 members of the LHG Board, the
majority of whom were practising health professionals and senior
managers. The overwhelmingly professionally-dominated
composition of the Board may have been intended as a sop to the
professions, to persuade them that they were in control of service
planning and delivery decisions. But the nature and number of
the structural constraints affecting the actual powers residing in
the LHGs tended to negate this intention, as Table 4.3 illustrates.

Thus structural constraints implicit in the way that LHGs were
established from the outset acted to limit LHGs' operational and
decision-making capabilities. These were further constrained by
their structural relationship to, and thus dependence upon, their
parent health authorities.

The following two sections of this chapter analyse the impact that
these constitutional arrangements had on the development of
LHGs in terms of their structural connections with, firstly the
National Assembly for Wales, and secondly, the health authorities.
4.3 National Assembly for Wales (NAW)\(^1\).

Clearly the government holds key cards in the policy arena, as the legitimate and accepted maker of policy and legislation. But, increasingly since 1979, "new policy directions have been bound up with new system designs, new funding and financial arrangements, new relationships between centre and periphery, and new relationships between state and citizen" (Clarke, Gewitz and McLaughlin 2000). This section, therefore, examines the extent to which the new relationships between centre and periphery - the Welsh Assembly Government and the new LHGs - flourished and developed, and why. It focuses on the impact of the structures put in place to support and monitor the new LHGs.

The first point to note is that the Welsh Assembly Government, set up in 1999, was not itself an autonomous agent, but was significantly constrained by UK policies throughout this period (Government of Wales Act 1998). Possessing powers to make secondary legislation, they were nonetheless unable to levy tax income, so remained dependent on the largesse of Westminster. During this period, as might be expected, the new Assembly was struggling to form itself into a cohesive organisation with a clear strategic focus. Since the newly elected Assembly Members were

\(^1\) The National Assembly for Wales began to call itself the Welsh Assembly Government in 2003.
local politicians, experienced in focusing on local issues rather than national ones, strategic leadership capacity could be said to have been constrained. On the plus side, Ministers came in with a fresh sense of determination to improve public services for people in Wales — eventually articulated through a series of policy documents from *Better Health Better Wales* (NAW 1998) through to the Health, Social Care & Well Being Strategies — through partnership and collaboration. The key strategic aim was to devolve responsibility for local services to local level — in this case, health care providers themselves. An implicit drive to increase efficiency underpinned this strategy: matching local services to population needs as a means of rationalising service provision, eliminating unnecessary duplication. Key concepts in the discourse of the policy documents (Atkinson and Coffey 2004) included "efficiency", signalling a return to the 'health gain' and 'resource-effectiveness' concepts put forward a decade earlier by the Welsh Health Planning Forum. Devolving decision-making to local level and combining accountability for clinical and financial decisions were foundation principles for the new structural arrangements. Integration and coordination of services replaced the previous rhetoric of choice and diversity, termed "wasteful and inefficient" in the new White Paper in 1998 (Welsh Office 1998a).

The NAW's intention to initiate change towards integrated primary care services across health and social services was further
evidenced by both policy statements and new legislation to back these up: the Health & Social Care bill, placing a statutory duty of partnership on health and local government organisations, together with a facility to pool budgets, gave clear direction of intent to local organisations, as Table 4.3 indicates. In addition, Local Authorities were given leadership roles in setting up Local Health Alliances, to bring together a wide range of interest groups across public and private sectors to address local health issues, including not only health and social services, but also education, employment, the police, and third sector representatives. This initiative proved problematic, again for largely structural reasons, as we shall see later in the next chapter.

External pressures on the Assembly included the need to be seen to be doing something distinctive and different from that of their UK counterparts:

"I think certainly the Assembly, I mean it's partly being driven by the pace of things in England, but its maintained par with. I think the determination that they've got to be more radical if they're going to have a "Made in Wales" that is right but distinctive to justify this new Assembly" (006.3: 16.07.01)

coupled with the need to justify its existence - and the public expenditure needed to maintain it – to the electorate.

But the Assembly seemed to lack the ability to inculcate confidence among LHG Chairmen, who often reported that they felt let down by the Assembly:

"The Centre is still not clear about what it wants from LHGs. When I came in I thought it was very clear: we would have a year on year
stepwise progression towards changing the world. I now see that changing in Wales. I sense that in fact there is an increase in central direction" (019.2: 22.05.00)

Chairmen perceived the Assembly as reluctant to approve locally generated initiatives, like local prescribing incentive schemes, despite noting the importance of these, in policy papers, in helping to change patterns of service delivery locally (and their frequent application in England). In the early days of LHGs, this was viewed by LHG Chairmen as lack of support. Similarly, later on in the study, the lack of direction about PMS pilots meant that there were none initiated in Wales, and, this, again, was viewed by Chairmen as a failure of support for change on the ground:

"Of course they have not and will not come out and say "we're not in favour", but they weren't pushing PMS pilots...my colleagues who spend hours and hours writing their bids for PMS status, they have been quite frustrated and disappointed. Not so much a negative response but a lack of response to their efforts shall we say..." (019.3: 18.07.01).

Both of these sorts of schemes, however, had the potential to change existing service delivery patterns significantly; both had been prefigured in the White Paper (Welsh Office 1998a). In contrast to this, English Primary Care Groups were using such schemes fairly routinely by this time, to reportedly good effect (Smith and Goodwin 2006). But, despite being in line with strategic intentions (Welsh Office 1998a), neither PMS pilots, or early attempts to create local incentive schemes, won support from the centre, leaving their champions at local level disappointed and confused about the Assembly's underlying
intentions. Such reversals did little to help Chairmen gain the confidence of their grassroots GPs:

The fact that...I mean these are the sort of things that are going to produce a sort of terminal inertia – like we've gone through the exercise of planning, we had a whole day on it and everybody had their input, and it was a useful document which related to Xshire. Now the fact that it sits on a shelf and come to the same time next year, who's going to bother turning up?" (018.2: 20.06.00).

Another potential instrument for changing service delivery patterns locally was Health Improvement Plans (HIPs), discussed in more detail later in this chapter. Briefly, here, the experience of developing HIPs themselves was viewed variably, though largely negatively, with comments ranging from: “a bureaucratic exercise by people divorced from the day to day realities” (019.1) to:

“There are already guidelines from Welsh Office, and they are being implemented by the centre in the Health Authority so they in turn give the guidelines and within the guidelines the local health group will have input into their local needs and then they will all be sort of analysed at the centre so that it is uniform throughout the country with special local flavours so I think that is how it should be working hopefully (011.1: 01.08.99).

This somewhat optimistic interpretation was countered by others a year on in the life of LHGs:

“Now we've got our own version [of the HIP] ... [but] it all comes back to the same thing...we see slightly different emphasis to the Health Authority, slightly different priorities, obviously, in the local view. So the question has to come my way on what's the use of a LHG if it can't address some local issues?” (018.2: 20.06.00).

And others who questioned the value of the process at all:

“One difficulty is that we have to produce this in a fairly short space of time. Whereas its going to take us two or three years possibly to get some of the relevant information...basically we will find a home for anything anyone thinks ought to be in there because I think producing it in such a short time...just put it away so that exists on paper...it has evolved and changed almost month by month as well and now it has become much more a health authority document with little sections for each of the five LHGs¹ rather than purely our document. So that's been drawn into the centre again really. I

¹ Within that health authority area there were 5 LHGs
think the health authority has been a bit nervous really that people would go off on their own" (014.1: 16.08.99).

So the perceived constraints of working to the health authority’s agenda, in relation to service planning and priorities, rather than setting their own, were widespread at LHG level. Process problems exacerbated this, acting to dilute further the LHGs’ input to setting local priorities. In the view of the majority of LHGs, the nature of the planning and priority setting process remained top-down despite the bottom-up rhetoric of the policy statements.

Clinical governance initiatives were another example of a nationally-led policy that had the potential to become a powerful lever for change locally. But GPs on the ground had reportedly (Williams 2002) viewed this concept with some anxiety, not to say cynicism, having expressed concerns about relationships across the patch, equity problems, regulation and control. Some saw clinical governance as a “real poisoned chalice”, expressing concerns about its implementation, and the extent to which it would be “admin led rather than GP led or profession-led”. One referred to the LHG itself as “... a means of ditching the responsibility” adding that in his mind, “clinical governance is the worst thing – a real rats’ nest of bother”.

GP Chairmen were acutely aware of these feelings among their colleagues and tried, on the whole, to take a constructive and
developmental approach to implementing clinical governance within their patches. Nationally, across Wales, however, little real leadership was apparent. Although LHG Chairmen all responded to the request to undertake baseline assessments of local services, the scope and quality of these varied tremendously - again largely due to lack of clear criteria about process. Not long after these baseline assessments were returned, the NAW Medical Officer responsible for Quality Improvement strategies left to work in England, after which responsibility devolved to a junior non-medical colleague, thereby exacerbating existing capacity problems within the NHS Directorate. The baseline assessments had been intended to provide a basis for performance monitoring, but their variability made drawing together national indicators problematic.

Across the UK, the government's determination to tackle variations in care through standard-setting was being implemented in practical terms through National Service Frameworks (NSFs) designed to specify key elements in patient pathways. GP Chairmen in particular were disenchanted by the Welsh Assembly Government's failure to attach additional funding resources to these:

"I support the NSFs, the concept of the NSFs, and I do think that the government has to, if they're pushing these things out, they have that responsibility of resourcing them. It seems to me to be a lot easier to decide where the money's coming from, this is where everybody gets very quiet, you know." (019.3: 18.07.01)
This comment, towards the end of the study period, illustrates a general dissatisfaction amongst Chairmen at this point in their organizational existence. Chairmen uniformly expressed disappointment that national UK initiatives were not perceived as being available in Wales to the same extent that they were in England. They tended to place responsibility for this failure at the door of the Assembly.

But the Assembly’s own initial capacity problems were being further exacerbated by other significant personnel changes at key levels. When the Director of NHS Wales post, a senior Civil Service appointment, became vacant, a replacement was not appointed for a further nine months. The Director of Primary Care retired when the new appointee came into post (Spring 2001); a replacement for that post was not appointed until 2003. Meanwhile, the professional advisory machinery within the Assembly was reported to be thinly spread during this period.1 In addition, or perhaps because of these factors, a new Primary Care Strategy was awaited. This strategy was finally written by a cross section of service chiefs in 2001 – and never implemented. These capacity challenges at national level combined to leave the impression of a vacuum around primary care development. Nonetheless, the newly appointed Minister’s commitment

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1 Personal communication to the researcher from an Independent Medical Advisor to the NAW, 22.08.2001.
remained firm. In an unprecedented move, after addressing LHG Chairmen at the final session of their initial induction programme, in July 1999, the Minister for Health & Social Care agreed to meet with LHG Chairmen on a quarterly basis in future. This decision proved to be singularly significant – possibly the most significant action of all in ensuring the eventual development and transformation of LHGs. On balance, however, during the period under study, the NAW lacked the capacity to provide the strength of leadership needed to counter-balance other drivers in the system, as the ensuing sections will illustrate further. In terms of factors that might be seen to predispose an organization to change, however, while the uncertainty and lack of direction from the National Assembly did leave a vacuum which LHGs decried, it also created opportunities, as later chapters will show.

In this context then, the NAW held the ring but failed to exercise sufficient leadership or direction to ensure the outcome it sought. As a result, existing interests and powers in the system were able to maintain their prevailing behaviours and intentions, so that the status quo was preserved. In terms of factors that might promote organizational receptivity to change further down the system, strategic vision, leadership capacity, and a learning orientation could all have been said to be notable for their absence amongst the new Assembly and its advisors. For these reasons, therefore,
the locus of decision-making remained with health authorities and
Trusts.

4.4 LHG and the Health Authorities This is partly because the
structural limitations placed on LHGs were, at the outset, and
remained through 2001, virtually insurmountable. Despite all the
good intentions expressed in successive policy documents (D0H
1997; Welsh Office 1998a; Welsh Office 1998b), LHGs’ powers to
effect change were severely constrained by the limitations inherent
in their structures, which, in turn, affected their relationships to
existing bodies, most notably to health authorities. These new
primary care organisations were intended to be the key
mechanism for shifting the balance of power – or, at the very least,
activity, and thus resources - away from acute hospital trusts to
the primary care arena (Welsh Office 1998b). But LHGs were
established in the first place as multi-professional sub committees
of Health Authorities, the organisations responsible for
commissioning services for their populations. Alongside this,
LHGs were given a substantial responsibility: to improve the
health of their local populations, by “commissioning local
services... and taking decisions about resource use” (Welsh Office
1998a paragraph 4.21), no less. Arguably this remit overlapped
with that of the of the health authorities’ themselves: to
commission services to meet local health needs. This role overlap
itself was inevitably going to lead to conflict, as health authorities
operated to preserve their own roles in the system and limit the scope for the new organizations to de-stabilise the system. The question arises then as to the extent to which the LHGs were able to marshal adequate resources to carry out this task. Right from the start, LHG Chairmen argued that there was a wide gap between what they believed they had been put in post to do and what their Health Authorities perceived their aims to be:

"I think there is such a need for education of so many participants to the project [the LHG], particularly health authority bureaucrats. Excuse my language but you know what I mean. I think that there... is a culture change which needs to take place and which will gradually learn what we are all about. I mean we are in this game to serve our patients; anybody who doesn't realise that should get out. This is what it is all about; it isn't about politics, its not about fighting for one's empire, its for actually... trying to determine the best possible patient services who fulfil the wants and needs of the community..." (010.1: 16.08.99)

This quote from one GP Chairman suggests both the conflicting views of roles prevailing among health authorities and the LHGs, and the extent to which the conflict was already, at this very early stage in the process (August 1999) being articulated in terms of power struggles.

"I feel let down, I have the feeling they don't really want us to change the world after all" (019.2: 22.05.00)

complained another GP Chairman some nine months later. Thus the relationship between these two agencies was proving to be problematic. Initially, Health Authorities were sometimes perceived as playing a protective role, shielding their embryonic LHGs from the harsh business of commissioning services – so much so that many LHGs came to view commissioning as outside their sphere of responsibilities, despite the fact that it was a
specifically stated responsibility in the guidance documentation

(Welsh Office 1998b):

"I think they actually don't understand, one or two of them, you know, that we are not actively involved in [the] commissioning process...they fail to understand – certainly us at the executive level – can't actively change things..." (019.3: 18.07.01)

"I think commissioning is the grand irrelevance, I don't want to commission. I'm interested in what a Dermatology service could look like! I'm probably alone in this view, I just hope change comes!" (002.2: 02.06.00).

These comments illustrate the extent of the differences in understanding of their roles among LHG Chairmen, not just at the beginning, but throughout the study period.

Other LHG Chairmen reported resentment at being in such a hemmed in position so late on in the process:

"Frustration, I think, more than anything. What are we here for, what are we doing? You go to any...you know, sort of set up a sort of sub group in any subject, and it all goes back to the Health Authority, and its still this centralism of the health authority that just produces...there's this tremendous inertia in the system..." (018.2: 20.06.00).

Health Authority Finance Directors retained accountability for expenditure, so were unwilling to delegate budget control to external hands, as yet unproven. Since all 5 Welsh health authorities carried substantial overspends at this point (1999), both Chief Executives and Finance Directors felt exposed and personally vulnerable. Emphasising this, more than one chief executive was removed during this period, signalling the centre's strengthened commitment to performance management and personal accountability.
More significantly perhaps, LHG “responsible officers” were Health Authority appointees – and employees. As such they carried significant responsibilities on behalf of the Health Authority, of which overseeing the operational activity of the LHG was but one. Indeed one LHG General Manager remained Director of Finance for the Health Authority throughout most of the years under study. This shared responsibility was matched by single accountability: General Managers were accountable to the Health Authority Chief Executive for their performance as managers. In this context the job title itself is significant: “general manager” does not imply the same level of responsibility as does the title “Chief Executive”. In this vein, one LHG general manager went so far as to label her LHG Chairman as a “non executive director” of the health authority (Personal Communication from GM 003 to researcher). Yet the LHG GMs were also responsible for implementing a new agenda, and setting up a new organisation and team for this purpose, in tandem with their Chairmen.

Most General Managers were also long-serving career managers, previously working within Health Authorities, and thus inevitably aware of the criteria by which their Health Authority Chief Executive would be measuring their performance.

"I feel I've got to keep an eye on the Manager...I think it means that its something which I really haven't expected I should have had to do...You see, certainly my view of it would be that...that the members of the Local health Group now - or the [executive] committee - is a decision making body and that those who work for the LHG like the Manager and the various officers, that their role is to implement decisions of the LHG, you see,...and the problem is that
the LHG makes decisions and these things aren't being implemented...and the thing is, yes, I mean s/he is accountable to me, isn't he? No, responsible to me and accountable to the [HA] Chief Executive”  (022.2: 10.08.00)

The difficulty that this Chairman was having in operationalizing this dual accountability chain was still problematic to him, sixteen months after setting up the organisation. Others concurred:

“It makes them feel that they've got two masters, in a way...who do you relate to, who do you prioritise, where does your duty lie? He is the responsible officer, its his job to report it back to the Chief Executive of the HA. He's the gamekeeper in the camp, if you like...” (021.1: 08.11.99)

Moreover, this accountability chain could be seen as biasing attention towards the concerns and issues as Health Authorities perceived them – and away from the aspirations of primary care providers.

Health authority chief executives reinforced this impression by their tendency to treat LHG staff as their own resource. So, mindful of the need to support five or six different LHGs within their catchments, they had no qualms about re-deploying LHG General Managers from one LHG to another one to fill a vacancy, leaving the donor organisation un-tended. This might have been reasonable for staff lower down the hierarchy, but GMs were pivotal to the functioning of the new organizations:

“We've got difficulty with our staff in a sense that we've got one person on long term sick leave...and then that's causing problems with the other staff, so that means people are being seconded from here, there, and everywhere, you know, so there is no sort of continuity.

Then the second ...latest problem, obviously, is our General Manager [seconded to another LHG] so that's adding to a problem of staffing...” (011.2: 24.03.00)
This behaviour re-enforced the tendency to view the health authority as “boss” to the detriment of loyalty to the LHG. It also exacerbated existing capacity problems. Inevitably, devolving responsibility for service configuration to twenty-two local organisations from five larger ones, was going to present capacity challenges, but placing responsibility for dealing with these challenges with the health authority, rather than freeing up the local organisation to deal with its needs, fostered centralisation rather than devolution of powers.

"...We've gone about it the right way, done all the right things: focussed on primary care, referrals, outpatients, prescribing and emergency admissions. And we're trying to build on our strengths. But the budgets, the [HA's] deficit, and secondary care are taking all our energy and time" (002.2: 02.06.00)

This central control approach was present from the beginning, informing the LHG recruitment process. Procedural rules for recruiting and selecting LHG Chief Executives included the stipulation that vacancies were to be advertised internally first, before going to external advertisement. This issue was one of the first to bring LHG Chairmen’s and health authority chief executives' different perceptions of their roles and remits into the open.

"Basically we've just enlisted staff who were there [in the HA] to work for the Local Health Group, which is not ideal. We really would have welcomed some new blood, some new ideas...we just had to take what was there in employment already, so we had to take on a group of them [from the HA], which again leads to problems down the road, I don't think they've got the skills to deliver...[and] this is the other problem; I'm not sure; I think some of them feel, well particularly they don't like change, and this is a major change, and they feel threatened by it and I think a lot of it will be 'let's try to keep the status quo, let's do what we did before' and just muddle along until someone gives us a [inaudible]....and we're bit in that mode
at the moment. We only got all our staff appointed about 3 weeks ago...“ (020.1: 07.12.99).

The health authorities' centralist controlling tendencies were further encouraged by the lack of any clarity over the LHG development process in Wales. In England, primary care organisations were established with a clear developmental pathway, marking the route and criteria to be met at each transitional stage (DoH 1997). In Wales however, despite a clear statement that growing independence was expected (Welsh Office 1998b), no developmental path was ever articulated – or even agreed. Steps were made in late 2000 to try to secure agreement on a way forward, using an external accreditation measure as the key indicator of “readiness” to progress to more independence – but LHGs failed to agree on either a mechanism or a need for one.

“I listen to the jargon ‘LHGs will fly’ that's what we're being told, but I think we're still taxiing down the runway, and the danger is that we'll drive right off the end before we get airborne! The National Assembly, I'm a big believer in local democracy but I think its producing delay; it seems to be fudging issues, so its not working so well” (002.2: 02.06.00).

This lack of direction allowed existing forces in the health system to flourish and prevail, further inhibiting attempts at independence on the parts of the new fledgling organisations.

Maintaining responsibility for development of LHGs within the health authorities' control, enabled them to define both the meaning and thus the content of “development”, and allocation of resources to the process. Health authorities put on very little – if any - training and development activity for their new colleagues,
LHG Chairmen. This reinforced the existing cultural divide among different players operating at different levels of the system.

Development funds had already become a bone of contention between health authority and primary care people following the mergers of FHSAs and HAs. At this point GMS monies – central funds allocated by the UK government for the provision of general medical services – came under the auspices of the HA, whose responsibilities went beyond primary care to encompass health providers across the system. Given the deficits the health authorities were carrying, and the periodic and recurring political embarrassment these created, the HAs had little incentive to ring fence these beyond any statutory requirements, thus the discretionary elements historically reserved for training and development of primary care staff, could be absorbed into general funds - or to plug other holes.

But significant development needs of LHGs revolved around health needs assessment of their local populations. Public Health specialists were employed by health authorities and had traditionally carried out the needs assessment process on a health authority-wide scale. A key purpose of the reforms was to strengthen the link between population needs and service provision at local level. Thus, post 1999, public health specialists were expected to carry out this task at LHG level, whilst retaining
their health authority responsibilities. Again, capacity problems reared up: the existing resource was inevitably going to have to be spread more thinly. And again, health authorities remained the employer, focussing loyalties at that level, thus re-enforcing the status quo:

"The first thing we did alongside the Health Improvement Plan was to plan for 5-10 years...[but] then that local one got overturned because they decided at the centre of XYHA...." (003b.3: 19.07.01)

Although some LHG Chairmen had little respect for the process of assessing health needs, claiming that as GPs they were well aware of the needs of their local patients, others were both surprised and disappointed by the lack of input the LHGs actually had in the assessment process, or in the subsequent development of the Health Improvement Plans based on these assessments. The Health Improvement Plans (HIPs) were intended to be the vehicle through which changing service provision would be articulated and then delivered – potentially very powerful documents locally. In the event however these were more damp squibs than rallying cries:

"The interim HIP was just waved past, it was already written by the Health Authority..." (006.1: 08.11.99)

"I think the difficulty with the HIP, the HIP development, is that I feel that there's too much...there's not enough bottom up, it's always...always this downward ...the Health Authority priorities, the NAW priorities, the frameworks, there's so much of this...I'm not saying they shouldn't be priorities but the thing about LHGs is that they should reflect community need. So I think this is not the same thing as the Assembly saying, "Yes, this is what should be the priority"" (010.2: 06.04.00)
The Guidance Advice (Welsh Office 1998b, p. 2) had specifically instructed health authorities to avoid "finalis[ing] even the interim framework HIPs scheduled for January 1999 without involving shadow LHGs in their area". HAs' collective nominal nod towards this directive may have contributed to Chairmen's cynicism about the process and its importance:

"I find Health Improvement Plans are tedious really. I mean its something you give lip service to really...I am sounding very derogatory but I think Health Improvement Plans are basically things designed by public health physicians and bureaucrats, I mean, yes it sounds very good and its all very important but in the real world it really isn't something that's pre-eminent in your head..."(019.1: 10.08.99).

Further complicating this picture, throughout this period health authorities' own management and leadership capacity was severely constrained, potentially inhibiting their ability to provide a consistent sense of direction and development support to the new LHGs. The five health authorities existing in 1999 were themselves the product of recent mergers with Family Health Services Authorities across Wales, and with smaller health authorities (Welsh Office 1997). So, for example, in one north Wales area, the Clywd and Wrexham FHSAs had merged in 1998, and then with Gwynedd had become a single North Wales Health Authority, encompassing the whole area from Flintshire through to Anglesey. These amalgamations inevitably focussed senior management attention on internal affairs, not only creating new internal support structures but forcing many to apply for new jobs. This pressure diverted attention away from the larger
strategic picture at a crucial time in the development process of LHGs. Moreover, there were significant leadership gaps at the very top of these new organisations throughout the period from 1999-2001. In four of the five new health authorities, there were changes at chief executive level during this period. As a result LHGs were sometimes left to “get on with it”; at other times embryonic initiatives were stopped from developing further:

“You know, at the moment, we’re sort of, it’s a bit like letting the rope out a year at a time rather than having...we don’t have a primary care strategy for Wales yet, so there isn’t a grand plan that takes us anywhere...we haven’t yet got clear devolved budgets...we are enlarging our role significantly its just that you always feel it’s like a big ball up a steep hill really, rather than an open door...it’s us sort of trying to stake out another bit of the claim, as it were” (006.2: 17.07.00)

“No we had the problem of no Chief executive haven’t we – effectively – X is still here obviously but decisions – people are being told ‘no that can’t be done until Mr Y changes it. I don’t believe I really accept that because I find it difficult to believe that an organisation just suddenly for the last 3 months does nothing because someone may go in and change it...” (017.1: 11.08.99)

Furthermore, during this period, more than one health authority chief executive was removed or moved on because of failure to manage the deficits adequately. This re-enforced the centralist tendency in the system, giving the strong message of increased direction from the wider UK government. The UK government exhortations about sticking to budgets was repeatedly reiterated during this period, with an increasing intention to hold health authority chief executives personally to account for any failures to do so. This centralist control was further strengthened through increased emphasis on Westminster’s stated priorities: to meet UK Waiting List targets, and, again, through strengthening
performance management approaches to this area of activity across England, in particular. Health authorities perceived themselves as having to pick up the pieces of NHS Trusts' overspends, as accountabilities of Trusts were weak during this period. This made it difficult, if not impossible, for LHGs' priorities to claim a large share of health authority attention.

When, after continuous pressure by LHGs and some warning signals from the centre indicating determination to strengthen primary care organisations – at least in the English context – health authorities began to devolve some responsibilities to their LHGs, this proved to be a double edged sword. In the words of one Chairman:

"Do you want me to tell you what our agenda is? This is what we've just been presented with:

- The management of the consultation of Cardiff & Vale NHS Trust Clinical Services Strategy changing for the better?
- We have to complete the Eastern Services project and
- Management of the consultation process on the findings
- We have to review the Orthopaedic Services across Bro Taf and produce a medium term strategy, and we have to
- Management of the local action team on emergency admissions in Cardiff and the Vale.

So those are our...that's part of our corporate agenda...I mean, its extremely challenging!" (010.2: 06.04.00)

This emphasis by HAs on directing LHG activity via annual Performance Agreements, although stipulated in the Guidance Advice (Welsh Office 1998b) further limited LHG scope for creative thinking and innovation. It ensured that LHG growth was constrained and that the status quo was strengthened:

"Our staff are being used for things which are health Authority duties not LHG, and so on. I want to be able to give them an
opportunity to really build up a team spirit, where they feel as though they really are making a difference, that they belong to an outfit which is going to effect change, and its not part of a stagnating bureaucratic process, but really is going to be a change on behalf of our community”
(010.2: 06.04.00)

The HAs' controlling tendencies became more overt as the LHGs tried to flex their collective muscles in an effort to assert their own agenda. The main tools the HAs used were political and financial. In political terms, the HA Chief Executives used their influence to try to curtail discussions between the Minister for Health & Social Care and the LHG Chairmen. Jane Hutt’s (the then Minister for Health and Social Care) remarkable decision to meet quarterly with LHG Chairmen opened up a way of circumventing the structural limitations inherent in the existing system: as sub committees LHGs had no official channel through which to air their concerns or issues. The HAs on the other hand had regular and frequent meetings (NACE) with the NHS D Director in the Assembly. Since the NHS D Director was ultimately accountable to the Minister this should have been a powerful communication channel to reiterate Ministerial priorities. But the heavy predominance of Trust Chief Executives may have helped to dilute their messages in that forum. It was not long before HA Chief Executives were insisting on attending the LHG Chairmen’s quarterly discussions with the Minister:

“[I suppose from the LHG perception, the attempt to have a dialogue with Jane Hutt has been, I would say, fairly successful, and Jane Hutt has, I think, gone out of her way to try and make herself available. But, as was noted in our discussion last time, the constant ever presence of the chief [executive of the HAs]...you know, they can’t be free to let us go, so you’re not allowed out anywhere without,}
LHG Chairs met monthly as a peer support group, helping Chairs to come to terms with their new roles and responsibilities and share problems and approaches. Their efforts to stage an all Wales Conference to highlight their progress were foiled by HAs who favoured setting up an all Wales Group which would encompass the whole of LHG membership. Since each LHG Board consisted of 18 people from a variety of backgrounds and interests, and since Chairmen themselves were still struggling to create cohesiveness amongst their Boards, the Chairmen viewed this as an attempt to limit their effectiveness and curtail their voices.

HA Chief Executives reacted negatively to Welsh Assembly attempts to support any evaluative research into LHGs. Having agreed funding for a study, through WORD\(^1\) (itself part of the Assembly's own infrastructure by then) by Welsh academics, the study's terms of reference were significantly curtailed after remonstrations from a Health Authority Chief Executive who expressed outraged that research into the authority's work would be approved without prior reference to her\(^2\). The argument that LHGs were already being "over-researched" won the day with the new Assembly, unused to commissioning research at this stage,

\(^1\) WORD: Wales Office of Research & Development
\(^2\) Personal communication to researcher
despite the fact that the only study undertaken had been an initial audit by the Audit Commission in Wales. Evaluative research was generally acknowledged to be under-developed in primary care in Wales at the time. The HAs’ political efforts to maintain the status quo reached their heights at a seminal meeting of the Health and Social Services Committee of the Welsh Assembly on 25 October 2000. This meeting debated the future of LHGs and the HA Chief Executive representative spoke out against structural change stating that ‘structural change now would be detrimental to the Assembly’s own agenda since it would take the services’ focus away from the inequalities agenda’. The actions taken by HAs indicated the extent to which they saw themselves as being in the driving seat, and that they intended to do all that they could to maintain that position.

This analysis has illustrated the extent to which the structural changes enacted still left a large number of tools at the Health Authorities’ disposal, and the extent to which the Health Authorities used these levers to maintain their own ability to direct the healthcare system.

Once the Minister announced the decision to remove the HA tier, in launching the NHS Plan for Wales (Welsh Assembly Government 2001), in February 2001, HAs were forced into a

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1 Personal observation recorded in field notes by researcher present at meeting 25.10.00
more developmental role. But, even then, the system dynamics worked against LHG input to the ensuing debate. A consultation exercise on restructuring was started, and a series of Task & Finish Groups created to propose models for the new organisations. The ten Task & Finish Groups each were Chaired by a Health Authority or Trust Chairman; and although each Group included an LHG Chairman and an LHG General Manager, this level of representation was small in comparison to the number of Trust, Health Authority and Assembly representatives on each Group (National Assembly for Wales Newsletter No 2, August 2001), the combined interests and views of whom easily outweighed those of the LHG representatives. Moreover meetings were scheduled in such a way that LHG Chairmen had little hope of getting to them. HA and Trust managers were able to clear diaries in a way that practicing clinicians with surgeries to provide simply could not match:

“I think you know, again, it shows the disadvantage of an independent contractor-based resource against the salaried base, you know. Its amazing how the Health Authorities have been able to wheel out. You know, everybody's gone over to the business of dealing with the Plan, and things have stood still a little. And the LHGs, really, in terms of, you know, the roles of Chairs, their available time, you know, you're so quickly overrun, they don't have the capacity, they don't have comparability in the resourcing and the opportunities and access stuff. And this process of discussion changed in such a short intensive way, really disadvantages them” (006.3: 18.07.001)

HAs also continued to use their financial positions to control the primary care development agenda. No budget of any significance was ever actually delegated fully to any LHG during the period under study. In the early stages GP Chairmen in particular were
struck by how little financial influence they were able to exert.

Many contrasted their position as LHG Chairmen unfavourably in comparison to the influence they had been able to wield as GP Fundholders. This collective political naivété was evident virtually across the spectrum of GP Chairmen (20 out of the 22).

“Yes but I think we have been told about this budget and that budget but there are strings attached to whatever they tell you to do so in the end you have to do what the Assembly or health authority [tell you] to, what the rules and regulations are. I mean there were rules and regulations for fundholding but...at least I had the money and I said ‘Right, I am going to spend this money within parameters given to us, on services’” (011.1: 05.08.99).

Another Chairman reiterated this growing disillusion:

“We are having so much difficulty establishing what the real budget commitment is from the health authority so we don’t really know what we can tell our constituent, I mean you can make vague promises and you can tell them that there are prescribing issues but these are still so vague.

We have delegated budgets down to practice level because we have had a drug budget setting from the health authority but it transpires that the budget setting activity for the LHGs was flawed so we are having to renegotiate that position with the health authority. It is also apparent that they have not delegated the whole of the resource down. For example I know that the Welsh Office budget to the LHG had a rise of 9.8%, well, they have only delegated down 7.4% to us so that somewhere in the system they are retaining monies for whatever purpose. I have seen a paper which hints that these monies could be diverted to other sources – well, we know where that is – that lies in the Trust you see because of the Trust deficit – so the focus of attention, really from the LHGs is between us and the Health Authority rather than us and the constituents” (004.1: 05.11.99)

“Get a budget we can manipulate – no point in giving me a budget which is all tied up and gone. Which is effectively what’s happened this year...which when you bear in mind the amount of money we had, with all its flaws, in fundholding is actually a retrograde step” (015.1: 29.09.99)

“You know, one of the major things is that, you know, they talk a lot of money, but when you actually devolve it downwards, it doesn’t amount to that amount” (007.2: 24.08.00)

Budgets remained a significant contentious issue throughout the period under study. They featured in each cohort of interviews, and discussions were characterised by initial optimism and
dashed hopes. LHG Chairmen highlighted early on in the process their belief that they could make a significant improvement in services locally by redeploying community nursing services. But budgets for these were held by Trusts, delegated by HAs. It is significant that no single Trust was ever able to identify budgets for community services accurately enough to devolve them to LHGs:

"You see, your only power is money in this business. If you've got money in your pocket. We're having enormous difficulties at the moment, we're supposed to have the Community services budget. Well, no money has come to us. We're still struggling with the community to give us figures on, oh, what the employment situation is with the various practices, community nurses and health visitors. Well, it's a struggle to get the information. If we had the money, we could say, "Look, this is what we want to purchase, and if you're not going to (unclear) we'll go elsewhere" (pause) and then they start to jump around" (004.2: 06.07.00).

HAs were very happy to delegate small amounts of money by the beginning of year two (2000), for example, those relating to bids from voluntary organisations, but this was almost risible in the circumstances; in addition primary care development budgets were generally devolved by 2001.

4.5 Summary

Health Authorities 'played hard ball' throughout the early years of LHG development in Wales, retaining tight control over all aspects of LHG establishment, day-to-day operations and development. They did this despite the evidence of a nationally set agenda to put primary care in the forefront of service delivery, and against the pace of English activity proceeding both more quickly, and in a
more structured fashion, towards this aim. Decision-making on every aspect of LHG activity remained at the level of the health authority. The health authority retained accountability to the Welsh Assembly Government on behalf of their LHG sub committees, through the GM to the health authority chief executive; the health authority also retained financial accountability and held the requisite funding allocations. Thus the structural connections served to locate decision-making firmly in the centre of the health system, despite the policy rhetoric of devolution. But, in many ways, the HAs can be seen to have held all the cards but lost the game (as subsequently became clear when the decision was made in 2001, to abolish them altogether), so the question remains as to why this was so. This chapter has illustrated the many structural constraints placed on LHGs by their inception as sub committee of health authorities. These initial structural constraints continued to work to keep LHGs isolated from potential support at NAW level, restricted their access to budgets, curtailed their attempts to create their own agendas and work programmes, and limited their access to critical public health support. These constraints were further tightened through the HAs' control over accountability links and employment of LHG secretariats and officers. In addition, and possibly most damaging, health authorities perpetrated a 'rationalist' (Lindblom 1959 cited in Boyne et al 2004) model of service planning and development which was at odds with the
reality of the system's functioning. As later chapters will go on to show, this model, although mythical, was very persuasive; it attracted the commitment and belief of the large majority of LHG Chairmen. In the end it is really only those Chairmen who were able to move beyond this model to create their own vision and LHG identity that thrived, as subsequent chapters will demonstrate.

But of course health authorities were not so powerful that they alone could have had such a stultifying effect on the new primary care organizations. The behaviour of players in other parts of the system, in terms of the decisions they took and the extent to which such decisions encompassed LHGs, also exercised a strong and constraining effect on LHG development. The next chapter explores the ways in which the new structures affected LHGs' ability to establish and develop themselves in line with their "duty of partnership".
Chapter 5: Structural Influences on LHGs: Partnership

Working

5.1 Introduction

The previous chapter analysed the impact that the new structural arrangements had on the distribution of power in the health system in Wales between 1999 and 2001, from the perspectives of the newly created Local Health Groups, in relation to the two agencies accountable for them. This chapter examines the ways in which the new structures impacted on organizations with whom LHGs were expected to work as partners, and the extent to which these structural arrangements acted as barriers or supporting mechanisms for enabling LHGs to fulfil their remits by building strong horizontal working relationships.

As the Tables 4.3 and 5.1 illustrate, when taken together, the structural changes introduced into the health system in Wales in 1999, outlined in the previous chapter, were counterbalanced by the existing distribution of power within the system as a whole. By June 2000, LHG Chairmen were complaining that the system was “in gridlock” (009). Table 4.3 illustrated the multiple ways in which much of the potential impact of the policy documents, and the specific remit given to LHGs, were eroded by the subsequent failure to articulate any specific developmental pathway for LHGs. Similarly, the National Assembly’s commitment to reducing inequality of provision and improved access to services was
undermined by the stronger impact of the combined operational pressures to reduce waiting lists and cope with winter pressures, as required by the central UK government's dictates, as the previous chapter argued. In that chapter, we also saw the extent to which the potential power of the newly-opened direct channel of communication with the Minister was outweighed by the lack of LHG access to decision-making fora at Assembly level, and further diminished by the frequent changes of personnel at the higher levels of the system.

As Table 4.3 indicated, financial levers, such as the introduction of pooled budgets and the injection of new monies from Westminster in June 2000, were weakened by the long time scale over which previous commitments of GMS and PCD monies ran. Financial potential was further eroded by the small amount of the new monies that actually made their way into the primary care arena. Table 4.3, therefore, helps to illustrate the ways in which central initiatives failed to effect a significant shift in the vertical balance of powers within the health system.

Table 5.1 also illustrates the constraints that operated, this time horizontally, between 1999 and 2000. This chapter examines the extent to which the structural changes introduced brought about changes in the distribution of power and influence across the
Table 5.1: Force Field Analysis: Pressures Facilitating & Inhibiting LHG Development (Horizontal Linkages)
August 2000

<table>
<thead>
<tr>
<th>Facilitating forces</th>
<th>Inhibiting Forces</th>
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<tbody>
<tr>
<td>LHGs’ statutory right to be consulted by Trusts</td>
<td>Trusts’ longer standing links direct to HA;</td>
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<td></td>
<td>Lack of LHG decision-making powers as HA sub-committees</td>
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<td></td>
<td>Potential threat of disinvestment from secondary to primary sector</td>
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<tr>
<td>Shared agenda re local service quality</td>
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<tr>
<td>Establishment of All Wales Chairs Group &amp; quarterly meetings with Health Minister</td>
<td>No statutory direct channel to NAW &amp; HA CEO presence at LHG Chair meetings</td>
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<tr>
<td></td>
<td>Changes in Personnel at senior levels: e.g. NHS D Director, HA CEOs</td>
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<tr>
<td>Devolved budgets: GMS, PCD</td>
<td>Existing spends</td>
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<tr>
<td></td>
<td>Proportion of monies already allocated leaving marginal scope for manoeuvre</td>
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<tr>
<td></td>
<td>Skills deficit re preparation of effective Business Cases &amp; short timescales required for production</td>
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<tr>
<td>Local Health Alliances</td>
<td>Local Authority re-structuring</td>
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<td></td>
<td>Rivalry re ‘ownership’ of public health agenda</td>
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<tr>
<td>Public/voluntary organisations as potential allies in creating shared understanding of needs and common local agenda</td>
<td>Non-representativeness</td>
</tr>
<tr>
<td>Press/local media’s potential to educate re needs and engage public interest</td>
<td>Potential to twist agenda to emotive aspects +/- or local wants</td>
</tr>
</tbody>
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Key: The features in bold type indicate a more significant impact than its opposite force.
Source: derived by researcher using interview data, as a tool for checking accuracy of interpretation with participants. August 2000. See Methodology for further details

health system, by exploring the impact they had on LHGs’ abilities to create space in the existing organizational landscape across Wales, and thus to influence the actions of their ostensible partner agencies, Trusts and Local Authorities. Section 5.2 examines the extent to which structural linkages created helped
LHGs' efforts to build effective working relationships with their Trust colleagues, in pursuit of better integrated and more locally relevant services. Section 5.3 analyses LHG linkages with their local authorities, in terms of the impact of structures on these key relationships. Section 5.4 examines LHGs' efforts to build alliances with their community representatives, in terms of the structural influences and their impact on the LHGs' remit to increase responsiveness locally. In this way this chapter, together with chapter 4, addresses the first research question set for this study.

5.2 Trusts as joint service providers

The newly reconfigured NHS Trusts across Wales were key agencies with whom LHGs needed to build new relationships. As the major providers in the health service, the acute Trusts were dominating the agenda in the health care delivery system. As the largest service providers in any given area, these organizations were responsible, collectively, for the majority of health care expenditure each year (Health Statistics Wales 2007). For this reason, they were also a prime target for change in the government's drive to increase expenditure on preventive services and to shift activity away from the acute sector, towards primary care. Hospital consultants, as individuals, were used to determining the service development agenda, largely unopposed. Inevitably, then, the new local health organisations could have
been perceived as a potential threat to this long standing autonomy. The experience of working with GP fundholders had previously 'softened up' some consultants, and prepared them for the task of collaborating with local GPs. Thus, examples of GP/Consultant collaboration to improve local services were not unknown. Waiting list targets, too, had helped consultants realise that there were imperatives in the system other than – and often in conflict with - their own quality improvement drives.

Nonetheless, the new LHGs may not have been viewed as an altogether welcome, or benign, new 'player' in the 'game'.

As Table 5.1 shows, the 1998 reforms included a statutory duty on Trusts to collaborate with the new LHGs. Some Trusts reacted very positively to this new requirement, bringing their service development plans to the LHGs for their comment. And some LHGs responded with alacrity to such overtures, recognising the scope for improved services locally. One LHG, for example worked with the local Trust to put together plans and a business case for the appointment of an additional rheumatologist. Given Rheumatology waiting lists across Wales at the time, this would easily qualify as a win-win proposal from both perspectives:

"As soon as I was appointed as Chairman I was asked to go to a meeting to discuss the rheumatology problem in Xshire. And what I did was to look at the problem logically and obviously the rheumatology patients within Xshire were having a service, but where were they having the service?...obviously, it was outside of Xshire, but that was costing money. So, you know, the solution proved fairly simple, as far as I was concerned, as if you could identify the extent of rheumatology from Xshire, then you can assess whether or not you can reconfigure a service or redevelop the service in another way. And in the event we have identified
It is important to note that the initiative here came from the Trust. Moreover, despite this Chairman's ebullience at this point, he is also cautionary:

"The difficulty really is trying to create the partnership between primary and our secondary care clinicians, alright? And for both sides [to] seek a collaboration [which] has been of mutual benefit, alright? Now the LHG sits in the middle if you like...being the catalyst that brings them together"  (013: 13.10.99)

Other LHGs however, viewed such approaches with some scepticism, pointing out that such Trust-initiated developments were simply a continuation of the previously existing relationships and power distribution. The inequalities in the relationship grated, as Trusts were perceived as setting their own agenda and expecting LHGs to support them, rather than starting with a clean slate and building joint development plans for local services. When asked about the extent to which they perceived Trusts as potential allies, a different set of views emerged:

"No they say they are but I am convinced they have their own agenda – they have their own developments. They will go on developing, we haven't seen any signs that they are not developing along the lines that we have previously asked them not to, eg within their orthopaedic department, in the past we have resisted any development in orthopaedics because they have such a vast programme but they just continue: it'll become the Royal Orthopaedic Hospital of Wales if they have their way, rather than anything else, and other priorities in Cardiovascular or Cancer services will be sidelined as a result of it"  (004.1: 05.11.99)

The existing balance of power in the system was further reinforced by the predominance of the technical agenda in health care debates about service changes, and the consequent need to
"earn the right to comment' as one LHG Chairman pointed out somewhat ruefully:

I think the other problem is, really, that there is really a major technical agenda, you have to be prepared to work quite hard to be able to be...you know, its about, again, earning the confidence of most people that you understand the agenda and be prepared to do the work to understand it." (006.2: 18.07.01)

This Chairman's comment indicates the extent to which he perceived the prevailing health policy arena to be dominated by a medically defined agenda, skewed towards acute services, leaving the community oriented services and preventive activities that he represented further down the pecking order of priorities. This focus on acute services was, naturally, strongest amongst Trusts and the physicians employed by them.

Most LHG Chairmen perceived the resulting inequality of relationships keenly:

"I've never had a letter from AZ [Trust Chief Executive] asking me for x,y, or z - it just doesn't happen. I've had to write to him, but the letters don't come back the other way. So you know, its not a partnership..." (007.2: 24.08.00)

In the circumstances, then, the prevailing drivers in the system could be seen to have combined to ensure that LHGs' interests were a minor perturbation, and not much more than another step to be taken to get towards the Trusts' original goals:

"Well, we've managed to get a seat at the tripartite table, but we're still perceived as a small player, which we are, with a £4million budget compared to theirs! But the LHG wants to be at that table, but at the same time it takes our eye off the ball. So the structure itself is distracting us from the real task, focussing us on issues of concern to the Trust and HA." (002.2: 02.06.00).

These two Chairmen highlight the extent to which the new structural changes did little to impact on the strength of existing
channels of communication and ways of working between Trusts and Health Authorities.

The new structures may have actively inhibited the development of closer communication, or the creation of a shared agenda between LHGs and Trusts, by failing to include Trusts as formal members on LHG Boards. With hindsight, this appears to have been an extraordinary omission because it may have served to deepen the chasm between the acute and primary care sectors, and thus made it harder to begin to bridge it. The statutory ‘duty of partnership’ was sufficiently vague that it allowed the Trusts to remain in lofty isolation vis-à-vis the LHGs. This imbalance may have been further exacerbated by the number of LHGs to which each Trust was expected to relate. Geographically, many Trusts in Wales had at least three LHGs in their immediate areas, and this number could have been increased by existing referral patterns prevailing locally.

Thus, this existing imbalance in power was further reinforced by weak accountabilities in the health system as a whole. The fact that Trusts’ financial deficits were rarely punished, and instead, routinely written off, helped to bolster the view that they were inviolate. This tendency was widely perceived as “reward for poor performance” (Wanless 2003; Williams, P. 2002). It clearly indicated that any new incentives in the system were not adequate
to encourage the sort of collaboration that would change prevailing patterns of service delivery. The Trusts' seeming inability to provide LHGs with accurate figures on the sums they spent on community services in any one year was also symptomatic of their power and freedom from accountability in terms of service provision locally.

Politically, too, Trusts were powerful bodies, especially at local level where they were very often the largest employer in the area, particularly in more rural parts of Wales and in some of the post-industrial south Wales Valleys areas. Their position in this regard meant that attempts to debate different models for formal Trusts/LHG relationships were difficult to get onto the agenda, let alone debate. This was particularly noticeable in Powys, where the Trust—despite being a community organisation rather than an acute one—dominated and eventually prevailed in ensuring that the LHG did not become the main provider organisation. To some extent, too, the prevailing powers of Trusts combined to ensure that debate about alternative organisational models for community service delivery organisations never really got onto the agenda in Wales, as the outcome of the 2001 consultation exercise illustrated. Comments made by Trust Chairmen as the exercise was introduced were later borne out by the outcome, as LHGs became statutory agencies but Trusts were left intact, still retaining control of community services (NHS Confederation 145)
The powerful position held by Trusts, within the structure of the overall health system, was maintained throughout the period under study, despite all of the rhetoric of government policy to the contrary. It has been evidenced here by the ways in which Trusts went about their business 'as usual', taking decisions about service developments largely on their own initiative, with rarely more than cursory overtures to their relevant LHGs. This was partly due to the strong incentives operating to bolster their positions as providers. It was further strengthened by the fact that, as noted earlier, in some areas of Wales, Trusts were the main employers. But this strong structural position was further bolstered by the failure to provide stronger incentives for collaboration, particularly in relation to community services, or to embed Trust representation sufficiently in the new LHGs' infrastructures.

Chapter 4 illustrated the extent to which LHGs' operations and decision-making capabilities were limited, from the outset, by their structural relationship to, and thus dependence upon, their parent health authorities. This chapter has demonstrated the ways in which these limitations were exacerbated by the failure to build any additional constraints on the autonomy of acute sector Trusts into the structure, or to provide any additional incentives to promote behaviour changes on the ground. In terms of factors that might be seen to predispose an organization to change,
however, while the uncertainty and lack of direction from the National Assembly did leave an authority vacuum which LHGs decried, it also created opportunities, as later chapters will show. For now, in terms of overall context, another powerful statutory stakeholder needs examination for its impact on LHGs.

5.3 Local Authorities

Given the duty of partnership enshrined in the new policy documents and underpinning legislation, local authorities could be termed key stakeholder agencies of LHGs. Considerable hurdles arose in building strategic links with local authorities, despite the structural incentives of shared geographical boundaries, seats on the LHG Board, and the statutory duty of partnership.

Welsh policy had confirmed the coterminosity principle, as further evidence of the importance of the local community as the focal point for needs assessment and service delivery. But how far did the new structures go in clarifying roles and responsibilities for health care provision? Social Care was an overt part of the new NAW Minister's portfolio: her title was that of Minister for Health and Social Care, signalling the Assembly's commitment to partnership working across health and social care. But debate still ranged over who should be the dominant partner. This debate appeared to have more impact within the new Assembly
departments than in the field, but it nonetheless remained a potent factor in NHS decision-making.¹

Local Health Alliances were publicly launched during the course of the LHG Chairmen’s final block of induction training (2 July 1999). LHAs were presented as having a similar structure to LHGs and as enabling local authorities to play an active role in the production of “the Health Authority’s HIP”². LHAs would be responsible for health impact assessments and inequalities. Their proposals would rely on co-funding by partner organisations (LHG).

The Chairmen’s initial reactions to the announcement were not uniformly positive, with concerns expressed about territories:

“What is the public health agenda for LHGs, then? LHGs are trying to come to grips with this: it’s almost half their agenda...” (002, 1.07.99: observation)

“It looks like the Christopher Columbus Business Plan” (009)

Other Chairmen countered with the danger, and need to avoid, being “too GMS focussed” (016); one expressed a view, based on experience of a previous pilot exercise, that the LHA “informs and advises the LHG of what’s really happening in the community” via the elected LA representative on the LHG Board. It was also pointed out that LHGs would need to make sure that they had the

¹ Personal communication: remarks made by Director, NHS D during a meeting with researcher on a different topic. Sept 2002).

² Personal observation of ensuing debate, Study Block 3 all Wales LHG Chairs’ Development Programme, Caer Beris Manor Wales 2 July 1999
same input through to their Health Authorities, via their Chairmen, as Social Services Directors had to their Local Authority Chief Officers.

The majority of Chairmen appeared to be uncomfortable with a perceived tension between the health improvement part of their agendas and the management function for service provision (personal observation). Reconciling this tension was, however, central to their roles as Chairmen: they saw themselves as champions of service delivery and primary care provision locally, but the role required significant management responsibility. The trade offs each made, and how they made them, are examined in the next chapter. At this stage, the key issue is the extent to which the new structures facilitated the development of LHGs and their ability to implement their agendas. In this respect, Local Health Alliances were initially perceived as a potential threat, in terms of who owned the development agenda. And while pooled budgets sometimes had an impact at a local operational level, the subsequent internal re-structuring within Local Authorities (WLGA 1998; NAW 2000) later militated against a strong strategic contribution throughout the lifetimes of LHGs. Inevitably, as it did in the health sector, such a re-shuffling of responsibilities was accompanied by a focus inward, and jockeying for position, at least at senior officer level, while people prepared themselves to apply for new, or be confirmed in, existing posts. In the ensuing
shuffle, health interests were not always perceived as having been protected:

"He's [the existing LA representative on the LHG] lost his job in the reshuffle, so we don't know...we've asked for him to continue, but that...the reorganisation of the local authority and nobody...I mean, they've obviously been more interested in their jobs than they have about, you know, what they're doing with us" (008.2: 05.07.00)

LHG Chairmen reported this as having had two effects detrimental to efforts to build strategic partnerships. Firstly, in several cases, a health remit became subsumed within an Education portfolio at Director-level. This implied, to the LHG Chairmen, a loss of expertise and/or interest. Secondly, especially during the period of re-structuring, participation in LHG activity, as indicated by attendance at Board meetings, was adversely affected:

"Just as there has been multiple Trust reconfigurations, so there has been multiple [social] service reconfiguration in Xshire. And Social Services are now in their third department in 17 months, quite apart from the adverse reports in audit. So they're now housing, catering and social services, I'm not sure which it is!" (016.3: 12.06.01)

This Chairman expressed concern that this hiatus would mean further delays, even after a new appointment was made, because of the steep learning curve involved in getting to grips with the LHG's role and progress:

"I think the sad thing is that they haven't grown up with the rest of us. We're growing...evolving in nature and they could come in and talk gobbledygook and that could prove a bit difficult" (017.2: 29.03.00)

And as for the new appointee:

"He's been a Director of Education all his life...he's been a teacher and he's never dealt with Social Services..." (017.2: 29.03.00)
Nor was this was an isolated example. Other Chairmen reported similar frustrations at Board level in forging stronger links with local authorities:

"Its [the LHA] in a bit of abeyance because they've reorganised the Local Authority and a lot of the officers have been re-appointed and they've got a different sort of cabinet style local authority now. The new...we haven't had a Social Services lead for some time in that the Social services lead, which we had a very good relationship with, took over Education and ranked the two departments together. And now with the re-shuffle, has gone to Education and we're awaiting a new Social Services Director. Social Services has gone in with Housing as well, I think, so..." (008.2: 05.07.00)

Chairmen pointed out additional constraints on building more effective bridges with their local authorities, including issues of representation:

"The Health Alliance is just about ready to be set up, though the group that it was sort of evolving out of is still agonising a little bit as to the structure...I think the issue is about elected members and such like, which is always the issue for the Local Authority. But that's going forward,...and I'm a little disappointed that its taken so long, because when we started a year and a half ago we had a planning and collaboration group that was virtually a Health Alliance. I mean, that's continued on, but it's taken forever to evolve itself into the Health Alliance. I mean, I think then, you know. That will be our main source of alliance with the local authority." (008.2: 05.07.00)

Other Chairmen spoke of the difficulties inherent in trying to set up a new body whose functions overlapped with existing groups without a clear steer as to which should take precedence and how the handover should be managed:

"Again there's a bit of confusion between alliances and the JCC, you know, both things are still sort of ongoing...although they probably duplicate things...people are not quite sure what is going to take responsibility for what..." (018.2: 20.06.00)

But another Chairman began to identify a way to turn this constraint into a positive force:

"The joint working project didn't entirely arrive out of design I suppose, but out of reality! But the reality is that both the Council and the LHG"
staff are reluctant to continue to support the advisory planning groups because it took a lot of their time to do it. The advisory planning groups are the main input of the users, carers and providers in Xshire...and it's a good structural base and a particular way of developing it had been agreed, but that was before we had yet another change. And the man in control now just ignored it, and said no. But out of that total deadlock something has come...the concept is this, that you have in local authority, and in health, and in the voluntary sector, three different planning cycles. **Now if you can bring those cycles together, the first thing is you save an awful lot of time, you don't have to wait for one part of the planning cycle to complete its 180° or whatever it is before you can move forward....**" (016.3: 12.06.01)

So, the much-vaunted changes in structures were not enough in themselves to overcome the existing structural barriers to joint working, at either strategic or operational level, in any sustained way. The structural barriers constraining effective joint decision-making included lack of clear budgetary controls, and insufficient authority to commit resources on the part of LHGs. These deficits contributed to local authorities' scepticism and reluctance to commit resources to joint working. This reluctance was further exacerbated by reshuffling activity within local authorities across Wales. Thus, as Table 5.1 illustrated, these factors combined to maintain the status quo, in relation to decision-making and joint planning.

5.4 Other potential allies: politicians and the public

Local and national politicians were another potential source of allies for the new primary care organisations. Along with the new Welsh Assembly Government came a new tier of elected representatives at national level. UK Parliamentary representatives were another potential source of support. Given that the devolution of responsibility for health service decision-
making to local level was a much vaunted part of the Labour
Government's attempt to 'modernise' public services, support from
politicians might have been expected to be a given. Mindful of
this, some Chairmen made early overtures to politicians, but few
indicated that the effort expended had reaped rewards:

Our local MP, I made the effort to go and see him because I think he
thought we were some sort of mini pressure group—he knew nothing
about his own health reforms whatsoever. But, you know, he knows
we exist now. He's all right but he's one of these who gets a bee in his
bonnet all the time about different things. And I'm not sure he's going
to be sort of use to us, he'll just be complaining when things go
wrong...he still didn't quite get it, I don't think, even when I'd finished
an hour with him. (014.2: 24.05.00)

And as for the Assembly representatives:

I said to our Assembly member, you know if you ever want an unbiased
view point,...if there's something you don't understand or something
about health care that you might find you want to be able to help with,
please feel you can come to us because we are unbiased. And the
comment I got back was, 'well, we've got lots of good people in the
ABC party'. And I thought, well, that's a real shame, you know, she
has somebody actually offering you free, gratis and for nothing, you
know a bit of advice if you ever wanted it...and I get that sort of put
down from a 27-year-old...I just thought it was a shame really...(005.1:
26.10.99)

So both Assembly level and UK parliamentary politicians tended to
be viewed more as a constraint than as a facilitating force in the
work to establish the new organisations. No formal or informal
communication channels existed to facilitate the exchange of ideas
between these two groups. Even when dealing with politicians of
the same party as the government, the perception of Chairmen
was that this was yet another group which needed to be
"educated" about the role and potential contribution of primary
care organisations about some of the more intractable problems of
the NHS in Wales, rather than as an additional source of support.
Similarly, responsiveness was another key aspect of public services that devolution was meant to promote. To what extent, then, were the public involved in the development of a distinctive LHG agenda or approach to service delivery locally? Since LHGs were set up to reconfigure services to meet local health needs, how much influence did local people have on LHGs? LHGs were set up as public bodies, whose Board meetings were open to press and public alike. Each Board included one lay member and a voluntary sector representative.

Several LHGs made extensive efforts to introduce themselves to their local community, using newsletters, websites and public meetings. Nonetheless most reported an uphill struggle, as this one illustrates, 15 months into its life:

"Local politicians and local people in general don't know what an LHG is. That's been...that's one of the key things that we've highlighted in our [Board] Away Days and on the Press releases, people just don't know what an LHG is" (018.2: 20.06.00)

This Chairman blamed the LHG's silent entry into the arena, the lack of any formal introduction or national campaign to explain the role changes and their potential for service development locally. Others pointed to the size of the task of involving the public with such a small resource.

"I've gone down the road of public consultation earlier than most...but I'm not...I asked the Health Authority the other day what papers they have got on public consultation, and I met with a completely blank wall because there is nothing." (017.3: 12.06.01)

"There's a problem as to how to do it! No lack of desire, but how on earth do you do it, really, I mean it's the problem that...unfortunately the lady who is rather difficult on the Board and on the...in the groups..."
is actually represented...well, not the public but the voluntary sector, and that isn't a great help to us, but she...unfortunately has several items on her agenda and that's all she wishes to deal with...I think in terms of the various groups that we've had where we've had users and carers, the voluntary sector, community health councils, we have found that the people who have come have been unrepresentative of the general public and really have had particular axes to grind and we're not very happy with that..." (008.2: 05.07.00)

The evidence suggests that the structures for selecting lay representatives would not ensure representation in the electoral sense, but nor did this necessarily negate the development of a more responsive agenda. On the other hand, there was only one representative of each of the three other independent contractor professions, so the same charge of tokenism could be made for them. Nonetheless, taken together, the independent contractors could form a cohesive block. This tendency often heightened conflicts on LHG Boards, and possibly also provided a convenient rallying point for the professional Board members. It also enabled lay members to be branded as "troublesome" and thus to be marginalized.

"Take the Lay Rep for example. She thinks she should be in charge of public consultation. But that's not how I see her role - she's just been in here, nagging the pants off T's [GM] Number 2 because her poster isn't ready. Well it's not her job to be making posters. I think I know what her job is and it's not that!" (002.2: 02.06.00).

Lack of clarity about the nature of the lay representative's role, coupled with the technical nature of the agenda in health, was recognised as an additional barrier to effective lay contributions in an arena dominated by medical professionals.

"It is a demanding combination, really, because if you take your general public representative or elected member, I don't think they would find it at all easy to enter this world unless they've had a real, you know...They've got a professional background in some way or other that then they became an elected member. I think that being a
representative of the people might be fine in a local government context in the kind of framework that we just touched on, but I don’t think it will do in the health one, you’ve got to combine that with a fair slice of a professional knowledge base” (006.3: 12.07.01)

“It is difficult because again you have to remember that medical and NHS jargon is not commonly known outside the health service so people who haven’t used, even people working within - dentist, pharmacist, optometrist- they find it difficult how the primary care runs so they need to learn and lay people need to learn more than that because they don’t know anything about anything” (011.1:05.08.99)

This emphasis on the technical nature of the debate may lie behind the reported reluctance of lay representatives to join in discussions about what they perceive as the roles of the statutory agencies in relation to decision-making and any consequent rationing of services:

“One of the interesting problems that we’ve had is that on the Mental Health Group when it started to make decisions about prioritising service, you know, who had the money and which bit was developed, the voluntary sectors and the users and cares said they didn’t want to participate in that...they didn’t see that that was their role to make decisions. So one of the things we feel is that to involve them in the decision-making process is, you know, is difficult because, you know, they really see themselves as...in an advocacy role, I suppose, and when it is, well, “You know, right, well, you can have this but so-and-so doesn’t have that” and then they ask not to vote on those things. Which disillusioned me a little...you give them a seat at the high table so to speak, and then if they decline to make decisions, really, you query whether its worthwhile...” (008.2: 05.07.00)

So the extent to which LHGs had been persuaded into adopting a managerialist perspective by this point in the process (twelve months after launch) is interesting for the light it sheds on the value placed on different groups’ contributions.

Added to that, the amount of time it takes to build effective communication links with the local community was another barrier:

“In the HIP consultation, we used the X Council panel of 1,000 people for a consultation which was...which was helpful. We did engage in a certain amount of invited comment, but its very, very difficult. I mean,
I'm not despondent about it, I just think you've got to be realistic that this is the start of a continuing dialogue and that your first steps in that will not be productive. It needs to build up, people gradually need to think in terms of communicating with you about these things..." (006.2: 17.07.00)

Others tried to make tangible links with their CHCs as proxy representatives of patients: for example, several tried to share office premises as a means of facilitating communication:

"And round that also is the point that hopefully at least we'll have in the X-area our Community Health Council and LHG's office as an office that somebody can have access to, and they know where they can go to talk on those issues....It will also enable the LHG to give some sort of admin support for the CHC and also for the CHC to give more input more easily to the LHG - saying "Oh, you don't like this", or, "are you aware that...?" It's a way of keeping your eye to the ground isn't it? (016.3: 12.06.01)

LHGs lamented the lack of any guidance or concrete advice from either their parent health authorities or the Assembly as to how best to develop the public involvement element of their remit. But, reflecting perhaps the general lack of interest in this area prevailing amongst much of the health service management community at the time, very little guidance was forthcoming (004.2); as one put it:

The general feeling was that "everybody's trying, but nobody was very happy that they'd done it, quite honestly". (006.2: 05.07.00).

5.5 Summary

This chapter and the preceding one have illustrated the extent to which the structural changes made to the health system in Wales introduced in 1999, failed to change the existing distribution of power and influence within the system. Table 5.1 summarises the main changes made, in terms of horizontal structural links; the forces unleashed by the changes; and their effects on the
development of LHGs as of the end of December 2000. The Table indicates that, although a number of key changes were introduced to support implementation of the new policy to devolve power in decision-making to local levels, other elements of the system combined to maintain the status quo, in terms of power and decision-making, throughout the period under study. Thus, for example, the revolutionary rhetoric of Putting Patients First was severely undermined by the nature of the structural linkage to health authorities. The limited decision-making powers of LHGs were further curtailed by the failure to articulate, or implement, any sort of defined development pathway for LHGs. When LHG GMs and Chairmen did, finally, begin to work in concert, to propose their own solutions to the perceived impasse they found themselves in at the end of 2000, their efforts were hampered by internal capacity constraints. Consequently, even the injection of new cash into the system, in June 2000, appeared to have acted more to reinforce than to change existing fault lines.

This analysis of the structural constraints inherent in the establishment and development of LHGs illustrates how difficult a task faced the new Chairmen throughout the three years in which they worked to establish their legitimacy as local agents for change and to impact on service provision locally. Table 5.1 illustrates the forces operating to promote LHG development, and the relative strength of the forces opposing this growth. It
illustrates that the incentives provided to LHGs were too weak to enable them to challenge existing powers within Trusts. It points towards the weak accountabilities that further exacerbating this situation and confirms the inequality between the size of the task compared to the skills and capacities provided. Clearly a new approach would be needed. The next chapter looks at the Chairmen themselves and the skills and understanding they brought to their task. Chapters 7, 8 and 9 examine the new relationships they tried to forge in order to affect service delivery locally. Chapter 10 analyses the tools wielded by LHG Chairmen, and their impacts, as they tried to play this unequally weighted game. In order to understand their progress, or lack of it, towards this goal, it is necessary, next, to explore the perceptions of the key actors, and their interpretations of the social institutions and organisational realities in which they found themselves, viewing both the activity systems and formative contexts in which they worked from a social constructivist perspective.
Chapter 6: Chairmen as Change Agents

6.1 Introduction

The preceding two chapters outlined the political and organizational context in which LHGs were created. The aim of this chapter is to explore the ways in which the main participants in this story, the LHG Chairmen themselves, perceived their roles and key tasks. Their own descriptions illustrate different perspectives and assumptions that the Chairmen brought to their new roles, that, in turn, influenced the different approaches they applied to developing their teams and their organizations, and to building relationships with other stakeholders.

A distinct narrative thread can be identified in the words and metaphors, or images, used by Chairmen to describe the situation in which they found themselves, that helps us to understand the ways in which they experienced the new context in which they were working, in their roles as Chairmen. The sense that they made of the obstacles they encountered – in fact, the extent to which they perceived different forces or pressures as constraints in the first place – provides a sharp insight into the ways in which they perceived themselves to be working, and the reasons behind the actions that they took throughout their three year period in office. As Weick (1995) has noted, the specific constructs that individuals create, as part of their on-going efforts to understand
and make sense of their worlds, helps to determine the actions that they take. These actions may, in turn, exercise something of a determining effect on the worlds that they subsequently experience. Critically, these constructs rely on individual actors' interpretation of "cues" from other actors in the system, and tend to conform to, or reinforce, [their] existing notions of identity (Weick 1995 in Checkland et al 2007, p. 96). The metaphors, or descriptive images, that the Chairmen used throughout the study thus help us to understand their individual and collective paradigms, in other words, the ways that they themselves perceived their new working context.

Section 6.2 outlines the Chairmen's roles and responsibilities, as specified in the Guidance Advice (Table 6.1). Section 6.3 explores the electoral process to show how Chairmen came into the roles in the first place. Section 6.4 examines the personal characteristics and career backgrounds of the Chairmen. Section 6.5 explains their personal motivations for taking on the role. Section 6.6 analyses the sense they made of the role in terms of, firstly, their interpretation of the context in which they found themselves; and secondly, the emerging descriptions of the leadership role they expressed; and thirdly, the leadership styles they evinced throughout the study. The distinctions which emerge reflect nuances which became more apparent over time, from their own words and images. It is important to note here that, since this
study did not set out to measure leadership qualities, the
categorizations discussed here are not fixed or innate. Rather they
are the product of the researcher’s attempt to distinguish between
the different Chairmen’s approaches, based on their own
descriptions of themselves in this context. Section 6.7 explores
the ways in which Chairmen defined those groups they considered
to be their prime constituents. Section 6.8 analyses some of the
limitations on Chairmen’s authority. Section 6.9 consists of a
summary of the key points made in the chapter.

6.2 Role and responsibilities

As noted in chapter 4, Welsh Office guidance (1998b) stipulated
that “LHGs must be vehicles for decision-making, not just
maintaining the status quo”. Table 6.1 outlines the roles and
responsibilities of the LHG Chairman in pursuit of that
organizational objective. The Table indicates that a strong and
effective leadership role for the Chairman was specifically
articulated in the initial policy guidance.
Table 6.1  LHG Chair Job Description

<table>
<thead>
<tr>
<th>Role of the Chair: Key Functions</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide leadership to the LHG</td>
<td></td>
</tr>
<tr>
<td>To agree with the health authority on behalf of the LHG the range of functions and responsibilities to be undertaken.</td>
<td>1. To reflect the position in an annual performance framework agreed with the health authority; and 2. To agree a plan for the future development of the LHG.</td>
</tr>
<tr>
<td>To review the performance of the LHG and be responsible for its effectiveness</td>
<td>To ensure they are sufficiently informed and supported to undertake the functions delegated to them</td>
</tr>
<tr>
<td>To facilitate the participation of all members of the LHG</td>
<td></td>
</tr>
<tr>
<td>To provide sound advice to the health authority on all issues pertaining to local health needs</td>
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</tr>
<tr>
<td>To ensure that all members of the LHG act as a corporate team</td>
<td>1. [To] operate within the principles of sound corporate governance and 2. [To ensure that] collective responsibility is recognised and realised</td>
</tr>
<tr>
<td>To ensure that principles of good clinical governance are taken forward in the LHG under the leadership of an identified senior clinician from within the LHG who will take responsibility for this area of work</td>
<td></td>
</tr>
<tr>
<td>To ensure that the needs of local communities and the people who live there are at the forefront of the LHG’s business</td>
<td></td>
</tr>
<tr>
<td>Role of the Chair: Key Functions</td>
<td>Objectives</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>To obtain full value from LHG meetings by:</td>
<td>1. being even handed, impartial, willing to listen; 2. being clear about aims of meetings and 3. ensuring that those aims are understood and shared by colleagues</td>
</tr>
<tr>
<td>To guide the LHG in leading the organization, rather than managing it</td>
<td>To heed the distinction between the role of LHG members and the secretariat</td>
</tr>
<tr>
<td>To be responsible for the links between the LHG and the Chairman and Board of the health authority, the media, local MPs and Assembly members, CHC and others</td>
<td>1. to be as open as possible about [LHG] affairs 2. to build goodwill towards it [the LHG]</td>
</tr>
<tr>
<td>To represent the LHG externally</td>
<td>[To identify] further development requirements [of Board members] through a process of continuous review</td>
</tr>
<tr>
<td>To be responsible for the effective induction and development of LHG members</td>
<td></td>
</tr>
<tr>
<td>To ensure that LHG members have appropriate arrangements in place to consult and feed back to their sponsoring bodies</td>
<td></td>
</tr>
<tr>
<td>Working with a small executive committee, ensure that the business of the LHG is conducted smoothly and cost effectively</td>
<td></td>
</tr>
</tbody>
</table>

The Table indicates the wide range of functions and responsibilities expected of Chairmen, in the two sessions a week they were expected to dedicate to the role. The next section looks at how they were elected to the role, and following sections examine the different ways in which they interpreted that role, and why.

Section 6.3 The Electoral Process for the Role of LHG Chair

Local Medical Committees were given responsibility for conducting elections to the LHG itself. Each LHG then elected the Chairman from amongst the full membership, but with the clear indication that the Chairman should be a GP. Although this sounds reasonable and straightforward, in practice, a more complicated picture emerged from Chairmen’s own accounts of the process. This was partly due to the context in which the LHGs were set up in the first place, which included widespread pessimism about the concept of LHGs among GPs across Wales, as well as scepticism of the electoral process in terms of representativeness of local GP opinion (Williams 2002). Chairmen were well aware of this concern amongst their peers:

"...the relationships are there but I think the problem has been that there's a lot of scepticism about local health groups at the grassroots level. And you know a lot of practices do not see their relevance and I think we will have to prove our relevance really" (008.1: 3.11.99)

The scepticism of ‘grassroots GPs’ may have been further strengthened by the electoral process itself, which was widely
reported, by the survey respondents, as ‘fixed’ in that it had been handled through the Local Medical Committee, and the timing of the process had made it hard for people from smaller practices to be involved. The Chairmen’s own descriptions of the process support the idea that the electoral process had been neither straightforward nor transparent:

“The one who expected to be the Chair didn’t get voted on to one of the six [GMP slots] or didn’t have the support of the others to chair it. It wasn’t an automatic GP Chair, *I mean they didn’t want it*. So I was then asked...well, not directly, but they wanted to have somebody, you know, and my name was put forward which was then supported by the Board which was then supported by the XXHA Board. A series of supports if you like” (012.1: 09.08.99)

“When it came to the elections for what was to be the LHG...*Some very funny shenanigans went on with the LMC...and it shows the real politics of it*. So I had been recommended as the representative on the XX Steering Group, and I mean I’m not even an LMC member, which was very strange, so I found out at the last minute where this meeting was and went along to that, so I got a little bit deeper in. And at the end of the day I’ve agreed to stand for the LHG and in fact mysteriously only six people stood for the [six places on the] LHG, which I find strange...”(016.1: 29.09.99).

This excerpt is important because it shows the extent of misinformation or inadequate information that clouded the health system, at primary care level, at the time that LHGs were being set up, even amongst those purportedly most closely involved. This lack of information inevitably skewed perceptions about fairness. The slow process of information dissemination out to practices from the centre combined with many individual GPs’ suspicions about the LMC – “the politicos” - to create a cloak-and-dagger picture of the electoral process:

“There was competition particularly on the Board – some members who felt they should have got on it didn’t get on it- *deep down I feel there was a little bit of political voting* on geography rather than on thinking what could the person bring to the Board because although the person who didn’t get on didn’t join in with other practices on
fund-holding – they went their own way – they could have brought a lot to the Board through his knowledge of Royal College higher politics and GMC politics, revalidation and stuff which would have been useful to the Board” (015.1: 29.09.99)

The electoral process itself was therefore perceived as skewed in favour of those who had previously involved themselves in local medical “politics” or activity. This tended to reinforce the prevailing reported scepticism of GPs on the ground towards the LHG concept itself.

This scepticism was further strengthened by the sense of bereavement reported to prevail among local GPs in areas where GP Fundholding had been extensive. Chairmen themselves used this term to express the feelings of loss of influence their colleagues were reporting:

“There are a lot of practitioners in XShire who are very irritated that fundholding has gone...whether people will come out [of that bereavement process], lots of people will come out and lots of people won’t come out the other side of it. They won’t do it again, if you see what I mean...[they] may never be that keen on a new system. You know there’s this huge amount of time making it into a system, and you know, you take it away...” (008.1: 03.11.99)

Grassroots GPs, already sensitised by such feelings of loss were, perhaps, only too ready to criticise all aspects of the new LHGs. And the choice of the LMC as the electoral vehicle may have contributed further to this negative perception. The LMCs’ role had traditionally revolved around representation of GP interests to Health Authorities. This role could have been perceived to have been downgraded in importance once Family Health Services Authorities were abolished, since those primary care-oriented
authorities understood and respected the influence of the LMCs in a way in which health authorities - traditionally more used to working directly with Trusts - might be less inclined to value. Using the LMCs as the electoral mechanism might have been intended as a way of reducing any potential resistance LMCs themselves might have had to the LHG concept - particularly as the LMC may well have had concerns about the potential impact the LHGs would have on their own roles (discussed further in Chapter 9).

"When it came to the elections for what was to be the LHG, the XX doctors, who had a good group... were told by some of the doctors in the eastern side, quite inaccurately, that it had been discussed and it had been decided that nobody would stand for the elections for the LHG, for general practitioners, unless we knew how much they were to be reimbursed for locum fees which was quite an issue... and how much time would be required to be put into LHG work, and they said only sensible people would undertake this sort of work if they knew those two things. And actually that was quite true but it was untrue that nobody had agreed to stand and so unfortunately all of the XX doctors then, who were the most coordinated of the three groups, now stood down. So I was one of the two representatives from the eastern side, and on an informal basis, so I went in on that...(016.1: 29.09.99)

This quote emphasizes that, despite all the efforts put into trying to ensure an equitable and transparent mechanism for electing GPs and Chairmen in the first place, the complex environment in which the elections took place meant that back room deal-making was an almost inevitable part of the process in practice. This may have been further complicated by the nature of the reimbursement for the role of Chairman. This last excerpt shows that the GP Chairmen were already well aware of the strains their roles would place on their GP partners, by their absence from the practice 2 sessions a week. In addition, almost all spoke of their
concerns about the levels of reimbursement compared to the amounts of time they felt necessary to devote to the LHG role. In contrast to GPFH practices, there was no management allowance and the Chairman's reimbursement was viewed more as an honorarium than a salary for the job. This arrangement might have been acceptable to the individual GP Chairmen themselves, but their GP partners were less sanguine, given that locum costs needed to be subsidised by their own personal incomes, from shared partnership earnings. This proved to be an added strain for GP Chairmen throughout the years under study. Thus, elements of negativity in the context in which the LHGs were being set up, may have been aggravated further by the arrangements made for electing GPs to the role of Chairman; the reimbursement arrangements for the role of Chairmen created an additional source of resentment among their closest colleagues. The next two sections explore the personal characteristics Chairmen brought to the new role and their motivation for taking it on against this thorny background.

6.4 Personal Characteristics and Community Links

The 22 Chairmen finally elected by their LHGs were mainly, but not exclusively, practising GPs. All 22 were male; most were middle-aged, between 40 and 60 years old; only two were in their late thirties. Initially elected Chairmen included one female, but she subsequently resigned due to a potential conflict of interest,
as she was married to a specialist doctor at the main NHS Trust hospital to which the LHG related. In a different LHG, the Director of Social Services was initially elected as Vice Chairman to a GP Chairman. However, the ex-fund-holding GP Chairman resigned soon after his election, and the Vice Chairman duly took up the post of Chairman.

All 22 Chairmen could be said to have been firmly rooted in their local communities, most having lived and worked in the same locality throughout much of their careers. All reported that they had forged good personal links locally, throughout their careers, a feature that Chairmen thought would prove useful to them in their new roles:

"I know the Chairman of the Trust personally, and through a number of other things like when he was Chairman of the Family Health Services Authority and having met with him when he was Chairman of the X NHS Trust; we haven't always agreed, but there are lines of communication. And, you know, that's all good stuff" (007.1: 23.12.99).

Others pointed to their long-standing ties with local voluntary groups, as advantages they brought to their new roles:

"...the Voluntary Council, 'XX Voluntary Concern', which, again, I had a little input into that, into the Steering Committee, setting that up..." (016.1: 05.10.99)

"I mean, I Chair the St John's Council for the county of X...so I've been involved in that for many years. I've Chaired it for two years." (012.1: 09.08.99).

Still others reported the strength of their own networks with local GPs and the broader medical community:

"...in the event many of my colleagues in Xshire came to me because of my previous involvement with postgraduate education – with vocational training. My involvement as a clinical assistantship with a hospital."
And because really I had been involved in health service development within my own community” (013.1: 13.10.99)

“I organise social events on a fairly regular basis...technically I was Secretary to the XX Medical Association which started in the 1920s and used to invite each new consultant to come to talk with them...” (015.1: 29.09.99).

Additionally, both of these latter Chairmen are emphasising their acceptability to other doctors, by virtue of having had educational roles amongst their peers. They expected this personal history to work in their favour, by conferring elements of credibility and neutrality, and thus to dilute any concerns about potential threats to established interests. That these attributes of acceptability, credibility and safety were perceived as important assets indicated the Chairmen’s recognition, from the outset, of the existence of some significant underlying difficulties to be met in taking on the role of Chairman.

The extent to which Chairmen had backgrounds in primary care development work among their peers was also perceived by several as having been influential in their becoming known figures locally, and thus in increasing their acceptability to their colleagues. All of these personal associations were regarded as useful ‘oil’ for the organisational links they were trying to forge as Chairmen. These descriptions of their personal histories and their perceived impact on their election to the Chairmanship role provide useful starting points for understanding their individual motivations. They also point towards the metaphors, or images they used to make sense
of the expectations they perceived to be facing them in these new roles (Weick 1995; Morgan, 1980).

6.5 Motivation

Chairmen tried to downplay their own personal ambitions, by highlighting the extent to which the role was perceived as unattractive by many GPs throughout 1998 and early 1999. They claimed that, in many areas, there was little competition for the post: “I don’t think that anybody else would have done it...” (005.1: 26.10.99). This sort of frequently-made comment also served to emphasize their own, personal, commitment to public service in taking on the role, as the following extended extract shows:

“I became involved because I was asked to get involved in the Commissioning Forum...and I had done that for a few years, and I suppose that the real reason why I did that was that I wasn’t happy about fundholding because I thought it was divisive, and I had a feeling about it that that was not the correct way to have the patient get the primary care services that they deserved and that they should have. . .So I got involved because I thought it was a better way to provide care for patients, to influence the authorities...so I thought that having had the experience that I did with the Commissioning Forum, I could contribute something of the knowledge of that process, and the fact that I’d chaired Local Medical Committees, Secretary, and been involved with the BMA, GMSC as it was then, and also I was coming at it from a different perspective in that I’d been involved with Vocational Training, and Course Organising and was, until July of last year, CME Tutor at the local Postgraduate Centre. So I thought that I had an input which may have had some influence on the forming of Local Health Groups...” (007.1: 23.12.99)

Virtually all 22 Chairmen reported a strong personal commitment to developing primary care in their own localities:

“I think that there is...that the crisis is here, that secondary care is moving ever more specialised in its outlook. ... The old-fashioned general physician role that absorbed all the secondary care work is not going to be there, and there seems to be a need for primary care to absorb that role, which is difficult, because if we need to
absorb that role, then we need to find somebody else to do the role that we currently fulfil. And the challenge of how to manage that change is something that's necessary, but very difficult." (001.1: 6.10.99)

Many reiterated this aspect of developing primary care via devolving "generalist" activity from the acute sector outwards to the community, thus freeing up acute sector resources and, at the same time, adding a more sophisticated range of activities to be undertaken within the primary care sector. Such expression also reflected a key strand of government policy aimed at reducing demand in the acute sector.

"I took early retirement. One of the reasons for my retirement was because commissioning was on the horizon. I've been a GP for 30 years. I've gone through so many changes. I was in recent years a very successful fundholder and all of a sudden the rules have been changed...so I thought...I can afford to go. So I'll go. And you get on with your own game. However in the event ....I realised that morale was low in primary care, and all of a sudden I thought, well if I do go back then it might give me an opportunity to be able to influence things for the better as far as primary care is concerned. I thought Okay, I looked upon it as a challenge." (013.1: 13.10.99)

This comment also suggests that another motivating factor may have been a function of the age range of the Chairmen themselves: many spoke of finding themselves looking round for new challenges, just as LHGs came on stream.

"Mind you at the same time [as I was applying for the Chair] I was also planning to take a sabbatical as I was thinking of perhaps having a break from general practice and going to Australia for a year or something. I really fancied that but I got involved in this instead!" (010.1: 16.08.99)

Why GPs, as individuals, seemed to welcome this opportunity to be in the forefront of a major change in direction is interesting in itself. For some it was a case of needing a change personally, while others saw it as a chance to make a difference to services locally:
"Ordinary practice life can be a bit repetitive after a few years...There are things that should be done that aren't being done, you know, in the Trust and the hospitals and so forth, and so you sort of get this urge to change them really." (014.1: 16.08.99)

"I reached the age of 40 three years ago ....and I was feeling intellectually bereft so I decided I needed a challenge personally, and, as luck would have it XX Out of Hours service was set up and I was instrumental with a few others in actually making that work and we did this together, 10 local practices, 106,000 patients in total and we did it in just under 10 weeks.....I really enjoyed the cut and thrust of holding 10 very different practices together" (009.1: 20.08.99).

Key words here relate to both the perceived ability to make a difference, and to previous personal experience of having had an impact on direct patient care delivery services within a relatively short period of time. All 19 GP Chairmen repeatedly expressed this deep personal commitment to making a difference in primary care delivery locally.

This personal commitment to change was expressed equally by non GP Chairmen:

"Well ... I see it as a wonderful opportunity to forge links - our links with the health authority are there, and with the hospitals are very good, we have people in there and that all runs very smoothly but relationships in this area, in the community are 'overdue for attention'. I suppose in XXX we identify with the primary care agenda, a sharing of the Cinderella services agenda, and we see a need to control the more high profile high spending acute sector. I saw this really as a chance to make a contribution here, a real opportunity to make a strategic shift." (006.1: 08.11.99).

"My wishes, my aspirations if you like, are based on the fact that there now is or could be collaboration between the health and social care. I think that could be quite advantageous, you know, if channelled in the right way" (012.1: 09.08.99)

So, again, the "opportunity" to make a difference was expressed by all twenty two Chairmen, irrespective of occupation or experience.
But it is important to note, within this uniformity, that key variations in emphasis had emerged, right from the outset, as some Chairmen noted the broad strategic impact of reconfiguring services, whilst the majority of Chairmen referred to the local operational benefits they hoped to achieve in their new roles.

Despite Chairmen's uniformly strong conviction of the potential value of the new organisational form in developing and changing primary care, and unanimously expressed personal commitment to effecting such development, their motivation for taking up the role of Chairman was more variable across the twenty-two post-holders.

But the Chairmen, as a group, appeared to be sensitive to charges of being labelled as either "ambitious" or "political". Negative connotations appeared to be associated with these characteristics by both GPs in the field and Chairmen themselves. Chairmen used a variety of terms to explain their own individual motivations, and to distance themselves from accusations of either ambition or political experience:

"Well you have to...it's a question of taking the responsibility. If somebody has the vision for what can be done and what needs to be done, then it's a sort of responsibility to try and achieve the goal" (001.1: 06.10.99).

The following lengthier extract includes a self-description followed by a narrative account of how the move to Chair of the LHB came about:
"I went in with the intention of being part of the Board as I feel myself and I think a lot of people would agree with me possibly not being a Chairperson as such but more of a Team Player. However things changed and the initial feeling was that I should become Vice Chair as the Chair was having problems sustaining initial support for some local political issues...Following on from there, there were internal disputes with the Chairman's practice: all the partners felt they had the work put on them because she was at meetings so often and as it happened her partner in her practice was also going for Clinical Governance Lead. It was a big practice, 6 or 7, but 2 people were away for long periods of time so she had an ultimatum from the other partners...so the natural person to turn to was the Vice Chair..." (021.1: 08.11.99).

This second account shows the extent to which the respondent was keen to distance himself from any concept of having actively sought a leadership position. Similarly, other Chairmen tended to respond modestly when asked why they had gone for the lead role:

"I think that the concept I found attractive. I think that I've always been interested in medical politics and this is probably the first opportunity, I feel, that doctors in primary care have had the chance to alter their work and have a direct influence on how they work...The reasons I'm the Chairman...is I think is I'm a job sharer, so I am able to, I can give the time commitment to do it." (022.1: 28.10.99)

This Chairman was unique in admitting an interest in 'medical politics' but was also noteworthy for the way he countered this with the suggestion that he was only elected to the role of Chairman because he was perceived, by his GP colleagues locally, as having more time available than other GPs. This widespread reluctance to admit to ambition or leadership qualities may have made it more difficult for Chairmen to come to terms with the realities of the new context in which they needed to work, since, as was pointed out in section 6.3, the LHG Chairmen's expressed commitment to making a difference in services to patients was in stark contrast to the perceptions of the role expressed by
"ordinary" GMPs in the run-up period before LHGs became operational.

6.6 Sense-Making: Interpretation of Context

6.6.1 Prevailing Paradigms

Clearly, individual actors do not make decisions or interpret others' decisions, in a vacuum. The context is part of what needs to be taken into account, but, in addition, each Chairman brought to this new role an underlying set of assumptions or view of the world that, in turn, influenced his efforts to make sense of the new context into which he had entered (Weick 1995). Examining these perspectives, or paradigms, is an essential prerequisite to understanding the rationale behind each Chairman's definition of his new role, and the approaches each took to fulfilling what they saw as the key tasks implicit in the role. In exploring these data I have found Weick's approach useful as a way of making sense of what is being said. By using the set of questions recommended by Weick (e.g. 'who are we?', 'what makes us different?' and 'what causal beliefs do we use?'), it emerged that the majority of Chairmen espoused a rational and linear model to describe the new context in which they found themselves. This model may have reflected their biomedical education and training. In this vein, many of these Chairmen tended to try to describe the policy world, and the decisions of the WAG, for example, using straightforward terminology which reflected belief in a step-wise
and linear developmental pathway. One Chairman frequently used the metaphor of human growth, from childhood to adolescence to maturity to describe the LHGs as an evolving organism:

"...we [the LHGs] are the front gear, and we're very juvenile and perhaps an appropriate analogy is that we're teenagers. I think we are in the throes of the teenage thing, and that we're learning, and perhaps by the time the three years are up we'll be in our early twenties. I certainly don't think we'll have achieved that middle-age type of situation..." (007.1: 23.12.99)

Many Chairmen also used simple cause-and-effect chains to try to understand the actions of other actors in the environment. Virtually all expressed belief that "planned" and "orderly" evolution was the ideal way to develop their organisations, in a stepwise progression:

"it's a natural process" (007)

"Need to build on what we've achieved in order to move forward"

"We're told to take things slowly and not bite off more than we can chew (014)

"...can't run before we can walk" (007)

This expressed belief in the prevalence of a natural order of things, and the rightness of evolutionary progress, implied, for many, the necessity for, or at least the appropriateness of, guidance and direction from a central authority, or 'parental', figure (Welsh Association of LHG Chairs 2000). Such a model neatly reinforced the prevailing tendencies towards control inherent in many bureaucratic organizational systems (Harrison et al 1992, p.14). In addition, the Welsh structures which limited the LHGs to advisory roles as sub committees of the much larger
Health Authorities further reinforced this impression. There was a constant undercurrent of belief, amongst the majority of LHG Chairmen, in the ability of the LHGs to influence upwards if only they could be seen to “toe the line” and be delivering the goods first, via a sort of earned competence. The difficulties began to be evident when different players’ (eg WAG, HAs’, LHGs’, and Trusts’) definitions of what constituted the sought-for products surfaced.

Chairmen universally expressed belief in the power of information and evidence to effect change and influence the other players in the system to see things they way they did: “If we’ve got the right information, people can’t argue with facts” (014). A constant source of frustration, therefore, was what they saw as the inability to get “hard information”. Over time, the Chairmen gradually began to realise how far outside the existing information channels their new organisations actually lay:

There’s a six lane highway running between the Trust and the health authority. The little LHG minivan can hardly get on the access ramp... (006.1: 08.11.99)

The lack of up-to-date prescribing information was put forward as an example of this information deficit, and seen as a serious handicap for interventions that had been expected to be fairly straightforward and to yield quick returns. The reality was that LHGs’ access to information was controlled by health authorities and Trusts, and it was very inconvenient for Trusts to find
themselves being asked for figures on community service spends, which they regarded as an important part of their own, already over-committed resource base. LHGs' collective inability to wrest this information from Trusts, as demonstrated in chapter 5, hindered their ability to make effective changes to community support services, a key plank to shifting demand from the acute to the community setting. This impression of being outside the mainstream of action and decision-making was further reinforced by the obstacles that independent contractor Chairmen faced, throughout 2001, in trying to contribute to the consultation about future models for primary care organisations in Wales. As explained in Chapter 3, their “day jobs” of scheduled clinics and patient appointments were arranged weeks in advance, thus committing their time; even when they could re-schedule, finding locum cover was almost impossible in some areas, even with advance notice. In contrast to this, the salaried managerial members of Trusts and health authorities were easily able to clear diaries for last minute meetings throughout the day:

“Its amazing how the health authorities have been able to wheel [everybody] out” (006.3: 18.07.01)

Moreover, by the end of the third tranche of interviews, in October 2001, most Chairmen still referred to their organisations as weak and powerless, because they lacked – and had failed to acquire – control over the budgets, and the information, as well as the skills
and expertise which they deemed necessary to develop primary care services.

The speed at which the agenda seemed to change was also significant, throughout the period under study. Chairmen tried valiantly to identify clues as to what the Assembly actually wanted from them and to steer their organisations to deliver it, in line with a belief that this would earn them more autonomy and a larger share of the pool of resources.

Their own commitment to primary care development never wavered but they gradually grew to detect that a different definition prevailed among their WAG and health authority counterparts.

"Everybody's gone over to the business of dealing with The Plan and things have stood still a little" (006.2: 17.07.00)

Chairmen bemoaned their collective lack of knowledge about how to influence upwards more effectively:

"We need proper lines of communication...to get the Assembly to listen and to hear what is acceptable to LHGs" (007.1: 23.12.99)

And they expressed a "constant fear of manipulation" and of "being politically cornered" (007.1).

Nonetheless, the belief that evidence would be enough to sway vested interests prevailed, despite their ongoing experience. This may reflect the technical nature of the medical role in the health
service, with a corresponding disregard for "politics" as being messy, ambiguous and somehow unwholesome. Idioms used by most Chairmen referred to structures and planning processes and of the value of an outcomes focus in order to build an evidence base for change. They spoke of continuity and systematic development as essential elements to progress. The term "politics" on the other hand was used negatively, to refer to empire building and game playing. There was virtually no recognition or understanding of the complex "soup" that is the world of policy makers. When faced with this complexity, many Chairmen tended to react by becoming more focussed on specific local medical service developments at operational level. This approach was often expressed by the view that GPs were ideally placed to "know" local service needs. The flaw in this perspective was the individual patient orientation implied and a failure to recognise the fallacy of generalising from such individual encounters. The power of this perspective was, however, a key pillar of the way the system functioned, and its prevalence dominated definitions of local need throughout the years under study. As the one Chairman with a social services background commented, looking back at the end of the study:

"I've become focussed around the health agenda [of GMS] rather than contributing the social services perspective" (006.3: 18.07.01)

The power of these underlying assumptions, or paradigms, can be seen further, in the following analysis, of the Chairmen's' descriptions of their roles, and the ways in which they articulated
the aims of their LHGs. These role definitions tended to flow from a technical model of biological (natural) development which appeared to conflict with the organisational reality of the world in which they found themselves. In addition, the way in which Chairmen perceived the role can be seen to have been strongly influenced by their previous organisational histories, which, in turn, influenced the way they approached the work and implemented it over the study period.

Variations in the descriptors Chairmen used to explain their new roles may have also reflected their general lack of concrete management experience, by virtue of working in relatively small and flexible organisations. Moreover, corporacy as a concept had not previously been a feature of the independent practitioner ethos. The independent contractor relationship to health authorities did not, historically, foster a sense of joint working towards a common agenda. Instead, rather more adversarial relationships may have developed around claims for payment for services rendered, and the relatively recent introduction, via FHSAs, of a monitoring and checking function in relation to those payments. Given their backgrounds and experience, therefore, the views they expressed of the Chairman's role don’t fall neatly into traditional organisational or leadership categories.
6.6.2 Leadership Styles: Chairmen's Descriptions

Section 6.5 illustrated that all twenty-two Chairmen expressed commitment to the role of the LHG as a change agent locally. But they varied in the way they described the leadership aspects of the role of Chairman. In the first tranche of interviews, Chairmen were asked specifically about the nature of their roles. From the initial analysis, some distinctions began to emerge between the ways in which Chairmen described their own approach to the role. A small number of Chairmen described it in terms of a broad focus on community needs, elicited by developing communication links across the community as a whole. Other Chairmen took a narrower focus, emphasizing local medical service provision. Table 6.2 illustrates the differences identified.

Table 6.2 Chairmen’s Focus as Leaders

<table>
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<tr>
<th>Focus</th>
<th>Strategic</th>
<th>Operational</th>
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<tbody>
<tr>
<td><strong>Remit</strong></td>
<td>Health needs of local community</td>
<td>Local medical service provision</td>
</tr>
<tr>
<td><strong>Definition of constituents</strong></td>
<td>Whole community</td>
<td>Local professional provider community</td>
</tr>
</tbody>
</table>

The Table indicates that some Chairmen interpreted the task of improving local services rather more narrowly than others. The Chairmen were unequally distributed across the two typologies, with seventeen that could be seen to be more operationally and pragmatically focused, and five that could be seen to be working more strategically, at the end of the first tranche of interviews.
Section 6.7 examines the extent to which Chairmen defined their constituents broadly or more narrowly. This section looks first at the definitions of leadership expressed by Chairmen.

Naturally, Chairmen's interpretations of their roles might be expected to change over time. Thus it is not suggested here that their interpretations were either fixed, or intrinsic, features of their own personalities. But distinctions did emerge in their own descriptions of the areas of the role that each emphasised above others, and in the styles of behaviours that they tended to use to describe the ways in which they carried out their own roles. For example, some described the role itself as an active force for change, using labels like 'Leader' and 'Catalyst'. Others described the role more as a vehicle for enabling new relationships to be built ('Focal Point' and 'Referee')\(^1\), which would, in turn, enable change to take place. Still others expressed the role as mainly providing leadership among local professional community members, or 'Lead Clinician', in the words of one Chairman (007). Inevitably, too, their perceptions of the role changed considerably - among some Chairmen, at least - over time, as their organisations grew and developed. Some actually used the term "leader" to describe their roles, and this echoes the language of the Guidance Advice (1998b), but, in practice, their descriptions of

\(^1\) 'Referee' is a label accorded by the researcher to this type of role description; the other labels are Chairmen's own.
the role varied over time and correlated more with their individual professional backgrounds and career histories. The impact of structural constraints was also evident throughout the process of coming to terms with the role over time, tending to re-enforce an inward focus, for many, which, in turn, proved to act as a constraining, rather than as a liberating force on the Chairmen’s views of the nature and scope of their roles.

Thus, the five sub sets of leadership styles described above could be discerned within these two broad overarching approaches: strategic or operational. Together, these five styles could be seen as a continuum, from active to more passive in approach, as illustrated in Figure 6.1. At the more active end of the spectrum were those whose own descriptions of the role seemed to match most closely to commonly accepted definitions of a Leader, articulating a vision of the way ahead and persuading others to work together to fulfil it. A second group included those who described their leadership role as Catalyst. In addition to these two groups, were those who saw their roles as Lead Clinicians. The Lead Clinician role implied a narrower focus, and a more operational orientation, than did the Leader or Catalyst descriptions, but was still a dynamic role. At the more passive end of the spectrum were those who seemed to describe themselves as focal points, around whom people could rally. An additional group, termed ‘Referee’ by the researcher, described an
enabling function, in which rules and processes were important constraints on action and aspirations. This latter group were, almost by definition, pragmatic, and operational in their outlook.

**Figure 6.1 Spectrum of Leadership Styles Described by Chairmen**

Before proceeding to examine some of the distinctive features of these five emerging styles, it is important to remind the reader that these labels are used here for convenience, as a means of distinguishing between reported types of behaviours. They are relevant only to this study in this time and place, and in light of the peculiar structural context under study here. Nonetheless using these labels, although the researcher's own, provides a useful device for reporting emerging distinctions among the 22 Chairmen.

**6.6.2.1 Leader:** Interestingly, the Chairman as Leader is the least commonly *expressed* definition among the 22 participants. Those who used this term tended to link it to concepts of 'vision' and 'strategy':

"Well, I try to sort of put forward the vision at an early stage and say, 'look, this is what needs to be done, this is what you were doing in fund-holding in effect...and maybe it's something we need to formalise in a much more structured way" (001.1: 06.10.99)

Another Chairman expressed this aspect of the leader's role with a stronger emphasis:
"Well I think we have to try to keep **driving the process forward.**"

(010.1: 16.08.99).

Most Chairmen, including the most operationally oriented GPs, reported a change in their understanding of their roles, by the time the second interviews took place:

"I am trying to change my role from being a GP representative to representing primary care interests" (001.2: 22.06.00)

"...it's a job, a job you have to do, **you're the tough representative of the doctors, and you're doing this job and there are certain rules** you have to follow and there are certain things you can initiate yourself. It's something that – I don't see myself as – **I don't see myself just as a representative** – **I have, I have to lead if you like** – **that's how I see the job** ... But the climate out there is really one of inertia. GPs are not terribly interested...I think you have to persuade them" (019.1: 10.08.99)

Here, two of the more operational, pragmatic Chairmen were reflecting on the need to broaden their approach. The extent to which they felt tensions between their natural instincts to represent their medical colleagues, and what the "rules of the game" allow seemed, however, to limit their understanding of their boundaries, and thus the amount of room for manoeuvre that they actually had as Chairmen. The second quote emphasises the extent to which this Chairman already felt hemmed in, from the outset. In the event, neither of these Chairmen’s descriptions of themselves moved out of the operational mode throughout the study.

Several Chairmen spoke of the need to use persuasion as a key tool in bringing their grassroots colleagues on board effectively:

“They’re not very good at obeying orders, are doctors; I **mean, we don’t give orders, we don’t work like that**; once you start giving...
doctors orders, you know you've lost, but I mean its still a matter of persuading people to a point of view..." (019.1: 10.08.99).

This pragmatic and operational Chairman expressed his recognition of the need to engage colleagues, implicitly recognising, further, the limited authority he perceived that the LHG actually had. This awareness of the LHG's limitations may help to explain why the definition of the leader's role in terms of its implementation was so frequently expressed in somewhat limited terms:

"The Chair role is about tone, you know, direction, vision, you know, occasional use of strategic...isn't it?" (002.3: 13.08.01)

Here, the very fact of posing the question, at the end of the three year period in post, illustrates how far uncertainty about their roles as Chairmen prevailed, stemming perhaps, from their uncertainties about the boundaries of their own authority in the leadership role. And, although many Chairmen's views of their roles developed and changed significantly throughout the course of the study, the leadership concept was not often expressed in terms of a Leader figure, even by the end of the study:

"...then, I saw it as a facilitator. I saw it as more hands-on as we were, certainly originally, because we had so little staff capacity. I hoped that we would build up a communication network.....We need to build up a team relationship in the relationship with the Board, and the Board and the team with each other, and to be clear who does what...and increasingly I think the Chairman has to take a more strategic view that the role is to try and actually get the Board with that and get it interpreted and implemented at an operational level" (016.3: 12.06.01)

This illustrates the scale of the challenges faced by Chairmen in carrying out such a complex role as that of the LHG.
Chairmanship turned out to be. Whilst recognising the leader's role in creating a vision and persuading people to work towards it, was expressed by a minority of Chairmen, the way the role was carried out in practice often failed to live up to this description, as they faced strong tensions between their intentions to act strategically and the drivers in the system which combined to push them into more operational modes, particularly at the outset, whilst they were responsible for establishing their own infrastructures.

6.6.2.2 Catalyst: Those who saw the role as a catalyst for change tended to see this as a multi-dimensional activity, encompassing local services as well as having an impact at a national level:

"I don't see the issue as the Chair having to force the policies through, I don't even see it as the role of the Chair to formulate the policies in the first place - at the beginning you do set the agenda but then you let other people run, finding the ones that run early on, that's good then because other people get a bit of confidence" (009.1: 20.08.99).

So the role of the Chairman as instigator, 'setting the hares running', is expressed here by a particularly strategically oriented Chairman. Here the emphasis is on putting up the issues for discussion and debate as the prime focus. Three years later this Chairman reiterated his view:

"Whoever chairs it definitely needs to be able to motivate and facilitate, but most importantly, understand..." (009.3: 31.08.01).

This is an important perspective, as it illustrates the role of the Chairman as listener and enabler. These qualities appear to be correlated with the inclusivity of this Chairman's definition of his
constituents, and with the strategic approach he adopted throughout his tenure in the role. More importantly perhaps, it also reflects his commitment to a grassroots-led or "bottom up" approach to change. Such an approach seems to equate to WHO's description of "community development" (World Health Organization 1978). This Chairman never really used the word "leader" to describe his role, but the descriptors he used portray a strategic approach to this work.

Fourteen months into the process of establishing the LHG, this same Chairman defined the LHG's success in terms of sparking debate, nationally as well as locally: "I think we've been successful in agitating the debate..." (009.2: 20.06.00), thus reaffirming his belief in the catalyst aspect of the role. This interpretation of the leadership role is the one most strongly correlated with a strategic approach to the job and the work of the LHG. This community development type approach was not a passive one however, as the mobilisation of the community was systematic and deliberate, and proved to have had a very powerful impact (006; 007; 009; 010; 022):

"I think we are starting to change the agenda" (009.3: 31.08.01)

"We managed to keep our own agenda running" (009.3)

This Chairman went on to refer to the "energy generated" amongst the local community of primary care providers and users, through this approach, reaffirming his initial views that local engagement
and ownership would prove crucial to success. An equally strategically oriented Chairman expressed this role as a multi-layered one:

"I feel it is important that the Chair is a link to build up good relationships with all the other parties you know, eventually the local authority and the Trusts as well as links in the Health Authority and the community. I think it is whenever one has the opportunity to strengthen the relationships and the links, I think that that is a very crucial role for the Chair" (010.1: 16.08.99).

6.6.2.3 “Focal Point”

At the other end of the spectrum, a more passive interpretation of the catalyst role was also evident among a sizeable group of Chairmen. This definition of the role, as focal point, is one of providing a rallying point for Board members. From the data, this comes across as more passive than active, and revolves around “enabling” and relationship-building:

"I've thought through and if you like what the LHG might want to do from the point of view of directions and I am trying to be a catalyst in the middle rather than the instigator" (012.1: 09.08.99)

"I mean basically as far as I'm concerned, I'm just the sort of person up front if you like, with regard [to] holding the fort" (012.2: 24.08.00)

lay at one end of the this part of the spectrum. In the first excerpt this Chairmen uses the term “catalyst” but in a more passive manner than those Chairmen included in that definition above. The second excerpt confirms this difference in emphasis. Another Chairman presents a similar definition, but from a more opportunistic standpoint:

"So, you know, carrying the Board along in that sort of direction...it was really focussing in on a problem that everybody was aware of as far as Xshire was concerned...I'm really, I suppose, the enabler as far as this is concerned because although these meetings have been initiated
by the LHG, and really I want them to feel that this is a meeting between primary care and secondary care, really I am sitting there in the middle, I am Chairing it" (013.1: x13.10.99)

Here, there is a suggestion of leadership in the sense of bringing people together to address an issue of common concern, and providing the forum in which solutions could be generated. In this instance the issue in question is interesting, too, because it exemplified a particular definition of “everybody”, ie the medical community, with an assumption that this implicitly incorporated patients’ views, while the issue itself was one initially highlighted by the Trust as a service deficit. Nonetheless, the LHG Chairman was particularly pleased to be included as central to the process of brokering a solution:

“I think its great to be part of something that is all of a sudden dealing with us” (013.1: 13.10.99)

illustrates just how far out of the decision-making process GPs had been until the creation of LHGs. Reducing the distance from the seat of power was a prime motivator for GP Chairmen to take on the role, but most still limited their conception of the role to the operational level.

On the other hand, the sheer size of the agenda facing the LHG required a willingness to concentrate on taking an overview, right from the start:

“I think basically in pulling it all together as I say there is no way you understand it all” (017.1: 11.08.99)
"The role I have got in this first year is setting up an LHG! And letting Joe Public know what XY and the LHG are all about. And practice managers and whatever you want to talk to, that's where we should be focussing" (017.2: 29.03.00)

But only a few Chairmen managed to put that sort of strategic intention into action in practice.

6.6.2.4 Lead Clinician More operationally oriented Chairmen, on the other hand, tended not to speak of having a vision of their own:

"I felt I had a few things in my mind of how we were going to progress, I felt that the people who were going to take part should have to be very much committed and they should have a viewpoint. I'm not talking in terms of theoretical point of view, seriously, I very sincerely feel that there should be some way of improved health provision..." (003.1: 15.11.99)

At the end of the study one particularly pragmatic, ex-GPFH Chairman, referred to the difficulties of trying to achieve on-the-ground service changes whilst the debate on futures and new structures whirled around him:

"We press on, we press on with the planning and the delivery. And at a general level we're trying to occupy our minds whilst the redevelopment goes on, with another development...in conjunction with the Trust, around musculo-skeletal services. So we've taken on...its quite a ...well, we've elected to have a go at a part of the service that is...that is a difficult part of the service, but on the other hand it means that lots of minds will be occupied in trying to get to grips with the service" (003.3: 01.06.01)

This urge to concrete action, to "get to grips with the service" is a common theme for more operationally focussed Chairmen, especially GP Chairmen, who had previous experience as GP Fundholders. With the benefit of hindsight, one Chairman expressed it as the distinction between a Chairman's role and that
of the Lead Clinician, implying that many of the GP Chairs had played more of a Lead Clinician role:

“If you look at the Chair of the Trust, I've certainly worked completely differently to the role of the Chair...I’ve worked more as a Lead Clinician...it's a different kind of operation. I mean, the lay Chair of a Trust works at purely a political level really. They get fed everything they need and...I...say they're purely a figurehead. It's a different role, a much more operational...” (018.3: 11.06.01).

So, with the opportunity of being able to look backwards in time, this Chairman reflected on his own more operationally focussed interpretation of the role. Again, this interpretation may be linked to the working history of most GP Chairmen, who aimed above all to be seen to be “getting things done”.

Amongst the majority of Chairmen, this practical focus was expressed more strongly as the period under study progressed, and the agenda grew, but “progress” seemed slow:

“trying to keep tabs on it all is real...the stuff that's happening in with the links with the local authority, of the planning group, or the community safety strategy or, you know, keeping tabs on it all. I mean, I'm still ok with the primary care bit, that's where I came in. But some of the big picture stuff...” (002.2: 02.06.00).

“I don't understand all this management stuff, but I think about it like tennis or golf, I'm not interested in tennis or golf. I think I'm there to kick ass and get things done...” (019.2: 22.05.01).

This latter Chairman’s frustration with the rate of progress, or lack of it, and the increasing pressure he felt himself to be under, to be seen to be delivering something, acted to reinforce a narrower definition of the role, and tended to work to strengthen a drive to control what he could, rather than to work to unleash creative forces in the wider community. Health authorities’
actions may have reinforced these tendencies by ‘delegating’ to LHGs work that more properly came within their own responsibilities, rather than supporting the LHGs’ efforts to develop a new and different focus (010.2).

6.6.2.5 Referee: This image of the role seems to be more about bringing together a clear consensus and presenting a united voice amongst the LHG Board members themselves. In this view, concepts like “fairness” predominated:

“I made clear right at the very beginning, the very first meeting, this is to all the members of the Local Health Group, this was the doctors, the nurses and as far as I was concerned as a chairman I wouldn’t tolerate any inner groups within local health groups, in other words I wasn’t there as a doctors’ representative, that I was there to represent the whole of the Local Health group and I certainly wouldn’t tolerate any little huddles or sub groups agreeing policy beforehand. So that has been made extremely clear right at the very beginning that any decisions we make are open...” (022.1: 10.08.99)

This same Chairman expanded on this theme three years later:

“I would like to think, whether it’s true or not, that as a Chairman, I wouldn’t tolerate people who sort of step out of line. I think that’s the role...I mean we had an understanding from the beginning that people who...if you felt strongly about something, you know, you would voice it within the Local Health Group but what you didn’t do is go outside and...if that’s how you feel about it you should resign.” (022.3: 12.06.01)

So, here, presenting a united front was important to this Chairman. And the commitment to a form of corporacy emerging also reflects a specific element of the Job Description. As noted earlier, this idea of corporate responsibility was a new issue for GPs, more used to working independently, and being free to express their views as professionals. This new cultural imperative created problems for several Chairmen, as the following excerpt
indicates, from another Chairman, impatient with one of his Board members, who doesn’t ‘toe the line’ in his view:

“I think they don’t appreciate the discipline of the corporate governance, they don’t understand that they have been elected and selected to a publicly accountable body, and that they have to be very careful that they don’t align themselves to groups which may cause conflict of interest...” (019.1: 10.08.99).

These Chairmen also tended to refer to the need to “tell” people what to do, and to focus much of their energies on being seen to be competent managers of the process, emphasising the importance, for example, of running meetings efficiently:

“I always like to have people sitting in named positions. I don’t like people sitting anywhere. You know, the same people sitting together, you know. That doesn’t enhance anything. The office manager always puts the name contact, before they are in it, and then they sit where their name is...we split the groups up if you like. So I think that is important....so I go around the room afterwards to make sure they are quite clear what happened and to ask if they’ve any contributions or any other comment to make, you know. So I like to do that. I think that is something that is the responsibility of the chair, if you like. You’ve got obviously to have a bit of discipline, so that the conversation doesn’t go off at a tangent...”(012.1: 09.08.99)

“I think that there is a sort of figurehead part of it in that somebody [has to] try to pull things together and formally at meetings. So taking control of the meeting. So that’s more the official and figurehead side of the job really. But as far as the day to day work is concerned there is a lot more to it than that....I sort of feel that I want to do a bit more than that really, because we have got a number of pressing issues and problems and we are told to take things slowly and not bite off more than we can chew and that’s fair enough. But unfortunately we do have quite a lot of pressing problems locally and I think just being a bit more dynamic about it, hopefully other people will follow as well.”(014.1: 16.08.99)

These two excerpts illustrate one end of a continuum of approaches to the Chairman’s responsibilities for the business aspects of the LHG. This aspect of the role was closely aligned to health authorities’ concepts about how their sub committees should function.
Although these five “categories” can be seen to emerge from Chairmen’s descriptions, it is important to note that they are not exhaustive or mutually exclusive. And each reflects an aspect of the role outlined in the Chair’s Job Description, as shown in Table 6.1.

In general, the over-arching distinction drawn between Chairmen’s emerging focus, between strategic and operational, can also be equated to two different typologies referred to in the literature on leadership: transactional and transformational (Bass 1985). In this study, the first of these two types tended to be correlated with those who tried to effect change at an operational and local level, working *within the prevailing system*. The more transformational Chairmen, on the other hand, tended to be working *around* the system. This latter type tended to work more strategically, and inclusively of the whole community, whilst the more transactional chairmen focused more on specific medical issues and often spoke of the local GPs as their main constituents. More transformational Chairmen, on the other hand, focussed more on the wider community and its needs.

### 6.7 Limits on Authority: Structures and Processes

A focus on the practical aspects of the role was, of course, embedded in the infrastructure, and further reinforced by the way in which LHGs were first set up, leaving Chairmen responsible for all the practical aspects of finding office premises, and their
continuing reliance on health authorities for staffing and support services. Trying to balance these operational tasks and maintain a strategic focus proved an impossible bridge to cross for many of the Chairmen.

More crucially, perhaps, was the emphasis on structures and the consequent need to be seen to be playing by the rules, prevalent among this group of Chairmen:

"The powers that be have certain rules...in procedural terms, things tend to be a lot slower because you have to present things to lots of committees, and there are ways, formalised ways of doing things..." (019.1: 10.08.99)

Perhaps the single most important distinction amongst Chairmen was that some did find ways round these rules, whilst others found themselves increasingly dis-empowered, almost by virtue of trying so hard to work within them:

"...there are strings attached to whatever they tell you to do so in the end you have to do what the Assembly or Health Authority tells you what the rules and regulations are...I think they try to keep reins on us really, that's what it is" (011.2: 24.03.00).

This latter Chairman was pretty sanguine at the outset, however, anticipating that this situation would change as soon as LHGs were able to gain experience and demonstrate capacity:

"Perhaps in a year's time they should really be loosening the grip on us and say 'look, this is yours" (011.1: 05.08.99)

Seven months later, this was not yet the case, and the Chairman's frustration was clear, as was his feeling of being "hemmed in" and unable to progress because of uncertainty about regulations,
and the need to work within them. These restrictions were all the more chafing as he tried to deal with changes in key personnel. His own General Manager had been re-deployed, by the health authority, to another LHG, leaving him without a vital link in the information chain, and he still had no office space to call his own, a full year after the LHG’s inception, leaving him feeling marginalised. By the end of the third year, his anxieties about the rules and room for manoeuvre were increased:

"You can’t change the system until, you know, the structure comes in, you know" (011.3: 01.06.01)

Three years on, this Chairman expressed an overwhelming feeling of frustration and inability to operate effectively due to ‘system’ constraints, and a feeling of being ‘out of the loop’ in terms of ability to influence the shape of the new organisations which would supersede LHGs. His constant concern with those very structures implied a conviction that to work within them was the only way to be effective, but, in the end, his account describes the many ways they constrained him.

These “Referee” Chairmen initially defined their roles largely as interpreters and keepers of the rules, and worked to identify ways to make the systems work more effectively within existing boundaries, and to keep their Boards ‘in check’ and working alongside them. But each found that this strategy constrained rather than liberated them. These Referee Chairmen, on the whole, were fairly narrowly focussed, both in terms of their
definitions of their roles as leaders and in relation to the groups they referred to as their main constituents. Many, but not all, were ex fund-holding GPs. All, as practising independent contractors, were small businessmen. As such, they had experienced the effectiveness of using delegated budgets to effect service changes, on a small scale, for their practice populations. They had become accustomed to being able to effect such changes fairly quickly, since there were no intermediate hurdles between making a decision and implementing it, within the confines of their own small businesses. This experience had inspired them—and led them to believe that larger system-change could be effected by ‘more of the same’ sorts of strategies. This proved not to be the case however. Moreover, many of the ex Fund-holding GP Chairmen had another limitation: they tended to define their constituents in terms of the local GP community. This parochialism created problems for them in terms of narrowness of vision as well.

6.8 Definition of Constituents

Just as definitions of the role of Chairman varied across the 22 LHG Chairmen, their definitions of their constituencies varied considerably. Some Chairmen expressed their new remits as embracing the wider community, whilst others limited their definitions to either the local professional community, or even restricted this further, to local GPs, as indicated in Table 6.1.
Looking at how Chairmen defined their constituents in the first place proved to be correlated with the extent to which they might take operational or strategic approaches to their roles. Some, very operationally focussed Chairmen, found it difficult to break away from the LMC mould, wherein they were expected to put the interests of the profession as a whole to the forefront of their thinking. This, in turn, may have reflected their previous working experience. In addition, other ex fund-holding GPs expected to use the LHG as a platform for making a difference to service configuration across the patch, in the same way that holding their own funds had enabled them to provide an expanded range of services to their own patients. These Chairmen also had a more operational approach to their roles as Chairmen, throughout the study.

A minority of Chairmen, on the other hand, spoke of their responsibilities to the people of the locality as their prime concern. Only a few LHGs stand out as exemplars in this respect (005; 006; 007; 009; 010). These same Chairmen also took longer range and more strategic approaches to their own roles and to that of the LHG. On the whole, those Chairmen who took both an inclusive approach to their definitions of their wider constituency, and also took a strategic approach to the LHG's role, were, by the end of the study, both more content in their roles, and perceived their
organisations as having been more effective, than those who
adopted narrower definitions of their constituents. For example,
one Chairman explained his interest in the LHG role in these
terms:

"...we began to think more instead of what patients' services there
were, we began to think in terms of what patients needed...it was a
totally different concept...and I found it gave me far more professional
pride and restored a lot of my morale" (010.1: 16.08.99)

By the end of the three years under study this Chairman looked
back and reported:

"it created far more difficulties achieving that than I originally thought,
but we are achieving it! We've actually put into being a structure
right across X area with four locality steering groups which reflect
all the stakeholders, representatives of primary care, and varying
members from primary care, there's not a predominance of one
member...we also have representatives of the Trust, the CHC, the
voluntary sector, and the local authority" (010.3: 24.07.01)

Another exemplar Chairman in this respect provided a different
explanation of similar change in personal viewpoint as underlying
the approach adopted by the LHG:

"Anyone who works here can realise that there is an odd mix between social
care and health care...and the way we supply services has been to fit them
within localities and the actual localities within the area change very
dramatically so we get pockets of deprivation within quite affluent areas,
whereas in the Y and in the Z you have large areas of deprivation that just go on
endlessly, so my ideas had changed...so that became the mind fix from
moving from the patient contact as an individual to the patient as part of
the bigger picture, so that was interesting and I was very lucky because I had
lots and lots of colleagues, who are very good doctors, and very good nurses,
and very good health visitors who have also stimulated the debate - they
have brought the challenges....I have found that everyone is committed to
something and making a difference and that is what we've committed ourselves
too - making a difference in XYZ area" (009.1: 20.08.99)

Those strategic and inclusive Chairmen also tended to have had
experience of leading, or working in, commissioning groups or
total purchasing pilots before taking on the role of Chairman of
the LHG. This experience may have enabled them to see beyond
the interests of individual practices and GPs as a professional
group. On the other hand, ex fund-holding Chairmen tended to be more operationally oriented - and all the more frustrated with their inability to effect change as time went on. On the whole, ex fund-holding Chairmen expected to be able to get their hands on specific levers, which they mainly defined as budgets or commissioning powers, in order to effect change. Their ensuing frustration with their inability to access these levers may have blinded them to the existence of other potential tools. They tended also to be more focussed on process and on “rules of the game”. More strategic chairmen, on the other hand, tended to find ways around perceived obstacles and to be able to take a wider view of the community and its needs, and thus to rise above the general melee of health authority-oriented in-fighting. This approach also enabled them to align their LHG’s agendas more closely to those of the Assembly - and, again, to be rewarded for doing so:

“I think it's about helping the process of encouraging ideas, its about trying to enthuse communities with the idea that they really can make a change if they're prepared to make an effort...and, as we've been so encouraged in the process, although not in its origins, we've been encouraged...and when the gentleman from the New Opportunities Fund came...he did say that [one of the bids submitted under the auspices of the LHG but emanating from a deprived community] it was the best bid they'd received in the United Kingdom...” (010.3: 24.07.01)

When asked about ways in which the LHG Board prioritised its efforts this Chairman replied:

“No, it wasn't that difficult, because when you look at our initial agenda, the idea for why LHGs were set up, you look upon the various ideals that were enshrined in Better Health, Better Wales, etc., they're all fairly self-evident, really” (010.3: 24.07.01)
A different but equally strategically oriented and inclusive Chairman took a different approach:

"At the local basis, I think that we've managed to identify areas where there is...there are possibilities to move and I think we have to identify those avenues where movement can happen" (009.2: 20.06.00)

He went on to point to the effectiveness of having concentrated on primary and community care opportunities initially:

"I think there's a new feeling about working together, for sure. Some of the professional barriers are beginning to weaken. There is a greater acceptance of the need for change. I think there's a greater awareness of the role that others can take part. I think people now understand that the interface areas are more...there's more to be gained than to be lost" (009.2)

And a year later this Chairman reflects on the progress made in getting his agenda aligned with national priorities:

"Yes we managed to keep our own agenda running. It's nice to see that some of our agenda is reflected in the national agenda" (009.3: 31.08.01)

These comments seem to indicate that taking a more strategic definition of the LHG role relied on taking more inclusive definitions of both constituents and needs, but that it then thus enabled a closer alignment with Assembly policy and strategy to be created.

6.9 Summary

This analysis of Chairmen's approaches to their new roles highlighted the clear distinction which emerged from the data, over time, between those Chairmen who tried to work within the system ('transactional') and those who worked around the system and existing structures to effect broad change ('transformational') (Grint 2001). Although all twenty two of the Chairmen might be
said to have shared the same positivist paradigm, by virtue of their training, those who were confident enough in their interpretation of the LHG’s revolutionary remit to act to exploit the power vacuums created by frequent changes of personnel at the most senior levels of the system, were those who reported the highest levels of satisfaction with their efforts and achievements.

These Chairmen recognised the need to influence a wider constituency in order, in turn, to influence the Assembly effectively. They worked to develop and empower this broader community as a means to creating their own power base:

“It’s got to be bottom-led; the LHG’s strength is that it can access the opinions and views at a low level” (009.1: 20.08.99)

These Chairmen formed unique and broad partnerships across their local communities, and through these groupings, aligned themselves with the Secretary of State’s somewhat radical agenda. In doing so, they managed to release sufficient creative energy to transcend the more bureaucratic and rule-bound approach of health authorities’ restrictions and constraints. They developed a form of strategic leadership which gathered strength and momentum from its broad grassroots base, rather than from their titles or positions in the system. Their leadership styles built upon their own strategic visions for primary care development. The breadth and inclusivity of their definitions of their constituents helped them to match their development approaches to their own ideological commitment. This combination of personal commitment to primary care development, combined with their
strategic and inclusive approaches, appears to equate to Butler's (2003) Ideological Vision as a key factor in developing organizations receptive to change. These Chairmen built local organisations which managed to thrive and grow, partly by the relationships they forged, and by the capabilities they identified and developed within their organisations, as the following four chapters will illustrate.

On the other hand, those who adopted more restricted definitions of their roles became embroiled in the thicket of local power structures and prevailing 'ways of doing things'. These more transactional and operational Chairmen remained handicapped by the limited views they took of their roles, strengths and potential. These limited views neatly complemented the health authorities' definitions of LHG roles and responsibilities as being restricted both in range and scope.

The following three chapters explore the ways in which Chairmen went about creating new relationships with key stakeholders, to "play" the game of institutional politics in order to get their new organizations recognised and accepted forces within the organizational landscape. Chapter nine examines the strategies and tools they used to develop their organisations to meet the challenges facing them, and the constraints they identified in trying to do so.
Chapter 7: Institutional Politics: Building Vertical

Relationships with the Welsh Assembly Government and Health Authorities

7.1 Introduction

As has been argued in chapters 4 and 5, Local Health Groups were established with very little going for them, in structural terms. They were given wide ranging responsibilities, but no real authority or power to deliver their remits. Their parent bodies controlled both money and information flows, and directly employed both their chief officers and secretariats. Moreover, the prevailing organisational structures and communication channels precluded any formal or direct communication with the newly devolved assembly government (NAW). These structural arrangements tended to inhibit the partnership-building behaviours they were ostensibly designed to promote.

On the other hand, LHG boundaries were drawn coterminously with those of the local authorities. The newly appointed Secretary of State for Health & Social Care continuously ‘beat the drum’ of partnership working (NAW 2000; NAW 2001; LHG Conference, March 2000). Thus LHGs were charged with a specific duty to work in partnership with organisations whose services overlapped with theirs, to improve patient care locally. This duty of partnership was later enshrined in legislation, making it a

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statutory responsibility. In light of this context, this chapter, together with the following two chapters, analyses the ways in which the new LHG Chairmen undertook this statutory responsibility, and the impact they thought their efforts were having on changing the configuration of services provided locally.

Whereas chapters 4 and 5 illustrated the extent to which existing structures tended to locate decision-making powers centrally, the aim of this section of the analysis is to explain local decision-making. This section introduces the concept of Institutional Politics as a key leadership behaviour. Section 7.2 introduces relationship domains as building blocks for creating and sustaining effective working relationships. Section 7.3 examines Chairmen's assessments of the importance of relationship-building. Section 7.4 examines relationships with the National Assembly for Wales, while Section 7.5 explores the complexities of relationships between LHGs and their health authorities. Section 7.6 summarises the key points raised in this chapter.

The capacity to build effective relationships was highlighted by Kanter (1958 in Pettigrew et al 1992) as a critical factor in effecting organisational change. Pettigrew et al (1992) concurred, based on their own empirical study of organisational change in the NHS. Pettigrew et al developed this concept further in light of their research, terming the capacity to form and sustain cross-boundary working relationships "Institutional Politics". This label
added an important dimension to Kanter’s concept, that is particularly noteworthy in relation to this study. Chairmen’s abilities to identify appropriate organisational partners in the first place, coupled with the capability to hone in on specific gains to be achieved for both partners, and then to lead their teams on to work towards them, appears to have been critical in effecting cultural change within their own organisations. This ‘political’ dimension appears to be integral, therefore, to success, in the LHG context studied here.

7.2 Effective Relationships: The Domains

In order to understand the nature of the factors influencing the formation of effective relationships between LHGs and their stakeholder organizations, two conceptual frameworks were used to report on the emerging analysis. The first framework was the organizational map designed by the researcher to use in the second tranche of interviews, and referred to in Chapters 4 and 5, as a means of identifying those organizations that Chairmen deemed to be key stakeholders of LHGs. This map was later adapted by the researcher to enable Chairmen to discuss the nature of their organizational relationships, with these stakeholder agencies, as of Spring 2001. In the third tranche of interviews, therefore, Chairmen were asked to describe the quality of their organisational relationships with the different agencies deemed to be potential partners. The ranking key on the bottom of
the chart was used to prompt discussion of Chairmen’s views of the relative merits of their relationships. The key ranged from “1” indicating a relatively poor relationship with little dialogue established, to “5” indicating the existence of two-way communication, with regular meetings and joint work being undertaken. This was not an attempt to measure relationship quality per se. Chairmen varied in the extent to which they referred to the map: some were not comfortable with using it; others did not have it to hand when the interview took place. The map was meant to stimulate discussion, and produce relative, rather than absolute, indications in any case.

The second reporting device used, in this and the following two chapters, was one originally designed to assess the quality and depth of inter-personal relationships. This tool, developed originally by Schulter and Lee (1993), for the Tavistock Foundation, was subsequently applied, by Meads, to Primary Care Groups, as they then were, in England (Meads and Meads 2001). The use of the underlying concepts, as opposed to the measurements, helped the researcher better to understand the context under study, and thus to organize the analysis presented here.

Table 7.1 summarises these indicators. The left hand side of the Table lists each dimension of relationship quality, while the right
hand side gives descriptive illustrative behaviours of each dimension. Although Meads and Meads (p.58) noted that these

Table 7.1  Relationship Quality Indicators

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Descriptor</th>
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<tbody>
<tr>
<td>Directness:</td>
<td><strong>Quality of the communication process</strong></td>
</tr>
<tr>
<td></td>
<td>Channels maximise information exchange</td>
</tr>
<tr>
<td></td>
<td>Direct, minimal delays</td>
</tr>
<tr>
<td></td>
<td>Listening, openness, honesty</td>
</tr>
<tr>
<td>Continuity:</td>
<td><strong>Shared time over time</strong></td>
</tr>
<tr>
<td></td>
<td>Investment of time/sufficiency of contact</td>
</tr>
<tr>
<td></td>
<td>Consistency of contact &amp; commitment</td>
</tr>
<tr>
<td></td>
<td>Maintaining continuity through change periods</td>
</tr>
<tr>
<td>Multiplexity:</td>
<td><strong>Breadth of Knowledge</strong></td>
</tr>
<tr>
<td></td>
<td>Awareness of work constraints &amp; opportunities</td>
</tr>
<tr>
<td></td>
<td>Understanding role/skills of other</td>
</tr>
<tr>
<td></td>
<td>Informal contact, goals, values</td>
</tr>
<tr>
<td>Parity:</td>
<td><strong>Use and Abuse of Power</strong></td>
</tr>
<tr>
<td></td>
<td>Involvement in decision-making</td>
</tr>
<tr>
<td></td>
<td>Fair distribution of risk &amp; reward</td>
</tr>
<tr>
<td></td>
<td>Common behavioural standards eg respect and integrity</td>
</tr>
<tr>
<td>Commonality:</td>
<td><strong>Valuing similarity &amp; differences</strong></td>
</tr>
<tr>
<td></td>
<td>Common views of objectives, priorities &amp; means of achieving them</td>
</tr>
<tr>
<td></td>
<td>Ways of working match shared understanding</td>
</tr>
<tr>
<td></td>
<td>Valuing different perspectives</td>
</tr>
</tbody>
</table>


five dimensions were each “necessary but not sufficient”, the analysis presented here suggests that not all of the dimensions
were equal in importance, in this context. This chapter, therefore first examines Chairmen’s own descriptions of the importance of relationship-building in their own terms, before moving on to explore the underlying factors that contributed to these assessments.

Figure 7.1 depicts the organisational landscape prevailing in Wales during the period under study. It is the same ‘map’ shown in Chapter 4, but with the addition of the indicators used by Chairmen to describe the nature and quality of their relationships with the relevant external agencies. The map is reproduced here, with the additional ranking key, for ease of reference.

7.3 Chairmen’s assessments of the importance of relationships

The extent to which the Chairmen collectively identified the potential value of establishing new relationships with other existing organisations appeared to be closely related to their career histories and the approaches they took to their roles, which were outlined in the previous chapter. Thus, those who took a wide ranging, inclusive and strategic approach to carrying out the LHG’s role were more likely to place a higher value on, and put more effort into, creating relationships outside their existing networks of local professional peer groups. They were also more likely to see the potential for influencing health policy decisions by building relationships with their AMs, members of the NAW
Health & Social Services Committee, and with local councillors, than were their counterparts who took a more limited definition of their roles. Thus, in the context of relationship-building, the distinction between approaches taken by more strategically aware Chairmen and those of their more operationally focussed colleagues was notable. Chairmen who adopted a strategic approach, and tried to build relationships across a broad range of stakeholders, reported more satisfaction with their relationships with partner organizations, over time, than did those who adopted a more narrowly focussed approach.

Although Chairmen displayed differing levels of interest and commitment to creating and maintaining relationships with potential partner agencies, most recognised the importance of their own roles in this process:

“There’s a role, I think, of the Chair, I think, is building up relationships all over the place...” (010.3: 24.07.01)

But how different Chairmen prioritised their relationship-building in practice proved to be illuminating. Chairmen’s own assessments of the quality of the relationships they had forged were important indicators of the value they placed on this part of the process of building their LHGs as organizations.
Figure 7.1: Organizational Relationships in Wales 1999-2001

National Assembly for Wales

Health Authority

NHS Trusts

Politicians:
(AMs, MPs)

Local Authority

Local Health Alliances

Voluntary Sector

Press/
Media

General
Public;
CHCs

Professional Communities

(LMCs &
(LDCs,
LPCs,
LOPs)

Local community councils
Local politicians

LHG Relationships

Key:
Relationships already in existence: eg Trust<->HA: — solid lines
Relationships to be forged by LHG: .. dotted lines

Quality rating:
1 = poor: little dialogue established
2 = fair: some dialogue in process, mainly 1 way and meetings infrequent/ad hoc
3 = good: 2 way dialogue, initiated mainly by LHG
4 = very good: 2 way dialogue, meetings regular and plans constructed for joint working
5 = excellent: 2 way communication regular meetings and joint working underway

SW 24/05/01
In the third tranche of interviews (Summer 2001), Chairmen reflected on the strength of the relationships they had created, using the scale on Figure 7.1. These assessments could also be seen to reflect Chairmen’s perceptions of the structural constraints prevailing at this point in the process of LHG development. For more operationally-oriented Chairmen, these assessments tended not to have changed by the end of the study (October 2001); for more strategic Chairmen, their assessments were, in general, reported as being more positive by the end of the study period.

In general terms, relationships with health authorities tended to be described as relatively poor (2-3 on the scale); local authority relationships tended to be described as being relatively good (3-5 on the scale). Relationships with the Assembly were discussed in negative terms throughout the study period, but were described as relatively poor (3) in this exercise. More strategically oriented Chairmen tended to report reasonable quality of relationships (if any at all) with politicians, whilst more operationally-oriented Chairmen tended not to have forged such relationships. A similarly divided picture prevailed for ratings of relationships with the public. The most strategically oriented Chairmen reported the strongest relationships with their local GPs and professional communities too. These reported ratings of relationships were not static but changed throughout the period under study. It is the
underlying factors contributing to these ratings, and their changing shapes over time, which repay further analysis.

7.4 History as an Additional Domain of Relationship Quality

As explained in Section 7.1, Schulter’s and Lee’s (1993) pre-conditions for effective relationships were applied by Meads to primary care organisations in England. These five dimensions are shown in Table 7.1: Directness, Continuity, Multiplexity, Parity and Commonality.

The Table indicates that, for example, for an inter-organizational relationship to thrive, direct communication links should be in place, enabling partners to be accessible to each other, and to communicate directly, rather than through intermediaries, using similar styles and language. Similarly, continuity in the relationship is fostered by stability in the personnel in place, as well as by the amount and regularity of contact between them. Multiplexity refers to the number of linkages at different levels of the partner organizations. Parity refers to the extent to which risks are shared, or perceived as shared, equally across the partner organizations. Commonality, on the other hand, refers to the extent to which organizational aims are shared or conflicting. These dimensions proved to be useful devices against which to report Chairmen’s descriptors of the conditions in which they found themselves, charged with a statutory duty to form
partnerships to foster more efficient and better integrated services at local level, and the problems they encountered in trying to do so.

This analysis suggests that, in terms of indicating a framework around which to build relationships, within the primary care setting, at least in so far as Wales is concerned, a sixth element should be added to Schulter’s and Lee’s typology: History. It appears, from this data, that preceding organisational history significantly coloured perceptions of partners, adding an important barrier which needed to be overcome before effective working relationships could begin to develop positively. This element may only be relevant in the context of this group of largely-GP Chairmen. But since GPs as Chairmen were an integral feature of the structures, the impact of previously shared history needs to be taken into account in order to understand the quality of relationships which were reported.

As Chapter 6 argued, GPs as Chairmen brought a particular set of characteristics and backgrounds to their new roles. Twenty-one of the twenty-two Chairmen had been working as independent contractors within their local catchment areas. Both the nineteen GPs, and the two pharmacists, had previous working relationships with many of the agencies with whom they had to create new links in their roles as LHG Chairmen. In particular, they had a shared
organisational history with - but very different culture from - their health authorities. This shared history included several organisational restructurings, which changed the responsibilities of health authorities vis-à-vis GPs, but never fundamentally altered the relationship from that of independent contractor-payer. The last preceding reorganisation, which amalgamated FHSAs and Health Authorities, could be viewed as increasing the distance between the two parties, since it removed the agency which had been solely responsible for the reimbursement of independent contractor professions, amalgamating them into the general pool of health service providers (Welsh Office 1997). This contractor and payer relationship included an element of monitoring performance, after 1990, thus adding another layer of potentially adversarial interactions between the two parties. In addition, health authorities became the accountable agency for commissioning services, and for developing primary care. The experience of trying to facilitate take-up of GPFH among local GPs, and monitoring independent contractor performance by people more used to working within clear hierarchies in bureaucratic organisations did not leave health authority personnel unscathed either. Where health authorities had tried to facilitate commissioning teams among non fund-holding GPs, relationships may well have taken a more constructive turn, as working partnerships gave rise to greater understanding of roles, functions and constraints. But, as Chapter 4 argued, the ways in which
health authorities implemented the new structures, keeping tight reins on their LHG sub committees, fanned the flames of dissension in most areas across Wales. An attitude of suspicion - and sometimes outright hostility - characterised the perceptions of most GP Chairmen, right from the outset:

"It looks that the health authority is hanging on and clinging to their powers and their budget holding, but then again they have been instructed by the Assembly, or Welsh Office what to do with that, so we feel we should have more freedom than we do now" (011.1: 05.08.99)

"I think that over these months [our priorities] are ones to establish the actual structure of the organisation and its going to take us through to about October to get there...The task after that is the credibility issue, of sorting out regular meetings with things like the Trust, and we become the actual focus of decisions. Because I don't think you can ever gain credibility if you are having to scuttle back and discuss it with our people" (018.1: 05.08.99)

"My concern in all of this one's that...I mean the health authority was quite a dysfunctional beast before the chief executive went, they really didn't work together as a team terribly well and there was a very strong, sort of, 'if we did all this, what's left for the health authority?' issue there, which is still there, I think" (005.1: 26.10.99)

Thus this shared history contained enough negative features to tend to predispose GP Chairmen to be suspicious of health authority motives and actions, as these comments, made in their initial interviews, indicated. This suspicion may have been strongest among ex-GPFH Chairmen, and least among those who had been part of commissioning groups, however informally structured. The impact of a shared history may be an element unique to primary care in Wales for two reasons. Firstly, the drive to focus on one organisational model to develop primary care was pushed more strongly in Wales than across the rest of the UK, largely because of the then Secretary of State's strong political
commitment to fund-holding (Redwood, 1993-5). Secondly, the Welsh model of primary care organisation was the only one in the UK to be predicated upon such a heavy GP presence, specifying a GP Chair and six GP Board members (Welsh Office 1998b), thus emphasising this element more strongly than in models developed in other parts of the UK.

Against such a background, it may be that all five of Schulter’s and Lee’s relationship quality dimensions (Table 7.1) would need to be met in order to build and sustain more effective working relationships between LHGs and their health authorities. But this analysis suggests that some elements may be more important than others. In addition to the role played by history, analysis of Chairmen’s views as they reported them over the three years of this study suggests that commonality may have been more important than any of the other five elements. However this analysis also suggests that commonality needs to be supported by changes in parity, to the point, perhaps, of positively discriminating in favour of the weaker partner. This hypothesis will be discussed, taking each of the different organisational relationships formed in turn, to assess the relative impact which each element appeared to play over time. This chapter examines the vertical, or hierarchical, relationships between LHGs, and the NAW, and then the health authorities; the next chapter explores the horizontal relationships developed to implement the duty of
partnership under which the statutory agencies laboured. Chapter 9 examines relationship building across the wider community, in support of the policy drive towards increased local responsiveness.

7.5 National Assembly for Wales (Welsh Assembly Government)

As highlighted in Chapter 4, no direct links existed between the Assembly government and LHGs, thus violating the first of Schulter’s and Lee’s dimensions: directness. This structural constraint became increasingly problematic for Chairmen, as the study progressed. The ways that different Chairmen perceived their relationships with the WAG was a good indicator of the way that they saw their own roles. For example, it was one of the most strategically oriented Chairmen who initiated, in July 1999, the quarterly series of meetings with the Minister, which became so pivotal in influencing their future as organisations. These meetings proved to be effective in enabling LHG Chairmen to get the reassurance they needed from the Minister that they were, in fact, meant to be “contributing to strategic thinking” about NHS service delivery, and “not just another department of the health authority”.¹ Such endorsements were essential for LHG development, in the face of the obstacles they faced. But not all LHG Chairmen responded to them in the same way. The more

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¹Jane Hutt, Minister for Health & Social Care, LHG Conference, 16 March 2000, The Metropole Hotel, Llandrindod Wells.
strategically oriented Chairmen identified the opportunity to align their LHG’s agendas to the WAG’s strategic agenda and thus lifted their sights above the interests of the local medical political arena by building much broader coalitions of interests, across their local communities. Less strategically oriented Chairmen, on the other hand, expressed the lack of central direction emanating from the WAG as a form of abandonment and tended to flounder in the wake of it. Notwithstanding this distinction, all Chairmen universally bemoaned the lack of clear direction from the centre, noting it as having had a significant negative impact throughout the study period:

"I think that from the Assembly’s point of view, I think it’s they that maybe should have done things differently...because when we started doing what we were doing, we didn’t know what on earth to do...I think maybe it would have been useful for us to have a better understanding of what was intended. It’s all very well seeing a few flashy documents and so on, but actually to spell out what we were intended to do and so, in turn, we [would have] had the opportunity to say what practical problems were likely to occur by virtue of trying to involve activists in primary care to develop into Boards" (010.3: 24.07.01)

This Chairman was decrying the lack of clear direction, against the background of three years’ experience without it, but, in doing so, he was also highlighting the unidirectional flow of communication that prevailed throughout the period under study, and contrasting that with what he felt should have been the case, of continuous dialogue between policy maker and policy implementer. Given the degree of organizational flux illustrated in Chapters 4 and 5, this skewed pattern of communication may
have been due to the relative immaturity of the health system in Wales between 1999 and 2001.

Such Assembly capacity problems were worsened by another, sudden change at the top of the system, when the Director of NHS Wales post became vacant in 2000. The vacuum thus opened up at the apex created additional concerns for this Chairman:

"It's difficult to know whether that still is the strategic direction of NHS Wales, because we don't know how that fits in, really. Although it fits in with all the Better Wales documentation and things, but it's not really knowing what sort of...what sort of structure does NHS Wales see in the future? Nobody knows that yet" (005.2: 12.06.00).

Such a vacancy of course further compromised both continuity and commonality in this crucial relationship during this period, making the Ministerial communication link more important to Chairmen.

Nonetheless the LHG Chairmen's creation of that direct communication channel to the Minister was not welcomed by health authorities. Despite the existence of a regular forum for health authority and Trust chief executives to meet with the NHS Wales Director (NACE: National Assembly and Chief Executives Group), some health authority chief executives expressed concern about the newly created direct NAW/LHG communication channel.¹ Throughout 2000, efforts were made by health authority chief executives to encourage the Welsh Association of LHG Chairs

¹ Speech made by Graham Coomber representing HA Chief Executives at the LHG Conference on 16 March 2000, at the Metropole Hotel, Llandrindod Wells: "LHGs have better access to Jane Hutt than HA Chief Executives do".
to become an all Wales LHG group; some Chairmen viewed this proposal as an attempt to dilute their direct link with the Minister, and the support it gave them. But this directness of communications between LHG Chairs and the Minister proved to be pivotal, despite its informal and oft-threatened status. This appears to have been because it enabled Chairmen to recognize the commonality of their own agendas and that of the Assembly, and thus to persevere in their efforts to build their own local identities and agendas, at the expense of that expressed by their health authorities. Thus, in relation to the NAW, directness of communication was the most valuable relationship dimension, because it enabled commonality of aims to be developed. And, of course, there was no previous history to colour perceptions of either party. This was not the case in relation to health authorities however, as the next section demonstrates.

7.6 Health Authorities

7.6.1 Directness could be said to have been a feature of the relationship between health authorities and their LHGs, since LHGs were sub-committees of the health authorities. In theory, therefore, direct communication channels could be considered to have been in place from the beginning. As noted in chapter 4, budgets continued to be held within the parent authorities; LHG senior-most personnel appointments were made through the health authorities; performance agreements were made between
the LHGs and the health authorities; and General Managers – the
LHG Accountable Officers – carried shared portfolios of health
authority responsibilities alongside their LHG responsibilities.
LHG Chairmen attended health authority board meetings, and
health authorities held several places on LHG Boards. Initially,
health authorities sanctioned every aspect of LHG activity,
including the allocation of premises and distribution of office
space (eg 010; 006; 022).

Thus the potential for direct communication, via this wide range of
direct channels, was established from the outset as part of this
close accountability chain. In practice, however, direct
communication was challenged by a number of competing
elements. In particular, a lack of commonality characterised LHG-
health authority relationships from the start. Health authorities
were under growing pressure from the centre to reduce their
deficits:

"Well, as many of us thought, you know, primary care doctors thought,
leading up to the formation of the LHG, our big concern, especially in X
area, was this is it. And then we...hang on a minute we don't want to
become part of this scenario where we've got a stone around our
neck and, you know, be the cause of us drowning" (013.1: 13.10.99)

The health authority reportedly countered such concerns with
reassurances: “No, no I don’t think you’ve got much to worry
about” (013.1) which soon turned sour: “And you know what’s
happened since, obviously, is that we’ve been exposed to the
full blast of the debt” (013.1). As this remark indicated, strong
central pressure led some authorities to adopt a number of creative strategies to manage that deficit to the perceived detriment of the LHG:

"For example, we have a prescribing budget, and we were given an 11%-15% uplift, I think. . . and then we find, hang on, they’re top slicing 3% of that. So hang on a little bit, how can we top slice?...‘ah, we’re keeping that centrally’. ..And then of course instead of starting off on a decent sort of playing field, they take 3% away anyway, all right?” (013.2: 14.06.00)

The conflicting pressures on the health authorities to reduce deficits and to develop primary care organisations at the same time coincided with the new Assembly’s attempts to get to grips with their own roles, and Westminster’s renewed determination to exert stronger control over performance in England. This downward central pressure on health authorities may have made it difficult to balance the conflicting demands they faced. This was no doubt exacerbated by the fall out from organisational restructuring of both health authorities and trusts still working its way through the system in Wales, at the time, as chapters 4 and 5 illustrated.

7.6.2 Continuity

Consequently, five out of the six Health Authority Chief Executive posts changed hands during the year following the inception of LHGs. This high turnover rate, at the most senior post in the agencies responsible for commissioning, impacted adversely on relationships along a number of domains. Directness of communication suffered as temporary arrangements were put in
place - or not, as was more often the case. It was a further 18 months after LHGs had been launched, before all the HA Chief Executive posts were filled. Whilst this vacuum was seen by some LHG Chairmen as an opportunity to develop their own interpretations of their remits, others experienced an anxiety that stifled action and forward planning:

"We had problems only because of the structural changes that have had to go on in Xshire. Well, I mean the Chief Executive's been sacked, and the Director of Contractor Services is leaving at the end of October, but no signs of any replacements, you've got... I mean, you've basically got no staff. I mean the only thing that is left intact is the Finance Department and the less said about the Finance department the better..." (005.1: 26.10.99)

In the space opened up by these vacancies at senior officer level, and consequent lack of direction, this Chairman took a strategic leap forward, organising a meeting of Local Authority and Trust Chairmen, and invited the Minister, Jane Hutt. This meeting gave the LHG the encouragement they needed to move forward along the lines they had drawn for themselves:

"I think for all of us in XLHG, I think the last six months have in a sense been quite frustrating in a way, not really knowing whether our vision and direction was what everybody was signed up to and, I think, Jane Hutt's meeting just managed to do that. So, we felt, I felt quite relieved after that I was able to say 'well, great, you know, we've got sign up from the centre' " (005.1: 26.10.99)

But these same anxieties re-surfaced as the delay in getting a new Chief Executive into post in that health authority lengthened:

"I suppose the difficulties for us at the moment are knowing how our strategic direction, if you like, fits in with what the health authority wants for us" (005.2: 12.06.00).

So, even a strategically-oriented Chairman expressed concern at the continuing lack of direction. Again this highlights the
importance of *continuity*, as well as of *commonality* of objectives. Thus, in relationship effectiveness terms, real failures in terms of *directness* and *continuity* indicators were reported to be impacting adversely on the ability of LHGs to develop their roles, midway through the study period. These failings, in turn, impacted on Chairmen’s views of the *commonality* of their objectives and those of their health authorities. Such breaches also emphasized the prevailing lack of any form of *parity* between the LHGs and their health authorities. Throughout this period (1999-2000) LHGs reported their sphere of action to be severely limited by relationship difficulties with their health authorities, as the following excerpt illustrates:

> "Probably 2 probably. I think the difficulty...I mean, I don’t think that’s due to anything else – you know, if you had to put an explanation underneath that it would be basically because there’s been so many changes in personnel. There actually isn’t anybody in the health authority to have a relationship with...we’ve got no Director of Public Health, we’ve got no...I mean the only person we’ve got is a new Chief Executive and an old Director of Finance. The rest of it is just not there – there’s no Commissioning Manager, there’s no Director of Patient Care any more, there’s no...well, we’ve got a locum Director of Public Health. There used to be a Director of Policy..." (005.2: 12.06.00).

Thus *directness* as a dimension of relationship quality between health authorities and their LHGs was more often violated than supported, not least because the nature of the communication channels established were dependent upon the individuals in post, or, more often, not, thus adversely affecting the *continuity* dimension too.
The preceding quotation emphasises the numerous *continuity* failures in the health authority/LHG relationship. Because this high turnover rate at senior level within the health authorities coincided with the birth of the new LHGs as organisations, the adverse impact on LHG relationships may have been more exaggerated than similar turnover rates occurring later on in the proceedings.

7.6.3 Parity The lack of *continuity* may have had a stronger impact on *parity* in the relationships between the LHGs and their health authority parent organisations on more operationally oriented Chairmen than on their strategically oriented colleagues, who, on the whole, were able to carve out distinctive agendas by building wider networks. Operationally oriented Chairmen expressed the need for external approval frequently:

"I think the most important thing is going to be, you know, to sustain the interest of the Board members, to see what we can do as LHG and not being, you know, directed by the Centre...I think that's the biggest thing, you know, one has to consider...Okay its not going to happen in a day or two, but there should be some sort of sign saying that, right, you know, we are progressing towards that goal, you know" (011.2: 24.03.00)

This Chairman, speaking one year into the LHG's life, perceived this need for affirmation as a central issue affecting the motivation of his 18 Board members. Pertinently, it also affected his own understanding of the limits of his scope for action. Although he repeatedly stressed the need for more autonomy for LHGs, he was pessimistic about getting it:
"We're hoping, but we doubt it you know, because the health authority themselves don't agree... But again I think, you know, the problem is, of course, that we are sub committee of the health authority, so anything that has to be done has to be via the health authority and not directly with us, you know" (011.2: 24.03.00)

And although this Chairman perceived the Health & Social Care Minister to be a significant light at the end of the tunnel, he recognised the constraints on her ability to unlock the system:

"We are putting forward suggestions [to increase LHG independence] to the Assembly, particularly to the Secretary of Health. But then she's got to take it through the Assembly" (011.2: 24.03.00).

This Chairman's increasing frustration at the lack of LHG autonomy was expressed repeatedly throughout his years in post. He attributed the constraints on the LHG as emanating from the health authority's determination to hold onto their existing roles and power to the exclusion of the LHG's development. As his frustration grew, so his focus diminished further, onto the constraints he experienced in regards to staffing, office accommodation, and the lack of any real monetary levers in the form of budgets or incentives which he perceived as essential to effecting changes locally. Throughout his period in office he attributed the perceived lack of progress towards obtaining these levers to the relationship problems, i.e. to the lack of more directness and continuity of communication between the LHG and the Assembly; the lack of parity in the relationship between the LHG and the health authority, and the lack of commonality of agendas among the health authority and the LHG.
7.6.4 Commonality of organisational interests, as perceived by the Chairmen, is one of the most interesting areas of divergence between strategic and operational Chairmen. This is because it illustrates the differences among the Chairmen so clearly. Strategically oriented Chairmen were more likely to be able to align their LHG’s aims with those of the overall strategy of the Welsh Assembly Government. In doing so, they not only built wider coalitions of interests among their constituents, but they lifted their organisations above the health authorities’ controlling powers, by making it almost impossible for their parent authorities to disagree with their aims. In this way, these strategically oriented Chairmen also changed the balance of the relationship, overturning the structurally-determined lack of parity between their LHGs and their health authority parent organisations. This would indicate that, in this context, the commonality dimension may have been amongst the most influential of Schulter’s and Lee’s five indices.

Demonstrating the importance of the commonality domain from another aspect, Chairmen who defined their constituents more widely than their GP colleagues, to include the local community itself, tended also to have a broader definition of their population’s health needs. This, in itself, helped them to align their development agendas with those of the Welsh Assembly. Fortuitously, too, the Assembly’s agenda was broad and focussed
on reducing inequalities in health experience through partnership working. The statutory duty of partnership created gave a clear message – but was heard and responded to differentially. Those Chairmen who recognised the links between the deprivation levels of their own communities and used this to tailor their agendas were markedly more effective in aligning their agendas with the Assembly, and then, eventually, with their health authorities, than those who did not. Interestingly, however, not all of those Chairmen serving the most deprived areas responded equally to this challenge. This differential response again strengthens the hypothesis that the more operational the focus, the less effective the Chairman, in terms of relationship building and, ultimately, LHG development. Building this broader vision of needs from amongst the local community was not a quick process. Moreover it, too, was partially dependent on the history of activity between the health authority and the GP community locally:

"It was interesting because we spent about three or four months, no, well, probably, six months really, in shadow form, spending a lot of time really doing workshops and trying to get everybody's ideas of what they were in the Local Health Group for, what they were trying to achieve. And we came out with aims and objectives for the Local Health group, really from the start of April, which we had agreed...and a lot of it was very much...you know, the main aims and objectives were to take forward clinical governance and rational prescribing. But the real big ones were that everybody wanted to go into it for the integration of health and social services. And that's very much was the driver forward. And that's actually one of our priorities in our Health Improvement Plan this year" (005.1: 26.10.99).

This LHG, then, was ready on Day 1 to move forward down an agreed pathway which they had already broadly paved. This Chairman also, however, pointed out that this agreement had
been achieved because of what he perceived to be the area’s head start in terms of being able to build on an existing model of local commissioning, via a previous putative Total Purchasing Pilot experiment in the area. Thus, both history, and the decision to use a process to articulate a broad vision from amongst the LHG members themselves, combined here to help develop a more inclusive and strategic interpretation of the LHG’s remit. By the end of the three years under study this same Chairman was able to look back and say:

"I mean, I don’t think there was any doubt all along that she [H&SC Minister] thought Local Health Groups were the way forward, and that was all part and parcel of Putting Patients First. And I do think that’s quite true, and I do also think that she felt that LHGs should – I think at the beginning, I think she felt LHGs should move towards primary care trusts. But she realised that if the process went ahead too quickly, there would be too much..." (005.3: 30.08.01)

This Chairman’s conviction, that the new models then (2001) being proposed to strengthen LHGs were closely aligned to the model this LHG had been working towards all along, was clear. This conviction was later substantiated as the LHG became a pathfinder pilot, in 2003, following the 2001 consultation exercise on the future of LHGs. Because of so many other factors at work during this period, discerning what the Assembly government’s agenda actually consisted of, however, was a difficult task, as the quote above illustrates. So, the process of aligning that agenda with the WAG’s was a constant effort of reinterpretation and re-alignment, during which the health authority became a less important player and the Trust a much more important one.
This Chairman's experience was mirrored by that of other strategically focussed Chairmen:

“Well what we've done is we've had several Away Days where we've looked at what the needs are, not as a group solely, how we develop our skills, how we expand our knowledge, how we work together as a group, but also are these priorities right...” (007.1: 23.12.99)

This Chairman went on to point out that the needs assessment built on existing information and previous special studies in the area. And he also pointed out the problem that the lack of direct channels of communication with the Assembly had created in this respect:

“Yeah, I'm concerned about the Assembly, and I'm concerned because I'm not sure how lines of communication exist into the Assembly, and how things come back out. One has a constant fear of manipulation, and...what's the word?...I just wonder if we won't be politically cornered to do things, because my understanding of Local Health Groups were put in place to serve the needs of their communities....”(007.1).

This clear commitment to serving the needs of the local population - “that should be the light that we follow” - was the crucial lever which lifts these strategically focussed Chairmen onto another level of activity outside that of their local health authorities' concerns. It enabled them to find a path through the tangled underbrush of health authority priorities and delegated workloads, to continue building their understanding of their populations' needs. In contrast to this, the more operationally focussed Chairmen either became too entangled to find their way out from under the weight of different priorities: “...it takes our
eye off the ball...” (002.1: 24.09.99); or they strengthened their operational service delivery focus even more:

“But about the LHG, well we really could have been going somewhere by now and we’re not. **We’ve gone about it the right way, done all the right things:** focus on primary care, referrals, Outpatients, Prescribing, Emergency Admissions – and we’re trying to build on our strengths. **But the budgets and the deficit and secondary care are taking all our time...**” (002.2: 02.06.00)

“...negotiations with our health authority are, I won’t say protracted, but they are flawed; **we can’t get hard issues out of our Finance Department because they have their agendas to meet...**” (004.1: 05.11.99)

In both of these cases, the Chairmen became heavily embroiled in the detail of financial flows, and therefore the ensuing lack of progress on delegated budgets weighed heavily, on the latter Chairman in particular, throughout the period in office. The **direct channels** of communication between LHG and health authority did not help in this respect:

“...we have a monthly Policy Board meeting where the [LHG] Chairs and the [GMs] managers meet with the authority to thrash out various policies but that becomes a debating shop rather than a policy-making shop and we find that the policies that you think have been decided come up on the next agenda and your assumption is that things are sorted and they are generally not; **it’s typical health authority – the way they work.**” (004.1: 05.11.99).

Again, in this case, **history** can be seen to be playing a part in the health authority/LHG relationship. The Chairman’s frustration was further exacerbated by the link in his mind between how things worked efficiently in fundholding, and the divergence from this model of the LHG:

“...having worked in fundholding at the sharp end you make a decision and its done and you know its over and done with. It was a hell of a shock after a few meetings to learn that certain points you
thought were in the pipeline of becoming policy and they hadn't really been decided. *It's very wearing and disheartening as well* (004.1).

This Chairman continued trying to extrapolate from the experience of fund-holding as a decision-making model for the LHG. He continued to focus on changes in the GMS budget as the principle tool for service development, and thus the LHG's role:

"Well we've had a certain devolvement of budgets with GMS and, as you know, there's been an increase in the allocation as well, so there's surplus money now in GMS so that we're attempting to spend it. So I was at a meeting last night with X town GPs, and encouraging them to put in applications for GMS money, for staff...clerical staff and nursing staff...particularly nursing staff, because I feel that if we can improve...developments with disease management, sort of asthma, diabetes, coronary artery prevention clinics, those sort of things" (004.2: 06.07.00)

By 2001, his mastery of the detail of the financial flow processes was impressive, but his relationship with the health authority was no further forward. Communication channels were, if anything, even less direct than previously:

"We have a slight problem locally with communication with the local contractor services in the health authority, in that they communicate directly with the professional community, ie the GPs, and they don't copy us in...for example, there have been some problems with the Section 36 monies locally, on decisions on minor ops, and that sort of thing. Well, they've been communicating to the GPs, saying that 'Yes you will be paid, but you will be paid by the Local Health Groups' - and we actually don't have any money for this! And it does impinge on our resources if they're being told a different story to us and also with relationship to our budgets which are heavily committed elsewhere." (004.3: 01.06.01)

This breach in communication might appear to be a minor issue, but it was these health authority relationship issues and the focus on medical services which continued to be the dominant issues for discussion with this Chairman throughout the three years of the study. Thus, the skirmishes with the health authority, even after
announcement of its impending demise, continued to impact negatively on the quality of the relationships formed, to the detriment of LHG development.

Another Chairman in the same health authority catchment area reiterated the challenges inherent in the LHG-health authority relationship:

"It's very difficult really certainly it's a very difficult relationship...really, as an organisation, they need to be fundamentally changed" (008.1: 03.11.99).

And again, in terms of continuity and directness of communication, the close enmeshing of LHG staffing with health authority roles could have been expected to act as a bridging mechanism. Most Chairmen saw this as an additional obstacle to effective communication however:

"You see, all the people here...they don't do exclusive LHG work, you know. They do a lot of work for the centre as well...so all of the staff are sort of...had two roles. But you know, what they are trying to do is enmesh the LHG within the health authority, sort of together, and I don't think it'll work" (008.1)

This Chairman articulated a reasonably strategic vision:

"Yes it's [the LHG] great potential. I mean its something that's got great potential for, you know, remodelling health services. It's how to do it without power. Talking of power sounds awful, but you can't do it without that and if the National Assembly or the health authority just can't see themselves through to doing it then it won't work..." (008.1)

but was conscious from the start of the potential for that vision's implementation to be thwarted by the different agendas of more powerful players. Again the impact on the Chairman's changing focus was illustrative of the trend to limit objectives, in response:
"I'm trying not to get too embroiled in secondary care, though obviously it's very relevant, you know, the interface, and its relevant to primary care. But I think, you know, sometimes in the past we've got too involved with the problems of secondary care really...I mean, to engage the practices, that's what we've got to do, and that's, I think, what we should be doing" (008.2: 05.07.00).

Here again the very close links - and shared staff - between the LHG and the health authority served to divide rather than to support the relationship, because objectives so often conflicted rather than complemented, emphasising the importance of the commonality dimension.

Within those shared staffing arrangements, each LHG General Manager had health authority-wide remits for commissioning certain service groups. Rather than being perceived as a development opportunity for LHGs, or a cementing of relationships, these arrangements proved to be another bone of contention:

"So each of the commissioning portfolios have been allocated out to the LHG. But it's not true that the LHG are commissioning those...the officer who are the general managers in the LHG are commissioning those [services]. But the LHG Board has no...we don't deal with that...it's really fulfilling a health authority role in the LHG offices, it's not, if you see what I mean, it's not an actual LHG role." (008.2).

This shared accountability could have strengthened the commonality factor. But as far as this Chairman was concerned, this ostensible link served only to deepen the divide.

Commissioning was seen by many Chairmen and their Board members to be an important tool for changing service configuration locally. But in this health authority, it was
perceived as a symbol of the different agendas, and differential power bases, of the two parties in the relationship. So commonality of interests was not furthered by an increase in the directness of the channels of communication. As a result, the relationship was damaged not improved. It may well have been LHG attempts to carve out a more distinctive agenda of their own, as a means of building their own power base amongst their professional provider constituents, that prompted many Chairmen to adopt a more operational focus in the first place. From that perspective, it may have seemed that such a limited focus was in fact the best way to reduce the potential for conflict with the health authority parent body.

7.7 Summary

Given that health authorities were responsible for both developing and monitoring LHGs, it can not have been easy to manage the tensions inherent in these conflicting roles:

"I think it's a basic lack of understanding at health authority level about what the way forward is for primary care. And a lot of dead wood, in the sense that they're in their old model, and I feel there is a major problem. I feel they've just created 6 more health authorities with the same people, and it's not an effective way forward." (020.1: 07.12.99)

Moreover, health authorities were under pressure from the Assembly government to deliver on priorities and targets set by Westminster, in particular to meet waiting list targets. Their deficits were a further source of embarrassment to the Assembly, particularly with an election looming in which devolution and
performance could be expected to be issues. In these circumstances, then, the system dynamics were weighted in favour of the larger established health authorities from the beginning, to the inevitable detriment of their new offspring organisations, thus violating parity. The structures themselves seemed to promote dissension and separation of interests, making commonality of aims more difficult to achieve. In the case of these vertical, or hierarchical relationships, history may have played a particularly significant role, overriding the multiplexity inherent in the numerous structural connections between HAs and LHGs. This meant that Chairmen needed to exercise sophisticated 'political' skills in order to influence their more powerful HA and Assembly colleagues.

The next two chapters explore the extent to which LHGs were able to form effective horizontal relationships, focussing firstly on efforts to create links with Trusts and Local Authorities as statutory organizations, in chapter 8, and secondly, in chapter 9, the LHGs' efforts to build relationships with the wider community.
Chapter 8: Institutional Politics: Building Horizontal Relationships and Influencing Strategies

8.1 Introduction

The previous chapter used Schulter's and Lee's relationship domains to explain Chairmen's descriptions of their efforts to build effective working relationships with the two agencies responsible for their development and operation. The analysis showed the impact that previous organizational history, in this case, had on LHG Chairmen's efforts to build constructive relationships within a hierarchical organizational structure. It showed that continuity, commonality of agendas and parity were all essential components to effective working relationships, perhaps overriding the directness and multiplexity domains, in this context. This chapter explores the extent to which Chairmen were able to exploit the statutory duty of partnership that covered LHGs, Trusts and Local Authorities, in order to build effective horizontal working relationships with the two key agencies with whom they shared responsibility for service provision in their localities.

8.2 Trusts

As we have seen, LHGs, as organizations, were very much 'new kids on the block', suddenly appearing on the scene, and charged with responsibility for roles which the health authority had previously held in terms of commissioning services to meet local
needs. The existing relationships between Trusts and health authorities were perceived by Chairmen to have been cosy ones, with communication links between Trusts and health authorities already well established. Moreover, as was noted in considering the lack of structural links with LHGs in Chapter 5, Trusts held well established and powerful positions in their localities, as both the main providers of acute care and, often, too, the largest employer in the area. Supporting this powerful position further, the structural reforms had not included any real mechanisms to limit Trusts' spending:

“You know what you've got, don't you with the Trust! You've got a sort of autonomous organisation that doesn't believe that any other part of the health service exists, really...I think in terms of the size of the Trust and what goes on within it in Xshire, it's a problem” (008.1: 03.11.99).

This Chairman's view of the Trusts was widely shared among other LHG Chairmen, perhaps limiting their expectations of the possibilities of changing things very much. But looking at these budding relationships between Trusts and LHGs through the lens of Schulter's and Lee's typology provided a useful way of explaining how and why such relationships eventually developed and flourished. And here, too, as in the case of the NAW and health authorities, more strategically oriented Chairmen reacted differently to the relationship challenges presented by Trusts and Local Authorities than did their more operationally focussed peers, as the following excerpt, from a strategically oriented Chairman, suggests:
"...it was about everybody talking together, the particular trusts, that if they had plans they should discuss them with the Local Health Group who, in fact, would be buying for their locality healthcare from Trusts. So I think we need to talk a bit more and we need to look and plan together for the future rather than perhaps hospitals or people within hospitals thinking that 'we'll make the decisions and we'll tell them what's available' " (007.2: 24.08.99)

This Chairman clearly saw the need to create different incentives and forms of communication if the aims of LHGs were to be realised. To that end, what sorts of channels did Chairmen try to 'create, and how did they deal with these historically entrenched working patterns and relatively long standing relationships, exacerbated by what many Chairmen saw as the health authorities' "ambivalence " (006.1) towards primary care development, illustrated in the previous chapter?

8.2.1 Impact of Previous Organizational History

The Chairmen themselves reported mixed feelings about the potential for creating productive partnerships with Trusts. And here again, history may have had a stronger impact on the effectiveness of the developing relationship than some of the other relationship quality dimensions noted in Table 7.1. For example, those GP Chairmen with experience of fund-holding, and those with a large number of ex-fundholders on their patches, were fully aware of the difference in the relationships between the GP community and their acute sector colleagues brought about by having had their own budgets. GP Chairmen who were ex-fundholders looked for similar changes, but on a wider scale, from
their LHGs. For these, largely more operationally focussed GPs, early initiatives from their Trust colleagues were welcomed as a means of establishing a new and practical basis on which to work together:

"What happened was that [our] priorities unfortunately were set aside because we thought that the sub group on commissioning has to continue, to carry out the priorities we set then. Then what happened was...as soon as we came in there was a slight issue about neighbourhood facilities which the Trust wanted to bring in...they wanted some sort of a community hospital to replace XY's, and a few other places, ABC health centre. It was with the health authority before the Local Health Group was formed; when the LHG was formed that decision came onto us" (003.1: 15.11.99).

It is important to note the reported impact of this initiative, from the Trust, in that it effectively changed the LHG's own newly formulated and agreed priorities, indicating that historical agreements and previously agreed plans of Trusts and health authorities were holding sway. The LHG Chairman noted that the idea for the new community facility "had been with the Trust for a very long time" but insisted that the LHG's role had been influential:

"...I tell you very frankly, and I don't know how much this is appreciated now, but on the other hand, LHGs took a very active role in that. We had about 3 or 4 meetings continuously, the Trust came and presented and the health authority's point of view and eventually we supported the whole thing. We were part of the health authority meeting then. The whole thing is now in process..." (003.1)

This Chairman reported that the new relationship was developing appropriately, but the words he used appeared to tell a different story. In this case, the relationship remained skewed in favour of the Trust, at least in terms of commonality, and parity, as the next excerpt illustrates:
"It doesn't... you remember last time when I spoke to you about the neighbourhood facility, I don't know how much progress that has happened, I haven't had a chance to ask" (003.2: 06.07.00).

This excerpt indicates that the Trust remained the dominant partner in this venture, which it had initiated, throughout the study period. And, having obtained broad agreement to their plans from the LHG, satisfying a rudimentary form of commonality perhaps, the Trust went its own way to develop them, indicating ongoing parity issues.

Another Trust quickly created specific liaison posts with each LHG to foster collaboration (011.1: 16.08.99) and approached the LHG for support for a new Community Hospital facility. In this case the initial drivers were external, but the initiative came from the Trust:

"At the moment we've got an acute problem which is the Y Unit at ABC Hospital... we've got a problem about recognition by the Royal Colleges. It's been in all the newspapers. But we are at the stage where there was an enquiry, you know, by the NHS on this Y Unit, and recommendations were, you know, that it wasn't safe... and there was a possibility of closure altogether..." (011.2: 24.03.00)

Such pressure from the Royal Colleges however was irresistible, taking precedence over any other issues, in this Chairman's view (011.2), perhaps indicating an underlying commonality of purpose, sparked by a shared understanding and sense of priorities, at a deeper level, with his medical colleagues in the acute sector.

In general terms, the more operationally-focussed GP Chairmen tended to turn first to Trusts to identify service development
opportunities. And ‘switched-on’ Trusts were often ready and waiting with a wish list. Possibly flattered by this new attention from Trusts, many GP Chairmen responded positively when approached by Trusts, but the degree of influence which the LHGs actually had on such proposals may have been minimal:

"We can't tell exactly at the moment because it's not a cottage hospital, it's not a district general hospital, but it's something in between, we might call it sort of intermediary...intermediary hospital, you know...They've got a Project Manager appointed...and he's the one who is in charge of all the management planning, you know, involving everybody, you know, clinicians and other agencies..." (011.2: 24.03.00).

Such invitations from the Trusts, however, did help to initiate dialogues which, in turn, influenced the shape of emerging LHG agendas. For the more operationally focussed Chairmen, this approach brought further challenges, as the following excerpt indicates:

"You know traditionally they've done what they want to do and, you know, if they wanted to change a service they've just gone ahead and changed it, quite honestly, I mean...and it's how to stop that happening which is the problem because they are providers" (008.2: 05.07.00)

Thus the history of working relationships between Trusts and their GP colleagues had a continuing impact on the nature of the relationships evolving with their LHGs. This history was not helped by the lack of directness between the two parties.

8.2.2 Directness

As noted in chapter 5, there were no direct channels of communication established between LHGs and their local Trusts via the introduction of LHGs. LHGs were not independent agencies in their own right, although Trusts were under a
statutory obligation to work in partnership with their LHGs.

Crucially, Trusts were not given any formal representation on LHG Boards; in fact, they were the only agency on the patch to have been so excluded. Thus it was up to Chairmen to create new channels:

“Yes I think its been adversarial in the past, but we’re beginning to be cooperative, and we’re having presentations each year of what their aims are, so that’s great. They come to the commissioning forum here to talk things through. We’ve had special meetings with the paediatricians and the clinical director form X Trust. ...We’ve made representations with cancer services, because they came to talk with us with the audit people, the oncology. We’re a bit disappointed with the outcome of that after we said, but we understand that it had been taken on board...” (007.2: 25.07.01)

This excerpt is evidence of the seeds of a more joint approach to service development, even though largely Trust-initiated. But it may also be that some Chairmen’s responses to Trust overtures inadvertently emphasised the responsive nature of the relationship, thus confirming the historical bias towards the acute sector. This was especially so for more operationally focussed Chairmen, who tended to be more responsive in their relationships, generally.

Another example of efforts to create more directness in relationships between Trusts and LHGs was the development of clinician-to-clinician channels. These sorts of communication mechanisms were pursued by several Chairmen, who sought to exploit common cultural norms and shared values as medical practitioners as a means of developing more equal partnerships organizationally:
"It's the single most positive thing that's come out, really, because one can start to enter into meaningful negotiations with the Trusts - clinical pathways, for example. Because previously who did the Trust negotiate with over clinical pathways? There was the LMC but they just represented doctors really on a well...from a Terms of Employment point of view really. And the BMA was not really local, and again it's a trade union for doctors, really. So in terms of primary care's widest concept - practice nurses, district nurses, you know, the whole shebang - it's the first time there's ever been a really strong structure that is in place" (008.3: 13.06.01)

Here, although the clinician-to-clinician channel was defined by a focus on medical services, the pathway element did include an orientation towards redesign of services rather than simply responding to requests for more of the same. The limitations of these channels became clearer, however, when it came to discussions about broader system change and re-configuration:

"At the end of the day it's in their gift as to what the structure will be...So I feel we'll influence the process and are influencing it as much as we, you know, can do, but at the same time it may be a small chorus of people who will actually have the say...I think that it's always top heavy, this secondary care, because even in the Primary Care Strategy Group, there's very few working general practitioners there..." (008.3).

It would appear that exploiting common cultures and shared values was one way of crossing the interface effectively between primary care and secondary care physicians about service issues where real power bases weren't at stake. But once issues about relative power came onto the agenda, battle lines formed along traditional interests:

"What I'm getting now is the impression that the Trust is trying to scapegoat us and to tar us with the same brush as the health authority. We have a little problem here about the Trust wanting a new position, but the whole business of how they've gone about it is divisive and not how we would like to see this sort of thing done. But you're trapped in a situation where your friends and colleagues in the hospital are pressurising you with all sorts of emotional blackmail, if you like, to say that we need this appointment. And yet when you come back and say, 'well, we haven't got any money,
things need to be done in a structured, planned way', they say 'well, it's just like the health authority, it's hopeless'. And there is the risk that they will use their media and political contacts to cause trouble, which is exactly what we don't want. And what we're trying to do is co-ordinate a programme of service development for the future rather than to just do ad hoc appointments all over the place, which is what's happened in the past, and which has led to chaos" (001.1: 06.10.99)

There is very little evidence here of a willingness to share a new vision for the future, or risks of any sort, in favour of maintaining the existing situation. Thus directness in terms of shared cultural values, language and norms was not enough to counter-balance the weight of opposing organizational agendas and power bases.

This again emphasises the importance of the commonality domain, and thus may help to explain some of the power of the approach adopted by more strategically sophisticated Chairmen.

8.2.3 Commonality

More strategically focussed Chairmen went about the business of building relationships on the patch proactively and systematically. This approach tended to have the effect of putting the Trust in a different position vis-a-vis the LHG's emerging agenda, rather than in the driving seat. It may well have served to promote increased commonality between the two parties, too. For example, one, more strategically oriented, Chairman took a carefully structured and deliberate approach to relationship-building with his local Trust, recognising that the primary and community care-oriented strategy of the LHG “frustrated our secondary care colleagues”:

*I think they have a real...I think there's a real problem with secondary health care professionals. I think they feel out of it. Much of the next phase is to make them feel part of it...by establishing working
parties for joint clinical pathways, that's one [way]. By joint training and education. And to ensure that, we're going to try and attempt to ensure that they are...that their views are taken on board with the next version of the Local Health Development Plan. One aim is to have a joint Social Care Plan and Health Development Plan...and we are leading on the formation of a new D Intermediate Care facility, and also on the development of C in Community Care facilities. So we'll use them as the vehicles to, if you like, pen everybody into the same ring!" (009.2: 20.06.00)

This Chairman saw the need to develop the LHG's vision within the local community as the first step, then to bring in the acute sector through a series of educational and developmental activities, structured around creating a common aim of quality improvement. Such avenues were ad hoc in one sense, but they were created to support the building of a broad consensus of aim and partnership, in which the Trust was not paramount, but one player among a host of others. Efforts such as this one could be seen as attempts to strengthen the commonality of agendas across the patch. The multiplexity domain was also addressed, through the variety of fora created to feed into this process, where more direct channels were absent from the structures.

Another Chairman recognised the limitations imposed by trying to work through existing medical fora in terms of communication with his Trust-based medical colleagues, as the following excerpt illustrates:

"I have been to the meeting of the HMSC1 and I have discussed things with the consultants and so on and the cardiac advisory group but they are very much left out at the moment and we have to very much try to bring them into things..."(010.1: 16.08.99)

1 Hospital Medical Staffing Committee
But this comment also indicates that, right from the start for this strategically focussed Chairman, Trust relationships were important for implementation of, but not central to the development of, the LHG’s agenda. Clear recognition of the LHG’s responsibility to include the Trust in the debating process to determine local health needs was expressed by this Chairman, whose commitment to ensuring a bottom up process of identifying local health needs remained constant and consistent throughout the years of study. In the case of this particular Chairman, the fact that he had three Trusts to relate to at the outset, which merged into one Trust during the first 18 months of the LHGs existence, may have helped rather than hindered this process. Another, equally strategically focussed, Chairmen reported a similar approach to relationship-building with the Trust in his area:

"It's got to be bottom-led; the LHG’s strength is that it can readily access the opinions and the views at a low level, and the bit that we are yet to crack is the patient level but from the service providers' point of view I don't think I want to be an Emperor with no clothes, in fact I would not like that at all. So it is all about ownership of it and I think the ... trick has been to show that the strength of having XLHG is that it is a big welly and the Trusts have recognised this...we have 58% of their commissioning so the XY patients are very important to that Trust and yet they have always been the poor relation, so one of the things in being an X LHG has been ....we [have] been able to put a much more aggressive message but to be fair the Trust has responded really well....the other thing we are concentrating on is community care having shifted it into secondary care trusts I think there is a real risk that they don't understand, so it is our role in life to ensure there is clarity of understanding..." (009.1: 20.08.99).

Three key points are relevant here. Firstly, recognition of the LHG’s strength in relation to service provision in the locality
appears to be jointly shared at this early stage, helping to boost the *parity* dimensions of the relationship. Secondly, the impact of the Trust reconfiguration during this period, with community services being brought into the acute sector as part of the preceding restructuring meant that the Trust’s management energies were likely to be focussed more inwardly than outwardly, especially in view of the focus on deficits, as this Chairman recognised: “when you’ve got a Trust in recovery it’s not likely to want to be a real player and it tends to be cynical” (009.1).

Thirdly, however, and perhaps most importantly, there was a clear emphasis on building a community-wide view of needs, in terms of “examining how we really *share the agenda*” (009.1).

This approach put the Trust’s potential role as a partner, with shared goals, into broader perspective and potentially reduced some of the power they had traditionally wielded. Here, again, the lack of *direct* channels was overcome by creating new ones which would also foster *continuity* (once the restructuring turbulence quietened down). But the very different focus – on needs of the community, rather than on existing services – also helped to create more *commonality of interests*, while the amount of business the LHG potentially influenced [“58% of their commissioning”] contributed to increased *parity* within the relationship between LHG and Trust.
The most strategically oriented Chairmen (005; 006; 007; 009 & 010) tended to focus their attentions on the wider community, as a means of developing a shared agenda across their localities, whereas more operationally focussed Chairmen tended to put stronger emphasis on medical services and relationships with their secondary sector medical colleagues. For example, the strategic Chairmen hardly mentioned the Trusts in the first interviews, emphasising instead the HA relationships and relationships with the community and primary care providers.

When prompted, one replied:

"...I think that if there are changes that will affect a particular service then they are going to have to be involved and their expertise will be as needed as ever" (010.1: 16.08.99)

This comment indicates a very different approach to the acute sector and to the LHG's role as a whole, than the comments of more operational Chairmen, who mentioned the Trusts far more frequently, and tended to adopt Trust initiatives as a first step towards generating activity locally. The more strategic Chairmen started from a different point, describing the role of the LHG as a means of building a new vision of primary care provision, which was bottom up, inclusively cross-sectoral and community-development oriented. In this approach, almost by definition, the Trusts would play a supportive, rather than defining, role. This sort of approach provided a stronger base for LHGs and provided a bridge across to their secondary sector colleagues by offering a vision to which they could both contribute and align themselves.
In many ways, contacts with the Trusts were promoted indirectly via the health authorities' delegation of work to LHGs:

"Do you want me to tell you what our agenda is? This is what we've just been presented with. The management of the consultation of DEF NHS Trust Clinical Services Strategy changing for the better... and management of the consultation process on Orthopaedic Services across AB [HA]...and management of the local action team on Emergency Admissions in DEF Trust...." (010.2: 06.04.00)

Much of this dominance reflected the direct employer/employee relationship of the LHG General Manager to the HA, discussed in detail in Chapter 4. But, in this case, then, the challenge for the LHG Chairman was to keep the community-needs based strategy to the fore in the face of strong opposing forces towards the HA/Trust's definition of the agenda. By the end of the study period he had successfully managed to turn the tables in the relationship with the Trust:

"On the Open Day [for a new cross-sectoral project] none of the Trust representatives turned up. So [the General Manager] and I had a meeting with the Chief Executive and the Chairman of the XY Trust, and we gave a very good argument why they should be involved, for a whole variety of reasons, and since then they've been very attentive in turning up for meetings...They are all senior people; we told them we wanted people who could deliver..." (010.3: 24.07.01).

In this case, the Trust had been brought in to support the LHG's agenda, not vice-versa. Reinforcing this change, this Chairman emphasised that the Trust was no different than any other partner when it came to bidding for money or putting proposals forward:

"They just have to present their case as well. They've got to go through various tools to analyse whether a bid should go forward...And if it doesn't have these tools, it doesn't pass the test, it doesn't get on to the next stage...as it passes through the process, they'll either be refined in a way that we can achieve what we want, or they'll be kicked back into touch..." (010.3)
These latter two Chairmen quoted above, 009 and 010, possibly the most strategically oriented among the 22, both sought to create distinctive LHG agendas focussed around community needs, before taking steps to bring their secondary sector colleagues on board. It is interesting to note that both of their reports focussed around broad partnerships and community development throughout the years under study. In both these examples, the Trusts did not figure prominently – in fact Social Services and the local authority got more mentions in interviews with these Chairmen than did the Trusts. In both of these cases, parity increases came about as a result of efforts to create commonality of agendas; directness and continuity issues appeared to have been viewed by both Chairmen as secondary ones.

Other, more pragmatic Chairmen took more service-oriented tacks, that also implicitly recognised the need to build more commonality of agendas, ranging from latching on to Trust initiatives “our mutual interest is common, we have an interest which is very much mutual” (003.2: 06.07.00) to grouping together with other LHGs to present a service delivery initiative to the Trust as a united block:

“We've elected to have a go at a part of the service that is a difficult part of the service, but on the other hand it means that lots of minds will be occupied in trying to get to grips with the service” (004.3: 01.06.01)
Here the LHGs within one HA area banded together themselves
and selected a cross-sectoral service delivery problem as a means
of finally getting a dialogue with the Trust underway:

"We had an agenda, yes. We had already decided that this was a
subject that we'd like to grasp. There were other points that we wanted
to make with reference to more contact, but we thought this was a
good starting point" (004.3)

The service selected resonated with the Trust's view of its own
problem areas, if not with the LHGs' service development
priorities:

"He [the Trust Chief Executive] has problems obviously within his own
organisation that possibly need to be addressed, and if we can
help...and you know, if the blocks can be removed and we can
organise...and if we can make this work as far as X services, it will
demonstrate that this is a service change, rather than a monetary
system change" (004.3)

In explaining why they took this approach the Chairmen went on
to say:

"They have their own commitment to various developments within
the structures. We've pointed out the inadequacies of some of
those development processes, and again, it's the poor specialities that
haven't got the management structures or are too busy or haven't got
enough time, they're over-worked. You know the larger specialities who
have more consultants, who are well organised, who are rich and
famous, they can organise themselves into getting a good case together
to say 'we want more of this'...in doing so, we're going to pull in some
of those specialties that can't organise themselves, they're in
desperate need of resources. Well, this is a way of tapping into a big
resource for them" (004.3)

So, although it took this grouping of LHGs about two years to
begin to rally around a new and more uniquely defined
commonality of interests, their approach did manage to begin to
skew the relationship more equally. Interestingly, too, the opening
was created, and initially developed, through managerial (albeit at
Chief Executive and Chairman level) rather than through medical
routes. Thus this data does appear to support the notion that
commonality was one of the most powerful relationship domains, if not sufficient by itself, to ensure effective working relationships, within this context and against the weight of previous organizational history.

8.2.4 Continuity as a domain was fostered by a history of personal relationships in the patch. As was discussed in Chapter 6, most Chairmen could point to a personal history of having lived and worked in their respective areas for many years. And this stability had enabled them to become known and respected figures locally, as this excerpt illustrates:

"And I know the Chairman of the Trust personally, and through a number of other things like when he was Chairman of the Family Health Services Authority and having met him when he was Chairman of the X Trust; we haven't always agreed, but there are lines of communication. And, you know, that's all good stuff" (007.1: 23.12.99).

So, a shared history of community service within their localities was a common feature of most Chairmen's backgrounds. This continuity of service and working relationships was prized by Chairmen. But, for many, even existing personal relationships were not enough to offset the realities of power differentials and different agendas.

8.2.5 Parity The lack of concrete power was perceived as a real limitation by operationally focussed Chairmen:

"There's no relationship at the moment with the Trust. It's again because we've got no financial clout. They're doing back door deals, we know they're doing the deals, and they'll just go on with their development. The long term agreements we've been involved in a very minor sort of way. It's lip service to it at the moment. As soon as we get the money they'll start taking notice of it. You know when we were fund-holders with money in our pocket they were knocking on your door, but, you know, without money you have no power" (004.2: 06.07.00)
The extent to which Trust/LHG relationships exhibited any real sharing of risks and rewards varied according to area and the Chairman’s approach to the role. But even the more strategically aware Chairmen often expressed discouragement at the differential power bases of the two agencies, noting the extensive efforts they made to get their agenda heard and understood within the Trusts.

Furthermore, there was little sign of equality when it came to sharing out “rewards”; the distribution of the new monies in June 2000 illustrated Chairmen’s concerns:

“You know, all the new money is going to the acute Trust rather than any of it coming into primary care which is always a bit concerning...” (005.2: 12.06.00)

“Trust and health authority’s recovery plan puts primary care on the back seat as of last Wednesday...they were told that any money not formally committed is to go back to the centre. No primary care development funds, GMS funds, you shouldn’t spend it...not much point in having an LHG, really!” (015.3: 16.07.01)

The pressures on the health authorities to reduce deficits were perceived as having a stronger impact on distribution of resources, including the new monies specifically aimed at “modernisation” of services, than other strategic intentions outlined in the policy documents. Thus Trusts were perceived to have gotten first call on any additional money injected into the system, at the expense of pump-priming new approaches aimed at changing the status quo:

“Undoubtedly what’s been going on these last few weeks has been this extraordinary see-saw from famine to feast to back to...well, not
to famine again but...it's extraordinary, really, I mean the health service hasn't seen such an injection [of money], but the feeling is that we're...that it's...we've been managing expectations down again because of the way they did the tranches. And I don't think primary care has actually seen very much as a result of that as a share of the resources. The proverbial Trust pulling power has...has once again exerted itself, really" (006.2: 17.07.00)

Although Chairmen differed as to the extent to which they viewed financial resources as their chief lever of power, the LHGs' lack of parity or "clout" in relation to Trusts was one of their most frequently voiced concerns throughout the study period. The impact of this imbalance was also affected, of course, by the number of LHGs to which any one Trust was expected to do business. In some areas of Wales Trusts had four or five LHGs to which to relate, potentially diluting the impact of any single LHG in the eyes of the Trust.

This imbalance was particularly evident in relation to community services budgets. Community services budgets were seen, by Chairmen, as an important lever for changing service delivery patterns locally. But community services budgets became part of Trusts' funds in the 1998 re-structuring which merged community services with acute sector hospitals. This structural change was accompanied by increasing focus on Trust overspends - so it may be that the funds associated with the takeover of community services were a welcome addition to Trust coffers. Despite many promises from Trusts to devolve these budgets, common across LHG areas, over the full period under study, no Trust in Wales
managed to either provide LHGs with figures on the number of community nursing staff employed by them, or to provide any sort of estimates on expenditure on this staffing group, thereby effectively preventing any changes in configuration at local level.

Yet this was one area of service highlighted by Chairmen, from the earliest days of the LHGs' existence, as being one in which they could usefully make a pronounced difference to patient care in their localities. One Chairman, for example, had used figures available two years previously (under the previous structure where community services budgets were disaggregated) to identify a significant variation in spends across the sub-areas of his LHG:

"we had a variation in district nursing [expenditure] within X HA per patient provision, was something like £60 to something like £91 per patient [but] our community is fairly even, you see, each one of the valleys, the population, the people, the problems, they don't vary a lot...they're sort of evenly deprived, if you like..." (014.2: 24.05.00)

He saw this issue as being an appropriate one for the LHG and thus an opportunity to do what the larger health authority couldn't, because of conflicting interests within the larger area and lack of incentives in the system:

"So I think for a health authority area, that's probably too big a problem to take on. But we can actually hopefully get down to much more...You know, we know what's going on." (014.2: 24.05.00)

He opened up channels of communication with the Trust to discuss the issue:

"what we wanted to do in our [community services] budget is to even those [variations] up a bit, you know, so that patients are getting a sort of fairly even distribution of what is needed. But we haven't actually got the budget yet; because we can't have it because they don't have the figures. So, although, you know, we're talking to the community managers, we can't really do anything concrete about it" (014.2: 24.05.00).
And although he had succeeded in getting the issue onto the agenda at both health authority and Trust level, he was continually frustrated by the LHG's inability to get either the budget itself or sufficiently detailed information to support the case:

"a large part of the community budget overall was supposed to have come to us on 1st April, but the Trust couldn't identify, you know, how much each bit was costing. It was a complete shambles, actually - dreadful! We never have been able to get this information, but they did know that we needed this information ..., but as I say, its historical, really... So somehow, in the past, the health authority must have been spending a big tranche of it, but you know, they don't seem to be aware of, in any remote way, as to how they've been spending it, they've just paid the bills..." (014.2)

By the end of the period under study, the position had not changed:

"So, we're supposed to have it now [the community services budget], but we've got the notional budget, which means that we can't really actually do anything yet to change the service. It's been a cause of a lot of talk and frustration between the Local Health Groups and the health authority and the Trust" (014.3: 01.06.01)

This comment indicates how LHGs were effectively prohibited from developing the sort of locally responsive services they were set up to create, by blocks in the system that remained too strong throughout the entire lifespan of the LHGs. Even the decision to remove the health authority tier, taken some six months previously, had not been enough to unlock this particular block.

In this case, the Trust in question covered all the LHGs in the health authority area. But even the concerted efforts of the constituent LHGs was not enough to overturn the existing situation:
"We're having enormous difficulties at the moment we're supposed to have the community services budget. Well, no money has come to us. We're still struggling with the community to give us figures on, oh, what the employment situation is in the various practices, community nurses and health visitors. Well it's a struggle to get the information. If we had the money we could say 'Look this is what we want to purchase, and if you're not going to give it we'll go elsewhere' and then they start to jump around" (004.2: 06.07.00)

As one of the Chairmen put it:

"Yes, I mean, when the Trust doesn't want to do anything, it doesn't really have to do it, is one problem. And secondly they don't actually know what they're doing and so being asked creates a problem for them" (014.3: 01.06.01).

This comment supports the interpretation that the system re-organisation had done little to change the dynamics operating within it. If anything, the vertical integration of the Trusts had strengthened the position of the acute sector, in terms of autonomy and budgets, without any parallel strengthening of the ability of LHGs to influence their behaviour, or incentive for health authorities to monitor the outcomes of their own commissioning processes, further embedding the *parity* imbalance. Although the data excerpts used in this last example come from within one health authority area, the picture was mirrored across Wales without exception. It would appear from this analysis that the existing relationships between the health authorities and trusts were never materially disturbed by the arrival or existence of LHGs. The existing channels of communication, and the shared management culture and beliefs which favoured the acute sector at the expense of the primary and community sector, remained intact. Thus *directness* favoured Trust and health authority relationships, further strengthened by *history*. Collaborative
approaches across LHGs succeeded often in getting specific issues on to the health authority agenda, but never managed to effect any real change in the balance of power (parity) prevailing between the acute and community sectors:

"Well the biggest problem...the problem of the Trusts is they're an independent organisation, and what they wish to achieve is self maintenance, isn't it, you know, immortality and all that?... so I mean, you know, their focus isn't on the patient or the client group, it's on organisational furtherance, to ensure that this organisation continues to exist mostly in its current form..." (002.2: 02.06.00)

This drive to self perpetuate was evidenced most overtly on an all Wales basis during the Welsh Assembly Government's consultation exercise exploring further structural change, carried out following the appointment of a new Director of the NHS in Wales, and as part of the information gathering which informed implementation of Improving Health in Wales, the NHS Plan for Wales (NAW 2001). This exercise consisted of establishing a series of "Task & Finish Groups", in August 2001, reflecting the various parts of the system deemed to be in need of attention if not reform (NAW Structural Change Newsletter Series 2001). Each Task & Finish Group consisted of selected senior representatives of Trusts and LHGs, constituting a form of expert panel on each issue, eg Workforce Development, Performance Management, etc. Although LHG Chairmen and their General Managers acted promptly to take up their places on these Groups, they soon found that the cards were stacked against them. Meetings were chaired by senior Trust or health authority managers; they were called at short notice, and the date for subsequent meetings wasn't set..."
until the end of each meeting, effectively excluding non-attendees systematically. LHG Chairmen found it almost impossible to commit to attending such meetings because, as practising clinicians, their diaries were committed to personally providing services months in advance:

"We don't have any power at the moment, and this is the difficulty. We can lobby, we can talk. The Minister does listen but obviously didn't listen hard enough. I know that the Director has the right view of the future, but I don't think that she has a lot of support" (001.3: 06.09.01)

Trust managers, practised in the mores of such consultation, and well organised as a group, bolstered by national lobbying groups such as the NHS Confederation, and their position politically as the largest employers within many LHG areas, saw an opportunity to influence the proposed structures in their favour, promoting an option to integrate primary care within their structures:

"I feel particularly frustrated by the structural change process, having been so closely involved with it, and having contributed considerably to what we thought was going to be a very decisive pattern of change, and then...by then it was watered down politically...because the obvious conclusion of the structural changes, it was originally seen, would have been a major shuffle in the way that trusts were re-organised, and that was felt to be politically unacceptable. So we've had to go through this pathfinder process, which leaves the whole thing up in the air again" (001.3: 06.09.01)

In this Chairman's eyes, the trusts had sufficient power collectively to block proposed change, even if insufficient to swing the pendulum completely in their direction:

"And its still in danger of being scuppered. The Trusts: 'we'll be non-viable, we'll have to close' etc, Because of what they've done in the past in terms of using the funds from the community services to support the acute services" (001.3).

Health Authorities supported the Trusts' positions, but from a different angle, arguing for the preservation of the status quo, on
the grounds that further structural change would detract
attention from the Assembly’s wider agenda of tackling
inequalities.¹

8.2.6 Summary Throughout the period of study, then, LHGs
remained under the domination of both of their more powerful
organisational neighbours, despite concerted collective and
individual efforts to build more mature and effective relationships.
In terms of effective relationship domains, this analysis has
showed that, firstly, the impact of organizational history made the
task of building cooperative working relationships with Trusts an
uphill struggle, further exacerbated by failures in the directness
domain. Secondly, against this obstacle, this analysis has
demonstrated the problems met by Chairmen trying to create
common agendas with Trusts, aggravated by the lack of parity
between the potential partners. Even the directness of
traditionally close clinician-to-clinician channels was offset by
failures in terms of continuity, despite the efforts of strategically
sophisticated Chairmen to bolster the multiplexity of linkages
between the LHG and their Trust colleagues. In the end, too, even
involvement in discussions about their futures was perceived, by
Chairmen, as an additional distraction from the LHG’s core
purpose:

¹ Chief Executive Bro Taf Health Authority, in response to a question posed by the
Chairman of the NAW Health and Social Services Committee, discussing the
future of LHGs at the meeting held, 25 October 2000, Committee Room 2,
National Assembly for Wales. Agenda Item HSS-18-00. Recorded by researcher
in own field notes and corroborated by Minutes published subsequently.
Nonetheless, most LHG Chairmen felt that relationship-building had been amongst their most important achievements during the period under study. The Audit Commission's initial review (2000) of LHG activity supported this contention. This view seems to be based largely on their perhaps unexpected success in building effective relationships with Local Authority colleagues.

8.3 Local Authorities

In terms of Directness, Local Authorities were in a good position vis-à-vis LHGs: the new system, and supporting infrastructure changes, was specifically designed to promote closer partnerships with Local Authority colleagues, particularly those involved with Social Services-linked activities. The statutory duty of partnership, included with the enabling legislation to establish LHGs, was an important steer. But perhaps more effective was the inclusion of two local authority representatives on each LHG Board, with the stipulation that one should be a member of the Executive Committee (Welsh Office 1998b). These specific and concrete arrangements should have facilitated reasonably direct communication between the two agencies. A number of features however combined to thwart this in several areas. Notably in one LHG, the Local Authority Chairman refused to allow any
representation on the LHG Board until the issue of whether the representatives should be drawn from the elected members or the officers was clarified. One year into the LHG's life, this was still unresolved:

"I would like to see the relationship with the local authority becoming more firmly entrenched and representatives actually beginning to take their place on the Board and make an active contribution..." (010.2: 06.04.00)

This strategically oriented LHG Chairman was effective in supporting the development of informal links with social services (010.1:16.08.99) to compensate for the Local Authority Chairman's intransigence, but his real weapon was the design and implementation of his community development strategy itself:

"...Since that period we've actually put into being a structure right across XTown with four locality steering groups, which reflect the...all the stakeholders, representatives of primary care and various members of primary care, there's not a predominance of one member...We also have representatives of the Trust, the CHC, the voluntary sector, and the local authority...they're all on the four areas around the city which follow basically Assembly member constituency boundaries...the structure we eventually settled on was enthusiastically received by the local authority..." (010.3: 24.07.01)

This example of a strategy aligning local priorities with national, together with the creation of a structure to enable needs to be fed in from the "bottom up", from within small localities and across professional groups, enabled the LHG to marshal local authority support, despite structural constraints and representational disputes that were more extreme than in any other area of Wales. In this instance, new channels had to be created to enable the partnership to grow, where the stipulated statutory channels had been left in abeyance. The implementation of this strategy
revolved around creating new channels of communication that enabled direct communication on a variety of levels. In this way, multiplexity in the relationship building was fostered too.

8.3.1 History The majority of Chairmen, whether operational or strategic, faced practical difficulties in trying to set up and maintain relationships with their local authority colleagues. Ironically, in some ways, relationship building may have been initially easier at operational level, benefiting the more pragmatically-oriented Chairmen, at least in the shorter term:

“Well our local authority links - although our local authority isn't the most wonderful local authority, it's had a lot of bad press lately - we have developed a good working relationship with them...take the refugees-oops, asylum seekers! We have a chance to make it all come together: housing, services, the lot...also Intermediate Care is quite good; through the Primary Care Development money we've been able to put some money into primary care and some into local authority services so we can complete the circle, so we can ring up for a sitter for Mrs Jones in the middle of the night and get that sorted.” (002.2: 02.06.00)

As a GP, this Chairman may, historically, have had a somewhat distant relationship with Social Services colleagues because of the differences between the “9-5” culture which GPs’ perceived Social Services to work within, as opposed to their own 24-hour commitment; moreover previous re-organisations within social services, away from geographically-organised services towards functionally-organised services, often meant that the idea of the named social worker for each practice disappeared, intensifying rather than alleviating relationship barriers. So the sort of practical bridge-building referred to above was attractive in terms
of local service delivery improvements, providing a way round previously frustrating hurdles. Similar early successes were frequently mentioned, particularly by more operationally-focussed GP Chairmen.

In areas where Commissioning Teams had been actively encouraged, *history* appeared to have helped rather than hindered:

”But we are very fortunate here as far as I’m concerned, you see, because the [LHG] General Manager was the County Commissioning Manager, the Joint Commissioning Manager was already on the team, two of the GPs on the LHG were two of the three GPs on the commissioning team…” (012.1: 09.08.99)

Further *direct channels* were created with the establishment of Health and Well Being Partnerships, in the wake of *Improving Health in Wales*. These groups were intended to look across health and social care boundaries to identify issues which impacted upon the local population’s health and well being in order to pinpoint specific actions within constituent partner authorities’ decision-making structures, to tackle them. Since Chairmen saw relationship-building across the patch as one of their own key roles, meetings at Chief Executive/Chairmen level were reasonably quickly instigated:

”But the thing I am very pleased about…and I guess where I haven’t really changed my mind, is the opportunity of health & social care being merged. I mean, I’ve sat in on quite a few seminars and I’m giving quite a bit of my time up to this at the moment from my other work…It’s the first time I’ve met most of these people at all, to be honest and they were looking at it from a different aspect than I’d looked at it, you know. From common sense aspects. So they’d say ‘what’s the point of giving someone anti-depressants if the cause of their depression is that the house is damp and water is flowing down the
walls'...that's a very sensible sort of, you know, a reflection as that really is what, you know, this is more of opportunity" (012.1: 09.08.99)

8.3.2 Commonality  This growing awareness of the potential to create a shared agenda in a concrete sense was also fostered, at least in theory, by the requirement to produce Health Improvement Plans:

"The Local Health Alliance has a real contribution here; I could see how the LHG could commission the Local Health Alliance to do things for it, to contribute to the needs assessment, to inform the HIP" (006.1: 08.11.99)

In practice, however, both timescales and pre-existing mores militated against this initially: "The interim HIP was just waved past, it was already written by the health authority; now we're working hard on next year's" (006.1).

Nonetheless, this feeling of widened opportunities and of a welcome different perspective was frequently mentioned by the majority of Chairmen. Strategically oriented Chairmen were keen to capitalise on opportunities presented by the establishment of Joint Health & Social Care Partnership Boards: 010.3 reported that both the Chairman and the General Manager had seats on their local Boards. In one LHG area the dialogue was stimulated by creating awareness of a health issue that impacted on all sectors of the community, coronary heart disease:

"I'm sure there's going to be increased contact between ourselves as a Local Health Group, and Local Authority. And, you know, I think we've made...I think X as an LHG have particularly made good impact on the Local Authority, more probably than any other LHG in Wales, that would be my guess..." (022.2: 10.08.00).
This initiative grew and acted as a "binding force" across various interest groups in the community, despite the fact the Local Health Alliance never really got off the ground in that locality (022.2: 12.06.01). In the same way, the community development approaches of 009 and 010 acted as unifying forces across agencies. But, all too often, both existing policy, structural changes, and work patterns militated against developing cohesive constructive new partnerships.

8.3.3 Continuity A lack of continuity in structures and members presented the biggest challenge to LHG/LA partnership working across Wales. The decision to re-shuffle local authorities, during this period of time, had the effect of turning officer attention inwards, just as it had, earlier, during health authority and trust re-structuring. In many LHG areas, the re-shuffling acted as a significant brake on the development of Local Health Alliances in the first place:

"Everything hinges on this HIP, and [Local] Health Alliances haven't taken off...we've had a problem in that in X Shire we've had one...the Director of Social Services was suspended last July or August so we haven't seen him...the Director of Public Protection was seconded to an authority in Y in October so we haven't seen him, so we've had absolutely no input for six months from the local authority..."  
(017.2: 29.03.00)

Thus, in the case of local authorities, an additional barrier to partnership-building was created by the amalgamation of key departments, so that social services, for example, was merged with education, as was noted in Chapter 5, in the discussion about structural influences on LHGs. Such changes were
reported, by Chairmen, as a loss of crucial experience and
knowledge. And, as noted earlier, the difficulties of new members
joining an established team would be made worse by lack of
knowledge of the issues and the brief. A year later the Health
Alliance in this area had yet to get going:

"It's kicked off, but not with a lot of teeth. It seems to be
floundering on issues where the County needs to respond. We don't
have a problem responding, because our remit is probably a lot simpler
and more easily measurable..." (017.3: 12.06.01)

This was a common report, emphasizing that in addition to
structural constraints on partnership working, each agency's
cultural differences were further emphasised by different
accountability chains and performance measures. This
Chairman's report was not unique; it reflected the majority of
LHGs' experiences with their local authority-led health alliances.
These differences added to the effects of the well-known and long
standing barriers of different funding streams and budget cycles.
In addition, the lack of continuity of interest as well as
representation proved to be problematic across Wales:

"...it's awkward when they don't turn up. There's a tendency to
send a deputy who's nearly as good but not quite...and then, worst
of all, you know, they say they'll do something and then do
something else...I mean, if this [top] team can't mean what it says, how
do you expect your middle management team to do it? I mean, actually,
how do you expect your deliverers on the ground, your social carers, you
know, your district nurses, general practitioners or whatever - how are
they going to do it and why should they?" (002.3: 13.08.01)

In addition to re-shuffling, the discontinuities in representation at
meetings led to barriers in commitment and action, thus
militating against efforts to sustain commonality of agendas when
it came to implementation stages, as well as raising *parity*

concerns.

8.3.4 Parity  In terms of structures, both Local Authorities and LHGs had much to gain from closer working relationships. Local Authorities historically had sought closer working relationships, and the ability to assert more control over service provision, since the 1974 reorganisation's removal of community services from local authorities' responsibilities. Traditionally, too, each partner tended to apportion some of the blame for delayed transfers of care to their opposite number's ways of working or lack of resourcing. Structural changes intended to enable closer joint working had been accompanied by strategic exhortations for the preceding 30 years, with Joint Care Planning Teams and Joint Consultative Committees being formed to look at issues of common concern, notably the development of tools to enable common needs assessments and resolution of disputes over boundaries (whether a bath is a health or a social need, for example). But different accountability structures, different cultures and working patterns, different budget streams and financial year calendars were all hurdles to be overcome along the way. The new LHGs were conceived as a bold leap forward in the direction of real partnership, with coterminous boundaries, representation at Director-level, and strategy supported by statute. Pooled budgets were introduced as an additional
sweetener, with legislation enshrining additional elements of flexibility in new spending powers. Given that neither agency had hierarchical control over the other, parity should have been enhanced by these measures.

In addition, existing constraints were released to create new flexibilities to support joint spending. Interestingly, however, these new monies were rarely mentioned by Chairmen as being helpful:

"Well we have some pooled budget work already, in substance misuse...but we're really awaiting the implementation of the flexibilities...The Continuing Care budget would be a prime candidate for pooled budgeting but XYZ Health Authority doesn't actually set a budget against its continuing care...so there isn't a resource which you can actually work with together, and that's really not helpful to pooled budgeting..." (006.2: 17.07.00)

Efforts to work together appeared to be built more on managing to create shared agendas either strategically (009, 010, 007, 022) or pragmatically on specific projects more limited in scope (eg 002), than on any examples of shared risks.

8.3.5 Multiplexity The creation of Local Health Alliances led by Local Authorities could also have been intended to provide additional direct channels of communication and thus to promote closer relationships with LHGs. But the initial launch of LHAs was met with some suspicion and hostility by newly appointed Chairmen, still struggling to define their own agendas and "territories". This uncertainty, and lack of clarity about respective

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1 Personal observation by the researcher, corroborated in field notes made at the time, of the debate that followed the launch of LHAs by two Directors of Social Services, at the final Study Block for LHG Chairmen, 2 July 1999, Caer Beris Manor, Builth Wells, Powys, Wales.
remits, bedevilled LHG relationships with many external agencies.

And restructuring had to overcome historical working patterns, relationships and organisational understanding, so that for some, Local Health Alliances acted as a brake on progress whilst everyone changed hats and places, even in areas where, previously, joint working had been going strong:

"Again, there’s a bit of confusion between [LH] Alliances and the JCC, you know, both things are sort of still ongoing...although they probably duplicate things...people are not quite sure what is going to take responsibility for what..." (018.2: 20/06/00).

These initial difficulties were gradually overcome by virtue of selective use of the small numbers of players in the same pool:

"Also the cross representation we’ve got. Because XY is the effective officer lead for the Local Health Alliance, and he Chairs the Local Health Group Health Improvement Programme Working Group. And what the Local Health Group is doing is commissioning work from the Alliance, particularly, let’s say, in sexual health strategy, to get them to do some work on some of these areas, which then comes back into the Local Health Group and hopefully we can then take it on in the executive way, which gives some value to the Alliance’s work" (006.2: 17.07.00).

This echoes the reports of 010, which highlighted the value of common membership on key committees, at executive level. The seniority of the role was seen as as likely to be important here as the person’s interpretation of the role and willingness to take risks within it:

"The big problem for us working with the Local Authority is, I don’t think X is a risk-taker...X is Y’s Number Two...Y took the risks and X was a safe pair of hands, I think. Now we’ve got the safe pair of hands, he’s a master team of safe hands, but there’s no one to take risks, there’s no one" (002.3: 13.08.01)

Thus it may be that the building up of shared history and understanding, and the consequent development of trust, was more effective in building relationships across agencies than any
other single factor, since a high degree of trust was an essential
pre-requisite to effective exploitation of any new opportunities
presented by legislative or structural changes. This could indicate
that *multiplexity* and *history* may outweigh other factors, at least
in situations where the playing field is relatively level, as it was in
the relationships between local authorities and their LHGs. In
this case neither had executive power over the other, but each
enabled access to key constituents needed by the other in order to
deliver services locally. It may also be that the budding
relationships between local authorities and LHGs required
relatively low levels of risk taking, for both parties, at this early
stage of joint working. Nonetheless, as the analysis above
illustrates, *commonality* of aims, which might have been implicit,
was hampered from developing by *continuity* problems.

8.4 Summary

Applying the sort of human development analogy, favoured by
many Chairmen, to understanding the relationship challenge
faced by LHGs in attempting to create their own identity in an
already crowded organizational landscape, health authorities
could be seen to have been acting *in loco parentis* mode. Health
Authorities presented a view of the world which had worked for
them, and attempted to instil amongst their fledgling LHGs a
variety of behaviours which they deemed appropriate for success
in the health system as they perceived it. Pursuing the analogy
further, Trusts could be seen to have been behaving in the role of 'big brothers': looked up to and respected by their LHGs, perhaps feared to some degree, but also a sibling of whom the LHGs had certainly got the measure. Local Authorities, in this vein, then, may have been perceived as 'sisters': unthreatening, meddlesome, and needing to be cajoled into working towards and supporting the LHG's agenda. LHGs, as youngest offspring of the 'parent' HAs, struggled to create their own identities, distinct from and unique, and capable of operating effectively in a new organizational configuration. Nonetheless the shared history of this 'nuclear family' did provide common reference points around which to stimulate debate.

But these immediate 'family' members were not the only stakeholders with which LHGs needed to contend. A wider stakeholder group presented a series of different challenges and opportunities for LHGs, which the next chapter examines in detail.
Chapter 9: Engaging Stakeholders in the Wider Community

9.1 Introduction

In the last chapter, it was argued that LHG Chairmen encountered a number of obstacles in forging effective working relationships with the two agencies with whom they shared responsibility for providing services and a statutory duty to work in partnership. It was demonstrated that some Chairmen managed to circumvent the structural obstacles that impeded effective relationship building, while others found these harder to surmount. Applying Schulter’s and Lee’s (1993) relationship quality dimensions indicated that, despite the advantages conferred by such heavy duty incentives, relationship quality was affected by failures in directness, parity and commonality aspects in relation to Trusts, but more by failures in terms of continuity in relation to Local Authorities, with whom parity was less of an issue. This chapter uses the same domains to examine LHG Chairmen’s efforts to address policy directives to increase responsiveness and public involvement locally.

As new agencies expected to meet the health needs of local communities, Local Health Groups had to create ways, firstly, to identify those groups that they considered to be their constituents, and, secondly, to find effective ways to communicate with them. This was wholly uncharted territory for the majority of Chairmen, so analysing the ways in which they tackled this aspect
of their remits tells us much about their own views of their roles and priorities. Responsiveness was a key policy aim (Welsh Office 1998a, 1998b) in setting up LHGs in the first place, but Chairmen differed notably in terms of the different groups they included in their own definitions of their 'constituents', and thus to whose interests they responded, and to the priority they accorded these different groups. Again, in this aspect of their work, the divide between strategically oriented Chairmen and their more operational counterparts was evidenced by the different approaches each took to the task of engaging and building relationships with these varied groups of stakeholders. For some, this responsibility to increase public involvement and responsiveness was central to their view of the LHG's remit. For others it was a lower priority, 'tacked on' to the LHG's agenda, and, thus, to which they paid less attention.

Because relationships with these groups were not laid down by statute, the task of developing them required the exercise of subtle skills. As was argued in Chapter 7, such skills in managing 'institutional politics' were considered to be essential leadership competences in creating new organizations capable of change and development. And, again in this section of the analysis, Schulter's and Lee's (1993) relationship domains have proved to be a useful tool in distinguishing between, and reporting on, the ways in which Chairmen dealt with the opportunities and challenges
presented in developing relationships with these disparate groups of stakeholders. This chapter examines, in turn, the more "peripheral" groups noted on Figure 7.1. LHGs were directed to "engage closely with local professional advisory machinery" from an early stage (Welsh Office 1998b, p.4), so the first group considered here are Local Professional Committees.

9.2 Local Professional Committees

As noted in chapter 6, Local Professional Committees (LPCs) held dual roles as advisors to health authorities and as representatives of the independent contractor professions locally. These twin roles meant that they were important stakeholder organizations of LHGs. But the precise nature of their relationships to LHGs was not stipulated in either the policy documents or guidance issued for establishing LHGs (Welsh Office 1998a and 1998b). Therefore, new linkages needed to be developed, and new boundaries drawn. In the case of LPCs, this was complicated by both previous organizational history and lack of clarity about roles. All four independent contractor professions responsible for primary care provision were formally represented on LHG Boards. Nurses, as a professional group, were also represented, but there were no formally constituted professional advisory groups with the same status as LPCs to represent nurses' interests. Many argued, therefore, that the LHGs' constitution simply re-enforced existing fault lines, and did nothing to ensure that the voices of those
actually on the front line, in terms of service delivery within the community health services framework, were represented effectively. Health Visitors, District Nurses, Practice Nurses and Midwives were all subsumed under the general banner of Nursing; Professions Allied to Medicine were left out of the structure completely, as were primary care managers. These representation challenges were further reinforced by the approaches taken by most Chairmen, who tended to prioritise relationship-building with local GPs and with LMCs, and then to leave the rest to chance, or to other Board members, to take forward. But even given this prominence, relationships with their Local Medical Committees presented special dilemmas to all nineteen GP Chairmen.

9.2.1 History LMCs had played the role of appointing bodies for GP representatives in each locality, as reported in chapter 4. This directness of involvement, from the beginning, might have served to reinforce the connections between them and their GP nominees. But two specific challenges countered this: role overlap and representation. Firstly, confusion over roles, or, more precisely, perhaps, territories, meant that the arrival of LHGs was not universally welcomed by LMCs, as the following excerpt indicates:

“They [the LMC] seem not to be sure of their role. There is plenty for them to do but, for instance, I've had a letter from a Chairman who sent a letter to all the LHG Chairmen about correspondence from hospitals and discharge summaries and so forth and that always used to be an LMC issue, but since we've had the commissioning group, like you know, we've been dealing with that kind of thing and one thing we won't
deal with is doctors’ union-type issues...we would like the LMC to stick up for doctors’ Union-type issues. And there is plenty of work for them to do and no one else is going to do that so if they would just concentrate on that and we’ll deal with the consultants with regard to discharge summaries and stuff and all of this administrative type of thing — you don’t need an LMC for that. **But you know, I mean, I had a letter back in reply to that and the chairman still feels that he would still like to be doing that so we still haven’t resolved that one yet...and I might be wrong, you know what I mean? No others completely know, like nobody has said ‘this is what each body will do’, you know. So a lot of it is just down to evolution, isn’t it?” (014.1: 16.05.99)

This Chairman’s report illustrated the underlying tensions between the LMCs and new LHGs, explaining the extent to which LMCs feared loss of authority and role in the face of the new organisations. Many LHGs worked round this problem by maintaining their joint memberships of the two bodies: in many cases the GPs elected onto the LHG were also members of the LMC. Some Chairmen considered this dual membership to be a benefit, as the following excerpt demonstrates:

“And professional committees, LMCs, professions allied to medicine and so forth. There hasn’t been really the involvement, other than...at local medical committee involvement there is, because there are regular meetings between the Chairs and the LMCs and that aspect is good — I would say “4” for that. But when it comes to other professional committees, there hasn’t been the close involvement” (022.3: 12.06.01)

This Chairman gives a relatively positive description of the relationship between his LHG and the LMC. But this dual representation, whilst perhaps supporting one aspect of the directness dimension of Schulter’s and Lee’s typology, nonetheless may have made it difficult for some GPs to see a distinction between the functions of the two bodies. The comment above, for example, made by a relatively strategically oriented GP Chairman
indicated that, for him, despite his emphasis on inclusiveness and the value he placed on multidisciplinary working, his own role, in terms of relationship-building, was focussed on the LMC; he left the relationships with other professional committees to the relevant LHG representative member. Such approaches might have reinforced an impression that GPs' interests were more important than those of other professional groups. And, since representation was heavily weighted towards GPs anyway (ratio of six to one) this impression would be further strengthened. Here, therefore, both history and directness may have been strengthened by the multiplexity of contacts through existing communication channels at the expense of building new, broader, ones.

At the same time, the fact that LMCs were not directly represented as such on LHG Boards, may have added to their concerns about role overlap. Local Professional Committees historically focussed their efforts to influence health authority policy by representing the interests of the relevant independent contractor profession. Mindful of the LPC's traditional role in this regard, one independent contractor Chairman gave it a wide berth from the start:

"I think the problem is that the LMC and the LPC...think they can control the [independent contractors] on the Boards – I haven't been to an LPC meeting on purpose because...I don't take the view that I need to be dictated to...but they have tended to think...that the Board report to them and its not that way at all..." (017.1: 11.08.99)
In this case, *history* provided a warning sign of troubles ahead which this Chairman was keen to avoid. He saw clearly that it was the narrow focus implicit in this background that could potentially have conflicted with the LHG's wider remit. His prediction proved to be prescient, as the next excerpt shows, taken from another Chairman's account of the difficult adjustments some of his Board members (also LMC members) were having to make:

"We have some dysfunction around some of the group, because one of the doctors has insisted he wants a doctors' group, which I didn't think was appropriate and we've had some harsh words about it, and we've had to agree to disagree, sort of thing....I think there are one or two people who really don't understand what they've let themselves in for...they don't understand that they have been elected and selected to a publicly accountable body, and that they have to be very careful that they don't align themselves to groups which may cause conflict of interest..." (019.1: 10.08.99).

Balancing these conflicts was particularly challenging for more operationally focussed Chairmen, especially those who were GPs, trying to find their way towards building an agenda for practical local action:

"What we've decided I think is to look at things in terms of, well, what are the real concrete problems we've got. The real problems we've got are prescribing, the costs, and the uh sort of policy issues. The other big one, which is, yeah, never mind health improvement plans, a big issue, is bed blocking in the X Hospital. Those are two things, two areas, where we think we can help" (019.1: 10.08.99)

Adopting this approach, however, added to the pressure he subsequently experienced:

"I need really though to be projecting myself more to the local professional community. I find I'm establishing good relationships at the top of the hierarchy... [but] it's a communications level problem – I am being asked by the local professional community: "what are you actually delivering?, and the problem is that I have insufficient support to deliver more" (019.1)."
Ironically, then, this narrow and operational focus on medical services may have actually made it harder for this Chairman to be seen to be 'delivering', in the eyes of his LMC constituents. In addition, the communication process he described above is mainly one-way: from the LHG outwards. At the same time, however, he appears to be holding onto an implicit notion of accountability back to the LMC. In such cases, *history*, combined with *multiplexity* and *directness* of links, may have contributed to increased confusion about respective roles as well as to the definition of a narrower agenda for the LHG. Chairmen tended not to refer to other LPCs in their reports, reinforcing the idea that their focus remained restricted to the LMC. This left LPCs to rely on the efforts of the nominated independent contractor representative on the LHG to represent their views, though this representative may not have been a member of the LPC. But for groups without an LPC, such as nurses, or other non-independent contractor professions, bringing a concerted professional viewpoint to the LHG was made even more difficult.

These groups, on the other hand, did not have any previous history of power and influence locally such as LMCs brought to the LHG. Thus, being relatively new to the decision-making process, these groups may have been grateful just to have gained
a seat on the LHG Board in the first place, as this Chairman intimates:

"I think the GPs on the Board, the morale is poor, because they've been involved with commissioning and things before, and they can't...they see that really nothing is happening. For the other members of the Board, like, you know, voluntary services...it's the first time they've been involved with medical stuff, so I think from their point of view things are not so bad" (020.2: 14.08.00)

In this Chairman's view, groups new to the process perhaps perceived a stronger opportunity to try to redefine the agenda for LHGs, beyond existing medical services, than did those with an existing LPC history. It would appear, however, that the ways in which some LHGs worked in practice militated against this. A review of LHG Board Minutes confirmed that the contribution of nurses to Board meetings had been limited and, on the whole, confined to nurse-specific issues, e.g. nurse prescribing and community services, throughout the period of this study. One Chairman tried to support his nurse representative, asking her to lead a particular development but his view of her contribution was not wholly complimentary:

"We even had a Nurse Chair for the group to give it more credibility, and we got a paper written pretty quickly, but it's June and we've still not got it out! It's all bogged down in Nurse-ology" (002.2: 02.06.00)

Such comments tended to reinforce the impression of tokenism in relation to nurse representation.

"Well I think the majority of the Board have been alright but I think a lot of them seem to be on it for their own professional interests, like the increase in various item fees for their particular group. So I'm a bit dubious about the role of these allied groups, and how they actually fit into the structure, and it seems to me when we're talking and discussing, it seems they go for whatever will improve their, like, more funding for pharmacists, or more for optometrists, rather than the corporate view...and I think some of them are still searching for why they are actually there, because a lot of the issues are basically general practice issues and prescribing issues and I think they feel..."
Here then direct representation on the LHG Board was not enough to counterbalance the weight of the multiple links between GPs and the LHG Board, and the historic dominance of GPs in the decision-making process. This Chairman’s attempt to square the inherent contradiction between the representation required by the LHG’s infrastructure and his own underlying view of the role of the LHG as being concerned in the main with “general practice issues and prescribing issues” was very telling. The weighting of representation in favour of GPs at the expense of other professions, the stipulation that the Chairman be drawn from the ranks of the GP representatives, and be elected by them was further strengthened by the historic predominance of the GP professional advisory structure compared to the other independent contractor professions, nurses, Professions Allied to Medicines, and lay and voluntary sector representatives.

Chairmen tended to play a leading role in building relationships with their Local Medical Committees, but were content to leave relationships with other professional committees to the relevant independent contractor representatives, thus potentially distancing themselves from the concerns of other independent contractor groups (022.3). The composition of the Board thus tended to reinforce a silo communication pattern and a focus on operational issues and, therefore, to make the task of engaging
local professionals more problematic. It would appear from the
data in this study that, in relation to LPCs, and wider professional
engagement, history continued to exert a powerful effect,
outrighting the impact of either directness or multiplexity. For
some individual professional representatives, multiplexity was
enhanced by their membership of both professional committee
and the LHG, whilst others, such as nurses, had no such avenues
available.

9.3 Engaging ‘grassroots’ GPs
As argued above, relationship-building was influenced by
individual Chairmen’s views of the LHG’s role and function, so
that the more operationally focussed Chairmen put a high priority
on medical service development and thus on responding to local
GPs’ concerns, while more strategically oriented Chairmen tried to
build definitions of need around the wider community’s views,
rather than along profession or agency lines. The following
section, therefore, examines the ways in which Chairmen worked
to engage their local GPs directly with the work of their LHGs, and
the relative priority accorded them.

9.3.1 Directness All Chairmen were conscious of the need to
persuade and to influence their GP colleagues, but were also
acutely aware of their lack of concrete authority or financial
powers in this regard:
"you've got to persuade them [the local GPs]...the reality is we're hesitant about doing too much because we're not sure how much budgetary freedom we've got" (022.1: 28.10.99)

To offset this, and engage clinicians directly, many Chairmen expressed interest in various forms of incentive schemes, especially in relation to prescribing behaviour:

"There are a number of initiatives we would like to put in place – practice-based initiatives, you know, basically in the areas of clinical governance: prescribing is the big problem, the big practical problem we've got ..." (022.1: 28.10.99)

But even these initial efforts to directly influence GP behaviour were compromised by structural constraints. As was pointed out in Chapter 4, efforts to create a prescribing incentive scheme failed to get off the ground:

"The incentive scheme for medics is another one. We're rolling out formularies here. We've got no incentive scheme except they all want to back it up. We've produced an incentive scheme...we've presented it to the health authority, and they can't do anything because the Welsh Assembly won't make a decision" (017.2: 29.03.00)

This Chairman had taken the precaution of checking the proposed incentive scheme's viability and feasibility with District Audit before taking it to the health authority. Despite obtaining approval from this independent government advisory body, the final go-ahead was not forthcoming. The impact of this was powerful, on both Chairmen's morale but also on their perception of their own influencing ability. Such reverses tended to reinforce existing prejudices and frustrations:

"...the sad thing is that we've got to persuade doctors to alter a culture, and the culture is that they write on a bit of paper exactly what they want. We've got to persuade them otherwise, and the only way..."
you can persuade them unfortunately is with a bit of money, a bit of dosh" (017.2)

So, even efforts to deal with a problem of these practical dimensions were limited by constraints within the decision-making process further up the line. This setback was doubly frustrating for Chairmen, because most looked on effecting reductions in prescribing as a reasonably straightforward “early win” for LHGs, the effects of which would promote engagement of local GPs, as well as achieve significant savings for health budgets locally and nationally. Here again, then, lack of sufficiently direct communication between the LHGs and the Assembly hampered progress locally, and caused Chairmen to question the Assembly’s commitment to LHGs as vehicles for change. By the end of 2001, when LHGs were metamorphosing into the new organizations they would become, the issue of prescribing incentive schemes was still being debated and discussed (LHG Board meetings Minutes, 002).

Despite this failure to operationalize incentive schemes locally, GP Chairmen still traded heavily, throughout the study, on the fact that they were practising GPs themselves. These GP Chairmen noted the value of “being one of them” in terms of persuading GP colleagues to engage with the LHG agenda:

“Selling what we’re trying to do to them from that stance, that’s fairly important” (003b.3: 19.07.01)
"Talking the same language" and "being in the same game" were also cited as crucial supports in promoting GP engagement, together with the ability to "understand what their views are and what they mean when they say things". This, of course, reflects another important aspect of the directness domain noted by Schulter and Lee. 'Being one of them', however, was not sufficient to ensure engagement of local GPs in the LHG's agenda when they perceived their own interests to be under threat (Williams 2002). More strategic Chairmen were aware of this and, rather than relying on history, multiplexity, or directness to deliver the loyalties of local GPs, they tried to engage them by taking a different tack.

9.3.2 Commonality Such Chairmen tried to foster commonality of understanding and agendas. This was a two pronged approach of broadly defining the groups included as stakeholders, and, in parallel, fostering a wide definition of their LHG's aims. Many used their local professional networks as one mechanism for enabling GPs to feed into this process of defining the local communities' needs. But one Chairman went a step further, to formalise this process, by building a series of inter-linked communication networks, across the LHG's area, over the study period:

"We've actually put into being a structure right across X with 4 locality steering groups, which reflect the, all the stakeholders, representatives of primary care and varying members from primary care, there's not a predominance of one member...well basically their essential remit is to win the hearts and minds of primary care, to have
This Chairman used the existing networks of GPs as a bridge across to the wider community, including a wide group of providers. And the aim of this larger network was to create two-way communication with the local community. For the more strategic Chairmen, focussed on creating ways to listen to the local community, the task of building relationships appeared to become easier in line with the extent to which they adopted a broader definition of both need and constituents. Such Chairmen also distanced themselves personally from the task of “meeting and greeting” their GP colleagues, delegating this to others, such as the Clinical Governance lead. Again, this distancing from the more operational issues strengthened their ability to work strategically, whilst at the same time taking their GP colleagues along with them. At the same time, the creation of these two-way communication channels may have added to local GPs’ perceptions of influence, by moving towards increased multiplexity in the relationship.

In a similar fashion, another GP Chairman, who had become increasingly strategic in his approach, over time, reported a complete volte face in terms of mechanisms for engaging local GPs, by the end of the study. At the beginning of the study, he spoke often of resource constraints, in terms of too few personnel on the ground, and lack of financial incentives. By August 2001,
however he spoke of the need for influencing strategies built
around engendering ownership and achievability of goals:

“What really works for me is the ownership...build[ing] people's need,
and desire and ability to achieve targets...lighten the load. There's no
point in telling people to achieve targets...you have to just make it
possible for them to achieve them” (002.2: 13.08.01)

Another Chairman emphasised this support function differently,
recognising the real workload pressures that reducing demand in
the secondary sector created for GPs:

“What we do is actually pressurise people even further, but we can sell it
in terms of support. Because the skill is in finding out which things
are required anyway...so we can help with that. So let’s take some of
the load off you” (003b.3: 19.07.01)

Both of these Chairmen had recognised the need to strengthen the
commonality dimension of their relationships with local GPs by
fostering shared understanding of problems and then working
together to develop common agendas. Creating fora for providing
information about the LHG’s plans and inviting comment came to
be seen as a more valuable tool for encouraging commonality of
aims by the end of the study, than at the beginning. But all of the
Chairmen cited lack of time as a significant constraint on their
abilities to engage their colleagues in such ways.

On the other hand, many of the more operationally focussed
Chairmen tended to emphasize the need to influence their peers in
a distinctly more controlling way:

“Somebody has to be around and keep nosing about and giving them
things to do otherwise they just don’t think you’re there and then you’re
not actually doing anything” (001.3: 06.09.01)
This Chairman reiterated the perception that LHGs were viewed by his colleagues as a poor substitute for fundholding, noting the better match between doctor’s ways of making decisions in terms of speed and autonomy which that model conferred:

“Its influence and people don’t feel as though they’ve got any” (001.3)

For this Chairman to say this, after nearly three years in post and on the cusp of seeing LHGs transformed into statutory agencies, illustrated just how rough a road had been travelled and how difficult the experience had been, in his eyes. Despite the very high hopes he had expressed on taking up the role of Chairman, and the strategic vision he had expressed throughout the study, he was retiring from the fray, battle scarred and weary, leaving general practice altogether, as well as the Chairman’s role. Despite the advantages of being a GP Chairman, trying to maintain his practice commitments and to be seen as “one of them”, the leadership role had required maintaining a degree of distance and thus isolation, and this may have taken a high toll. He was not alone in this, as, by this point in the study, several of the Chairmen expressed similar discouragement. It may be that the isolation from peers, implicit in taking on the leadership role of the LHG, was a factor here. On the whole, however, those Chairmen who viewed their GP colleagues as one among many, rather than as their main constituents, did not experience this same degree of isolation. Rather they seemed to gather strength from building a broader base across the primary care community.
Those Chairmen, who were keen to emphasize the need to build common agendas, tended also to try to create a range of opportunities for communication with their constituents. This appears to indicate the value of commonality and multiplexity, in addition to directness in this context. Parity, in this context, seems to have been considered to have been implicit throughout, perhaps by virtue of their roles as practising GPs.

9.4 Building Public Involvement and Voluntary Sector Links

The same could not be said, however, for lay and voluntary sector representatives. The charge of 'tokenism' in relation to representation on LHG Boards was particularly evident in relation to non professional groups. Each LHG Board included one representative of the general public; they also included a representative from the voluntary sector, often elected by the relevant “umbrella group” organisation for each county area. Despite the policy directive, many LHG Chairmen themselves reported some reluctance to be too proactive in involving the public for a number of reasons. Trying to establish confidence, coherence and corporacy amongst their 18 Board members was a difficult task, without having to conduct meetings in public, as they were required to do. The ambiguity of the LHG's agenda also acted as a brake for some:

“Well...we’ve been a bit low profile. I mean they [the general public] come to our meetings, the Community Health Council, they come on a regular basis and we have the public at our meetings, our regular monthly meetings, so there’s not a problem with that but we haven’t really advertised ourselves too much because we weren't sure what
Most Chairmen expressed similar anxieties about both the concept and conduct of public involvement throughout the study period. These anxieties prompted many Chairmen to adopt a carefully structured approach to Board meetings:

"We have tried to develop a situation where we have pre-meetings where the lay members are briefed on various items so that when you go into the [Board] meeting there are not prolonged silences or questions asked...so we brief the lay people or perhaps our dental or optic colleagues on what is happening" (004.1: 05.11.99).

This stage-managed approach to the LHG’s business was not atypical. The majority of Chairmen expressed doubts about the wisdom of the policy promoting public involvement in the first place. But even those more strategically sophisticated Chairmen who welcomed it, expressed concerns about the extent to which their Lay Representative could be expected to “represent” the community adequately. These Chairmen tended to take a much broader view of what constituted community interests, and therefore, to look at a variety of ways to stimulate dialogue. Thus, whilst the more operationally oriented Chairman quoted above saw little potential for involving the public in the debate about primary care development, others saw real opportunities for building alliances:

"I think it's [public involvement] a vital aspect. I mean that it's been useful - I mean there are a lot of jokes about it, but the Viagra debate has been useful in showing that the cash is limited and there is a flood of other new products coming along the line which are going to be in the same vein, all about - it's not just the next one to hit us will be flu medication, but people are going to have to understand what the debate is all about, it's not just a matter of one government not
funding something, its an issue way beyond that. We cannot afford
the health service that we're used to, and people are going to have to
make decisions about what is funded and what isn't" (018.1: 05.11.99)

This comment also echoed the concerns expressed by GPs in the
run up to the establishment of LHGs: that they would simply push
the focus of decision-making, and therefore the blame, outwards
from the central government to the new local agencies on the
periphery. Here then both history and culture presented
significant barriers to effective lay involvement, at least on an
individual basis. Chairmen who looked at the issue more
strategically, focussed less on their individual representatives, and
more on community groups.

9.4.1 Commonality The most strategically oriented Chairmen
brought the local community into the LHG's decision-making
structures in a number of ways, from involvement in the debate to
creating channels through which they could contribute to setting
the LHG agenda. One LHG developed a multi-tiered approach to
facilitating professional and public involvement, devising
questionnaires for primary care professionals and for the general
public, the latter under the auspices of the CHC, which they
termed "setting the agenda":

"Everybody has had the opportunity to say in the questionnaire what
they think of priority areas...so as regards identification of the issues
[everyone] has been involved right across the spectrum" (022.1:
28.10.99).
Others used public meetings to stimulate broad-based engagement:

"We're about to start a more intensive community consultation...and that will be aimed at a fairly saturated consultation process to get people to - to talk about how they see their health - and with community links of various kinds to get them to think about the health care agenda....

I just think that you've got to be realistic that this is the start of a continuing dialogue...and that it needs to build up, people gradually need to think in terms of communicating with you about these things..." (006.2: 17.07.00)

Similarly, another strategically aware Chairman changed the LHG's sub group infrastructure to encourage the public's involvement in the LHG's work across the board:

"The public participation group which was set up, and with all kinds of airs and graces, and then the penny dropped that every sub group, everything that the LHG did should have public participation. So having a group seemed to isolate - so it reflected on that and then decided to disband itself, and it came to the conclusion that it should disband and brought it back to the Board and said: 'Although you said this is what we should be doing, we don't think we should be doing it. We think it would be best if everybody took it on as a responsibility' " (009.3: 31.08.01)

Implementation of this policy was strengthened by setting up support systems within the LHG decision-making structure to encourage each Board member to take personal responsibility for involving the public in any initiative (009.3). Approaches like this one appeared to be more effective than those which relied on health authority policy steers, which tended to be hastily pulled together to meet required deadlines, rather than carefully thought out or comprehensive documents.
Such approaches to strategies for involving the public may have reflected mixed policy intentions. The dual messages emanating mirrored the NHS’s long held resistance to involving the public in what were, historically, thought to be the business of professionals.

CHCs still existed in Wales during the period of this study. These groups had the potential to bring another dimension to Chairmen’s efforts to involve the public (eg 005; 022), although it is fair to say that CHCs had their own challenges to meet in establishing relationships and raising awareness of their roles among the wider community locally. In some cases, Chairmen tried to forge formal links with their CHCs, to their mutual benefit. One LHG shared premises with the CHC (012), and produced a joint Newsletter for the public; others had regular “slots” in their CHC’s newsletters. Others co-opted a CHC member onto the LHG, affording speaking, if not voting rights, but also enabling more direct communication between the two groups. In one area, where the CHC had been particularly vocal about local health issues, the Chairman was reluctant to strengthen links, again illustrating the effect of history on relationship-building. But CHC links might have helped to offset the potentially negative effects of isolation of lay members on LHG Boards.
9.4.2 Directness

As noted above, lay representatives, as individuals, struggled with a difficult brief: "Well it's very difficult, isn't it? How do you represent the public as an individual?" (018.1: 11.08.99). Other Chairmen were less sympathetic to this problem: "The public knows nothing" (004.1: 05.11.99). This dismissive view may have reflected the tradition within the NHS generally to debate issues in technical terms (Harrison et al 1992) but it serves to highlight the cultural barriers prevailing and thus the size of the challenge which 'public involvement' presented to these predominantly medical Chairmen.

Despite their direct presence on the Board, many lay sector members were subject to complaints about their lack of any real representative-ness, due to the lack of a clearly defined constituency; this charge often undermined their legitimacy and thus the credibility of their contributions. The voluntary sector representatives, on the other hand, may have been able to be more effective because the obverse was true for them. Moreover, once LHGs took over responsibility for allocation of the health authority budgets for voluntary services, there was a ready-made commonality of agendas. The more strategically focussed Chairmen capitalised on this mechanism from the start:

"We're trying to get local groups to sign up to our Compact, you know, the agreement with local voluntary service groups in this locality? We did this, and launched it last week; Alun Michael came to launch it and we have contacts through that, and we're using the network which is
there. Because I think that people in the community, they’re comfortable with the way they can communicate their feelings whereas a big consultation exercise, very often, in our experience, it doesn’t work because you have two men and a dog turning up, and they may not be representative…” (007.1: 23.12.99)

These channels were perceived by this Chairman as being a vehicle for collecting information about community needs, which would then be fed into the Health Improvement Programme in an iterative process (007.1).

These “compacts” were also used as springboards for broader local activity, sometimes to stimulate debate, as well as to build local ownership of the agenda. The ensuing dialogue was strengthened through the number of channels used: The CHC had been offered Observer status on the LHG Board and patients’ organisations’ representatives also regularly attended Board meetings in this area. This approach was a good example of the value of multiplexity in enhancing relationship development. In this case, the strength of the local authority’s interest and commitment was seen as an additional spur to voluntary sector communication about health needs in this area. Access to the voluntary sector budget was however not universally available across Wales:

“We were hoping to take over more of the voluntary sector budget...last year it was nominal because by the time we got the information it was too late, because, you know, to do anything. And this year it’s still not clear how much of the decision making will come down to the Group...” (020.2: 14.08.00)

Here the language is revealing about the levers of power and the LHG’s position in relation to them acting as a brake on
development. Where budgets were devolved, their value may have lain in their ability to act as a spur to gathering increased resources over time. For example, another strategically oriented Chairman, faced with real difficulties in terms of local authority representation built links through a longer term strategy, creating geographically based channels initially and then providing support for working up bids for additional financial support to different community based groups:

"And the intention has been to develop locality groups which cover a whole area...a means by which people in a particular area of the city can feel they can have a route through the decision making process...I think it's the only way that we can tackle the quality problems...[and] address issues within the locality, we just can't tolerate such variations in health outcomes and so on and we had to tackle these issues...and we felt that it ought to be a natural development that should be allowed to go on in these various areas which would allow the process of encouraging people to participate and feel they can make a contribution" (010.2: 06.04.00)

By the end of the study this Chairman was able to report:

"We have a huge range of community developments in X, we have an absolutely huge range, and it's so many that I couldn't even begin to list them all for you" (010.3: 24.07.01)

This approach had not only proved successful in encouraging community support and involvement for the LHG, but had put the LHG at the service of the local community. It had also had the effect of opening up access to a range of funding for different initiatives, thereby increasing the flow of money into the community and enabling the LHG to, effectively, increase the resources available to stimulate service development and quality across the service provider community. (010.3)
This synergy between the local authority, the voluntary sector and the LHG sprang directly from the community development approach adopted by this strategically oriented Chairman. Here, although directness was compromised through lack of statutory representation, the direct responsibility for the budget allocations helped to stimulate commonality of agendas in a meaningful way. Multiplexity was encouraged by such an approach too. Parity may not have been achieved, but this may not have been possible within the short timescale of the study. In addition, the lack of any previous formal relationships between these groups may have weakened the potentially adverse effect of shared history.

9.5 Politicians

LHG Chairmen’s efforts to introduce their new organisation into the local community did not always recognise the potential value which politicians could add to the process. Where Chairmen did try to use this avenue, however, they met very mixed responses.

One Chairman, working in a geographically cohesive area, was delighted by the extent to which local politicians responded to the LHG’s presence. This Chairman used the media effectively to highlight key health problems facing the community:

"Well, basically, because of the headlines that we’ve got on the coronary heart disease initiative and the fact that we were given a half hour slot in the Council chamber and it went on for an hour, you see!" (022.2: 10.08.00)
This link had been created firstly by the LHG’s invitation to the Chairman of the Council to officially open the LHG. This astute move generated publicity locally and stimulated local authority engagement:

“You know and no doubt we, well there’s no doubt, I’m sure we’ll be invited to go there again to talk on health issues as well, so I’m sure that there’ll be, you know, there’ll be a forum for us there, really.” (022.2)

This localised approach was often more effective than trying to interest politicians with a national remit. One Chairman (014.2: 24.05.00) reported his disappointment with how little interest in or knowledge of LHGs his own MP, a member of the dominant party at the time, evinced. Despite the strong centralist tendency of the government, interest in the new local groups was not high amongst national representatives, according to Chairmen’s reports, as noted earlier, in chapter 5.

In contrast to this, the local political dimension was deemed both essential and effective by one Chairman, reflecting on lessons learned during his three years in office:

“I think the things which I think are very important and is something which I am doing now is to foster relationships with the local authority and the local politicians. Because I think that the way ahead really is for politicians to be aware of what’s happening in health locally. And that’s something you would need to do. Because that way they can vent feelings with their networks and they will know exactly what problems are being faced...”(022.3: 12.06.01)

This Chairman’s views reflected the reality of the political responsibility and control on health service decision making, but not all Chairmen attempted this approach, many feeling shy of promoting themselves in the face of lack of clarity about the LHG
agenda. The lack of a clear steer from the Welsh Assembly Government was bemoaned by many Chairmen, throughout their period in office, as one of the most crippling factors they faced. This may well have added to their reluctance to make more overtures to their politician colleagues. But, whereas commonality of agendas might have been predicted to be a useful lever in relationships with national politicians, the experiences reported by Chairmen in this study indicated that this was more the case at local and national (AM) level, than at the UK level, via MPs.

9.6 Press

Chairmen approached the media with even more circumspection. Again many expressed reluctance to try to broadcast messages or “raise public expectations” until they were clearer about their own agencies’ roles, functions and potential contributions. Only a small minority even tried to be proactive in this regard:

“Well I think it’s important – we’re going to have to involve the public and that is not an easy thing to do, so the first thing we have tried to do is to create an association with the local press. I think certainly with two of the local papers we’ve got an agreement to have a regular slot in the paper so that we can link that into the Board meetings so we can follow on from the Board meetings with a monthly slot in the local papers.” (018.1: 11.08.99)

This LHG Chairman was also among the first to create an LHG Newsletter to communicate with constituents. In this case, the media was seen as a bridge to another, wider group, and thus was perceived as useful. Most Chairmen, however, viewed this channel as bringing more costs than benefits. Nearly all Chairmen remarked on the need for caution with this
unpredictable potential partner whose need to sell papers through stimulating controversy would inevitably conflict with their need to explain complex issues. The commonality of agendas here was reported as low, alongside what many Chairmen deemed to be a much larger parity imbalance too.

9.7 Summary In this chapter and the two preceding it, it has been demonstrated that relationship-building was an important, but difficult, area for most LHG Chairmen. Schulter's and Lee's typology indicated that effective relationships needed to be built along several dimensions more or less simultaneously. These dimensions included commonality of aims, trust and risk sharing (parity) fostered by direct communication links, preferably on a number of different levels (multiplexity). It would appear from the data gathered in this study that the structures and tools put in place via the establishment of health alliances and pooled budgets were often counter-balanced by other structural constraints placed on the evolving health and local authority systems. These often made it difficult to jointly exploit opportunities effectively. In addition, previous local history has been shown to have had a strong impact on the formation of relationships locally, making the development of trust a slower and more arduous process. If clarity of objectives and shared purpose is an essential element in the process of building trust between partner organisations, then the lack of this clarity may have been one of the most important constraints on LHGs' development:
The single most important relationship, in terms of impact on the development of LHGs, was that forged between the Secretary of State for Health and Social Care and the LHG Chairmen as a group. In a structure in which no statutory links or direct channels existed between the Assembly and the new local health care organisations, and so little clarity about LHG purpose from the WAG, this direct link enabled the Chairmen to get reassurance that their vision was shared by the Minister and that their efforts were supported. This assurance was much needed in the face of so many violations of Schulter's and Lee's pre-conditions for effective relationship building. Those Chairmen who did perceive that their efforts to build relationships had been effective tended to be those who had adopted a broad and inclusive definition of the LHG's constituents, and who worked to develop a holistic definition of community health needs. In addition, they worked systematically and deliberately to create communication channels between the LHG and community groups, to foster ongoing dialogue. The next chapter examines the specific levers that Chairmen used to create unique identities for their LHGs, which enabled them to develop as organizations themselves receptive to change and growth.
Chapter 10 Building Organizational Identity and Capability

10.1 Introduction

This chapter looks back over time to analyse the ways in which Chairmen, as leaders of their new organisations, selected specific features of their LHGs to create distinctive organisational identities and then built upon these features to create new organisational capabilities (Miller et al 2002). This analysis examines both the features selected as distinctive to their organizations, and the processes that identified Chairmen applied to exploit them. This leveraging process has been referred to, in the literature, as "managing from the inside out" (Miller et al 2002, p.40). This chapter illustrates the ways in which Chairmen succeeded in mining their organisations' skills and knowledge bases to build unique products that not only worked to increase their organisations' capacity, but also helped them to differentiate themselves from other potential competitor organisations. This leveraging process also ultimately enabled these Chairmen to lift their LHGs out of the political treacle which embroiled and swamped many of their more operationally focussed counterparts across Wales.

The Chairmen identified as exemplars in this chapter are those five who emerged through the course of the study as describing a more
strategic orientation to their roles as Chairmen, as argued in chapter 6. As was explained in Chapters 4 and 5, all twenty-two LHGs had been established to the same specification (Welsh Office 1998a and 1998b). It would seem, then, that there was very little room for working differently within these stipulated guidelines. Nonetheless, as previous chapters have demonstrated, more strategically aware Chairmen, with the breadth of vision to articulate a unique approach to using their LHGs as vehicles for developing their local communities, and the leadership skills to build key relationships and alliances to persuade others to support their aims, were more able, more consistently, to move around the prevailing structural and political obstacles to create distinctive organisational forms locally.

We saw in Chapter 6 that ‘strategic vision’ – the ability to articulate an attractive picture of a desirable future state of being, and to persuade others to engage in the development and implementation of that vision, as chapters 7, 8 and 9 demonstrated, was a distinguishing feature of some Chairmen’s behaviours, throughout the study period. But, in addition, some Chairmen ‘played to their strengths’ further, by exploiting their unique organisational positioning as the one group that could legitimately lay claim to represent the whole community’s health needs. LHGs were the only group that could claim credibility to lead multi-agency partnerships
to reconfigure health services locally. Trusts had more incentives, financially and culturally, to maintain the status quo in service delivery terms, since they were paid according to activity. And, despite the continuous fog of uncertainty and ambiguity in which they were working, many of these identified Chairmen showed the ability to maintain a more consistent focus on their own emerging agendas. While virtually all the Chairmen seemed sure of their roles in developing and changing primary care locally when LHGs were first established, many grew less certain about what this meant and how to operationalize it, as time went on. By the autumn of 2001, almost all were anxious and uncertain about what their future organisations would look like and what the roles of GPs might be within them – if indeed they would have a role at all. This degree of environmental uncertainty destabilised the actions of many of the Chairmen. Only a handful displayed, through their own reports, a consistent ability to rise above this confusion to concentrate their own, and that of their organisations, energy on delivering a unique contribution locally.

This ability, to exploit their organisations’ potential effectively, differentiated these Chairmen from many of their Chairmen colleagues. Looking back over the study period, this chapter examines the ways in which these identified Chairmen leveraged
their organisations' assets and capabilities, thereby enabling them to "locate power and self identity" and then to build on this achievement to "win greater freedom of action" (Giddens 1999 in Butler, MJR 2003, p. S49). 'Leveraging' refers to the "mobilization of skills and resources" (Miller et al 2002, p.37) and "the mechanisms used by leaders to shape and influence policy implementation" (Butler 2003, p. S54). Section 10.2 outlines the specific organisational assets and opportunities that these Chairmen identified; Section 10.3 examines the ways in which these identified Chairmen "leveraged their asymmetries" (Miller et al 2002; Butler 2003) by exploiting these organizational assets over time. Section 10.4 explores the ways these Chairmen capitalised on the opportunities identified, over the time frame of the study. Section 10.5 concludes the chapter by arguing that this process of mobilisation, or leveraging, enabled these Chairmen to develop a capacity for implementation within their LHGs that in turn created a degree of receptivity to change which was unique to their respective organisations in comparison to the other 17 LHGs in Wales. This receptivity to change is increasingly acknowledged to be a key characteristic of successful organisations in both the public and private sectors (Pettigrew and Dawson 1994).

This analysis of organisational assets and opportunities has been undertaken longitudinally, across all three stages of LHG
establishment and development, between 1999 and 2001. The three tranches of interviews can be said to mirror three reasonably distinct phases of LHG evolution during the course of the study. The initial phase, April to December 1999, could be termed the formation stage. In reality most Chairmen reported that the formation of their organizations was still being undertaken during the second tranche of interviews, because of the instability in the environment locally and nationally. But it is also clear that, by that period, March to September 2000, they were all heavily engaged with the business of trying to create local initiatives and develop their organizations as well. In the final interviews, conducted between January and October 2001, consultation on further structural change was already underway, forcing Chairmen’s attentions on to the future, so this could be termed the ‘evolving’ stage. In some ways these three stages: formation, development and evolution, can be viewed as similar to Adair’s (1986) typology of the three stages of development which groups pass through, in the process of becoming effective teams: forming, norming and storming, as they come together as a disparate group of individuals to form a team, move on to develop standards to which to adhere in working together, and then testing those standards to the limit as they move on to settle into effective performance modes as teams. These three stages of growth provide a convenient way to look at the ways that identified Chairmen appear
to have, firstly, honed in on specific organizational assets and opportunities, within their LHGs, in the initial phase, of LHG formation, from April 1999-Summer of 2000, (the ‘forming’ stage). And secondly; the ways in which these Chairmen capitalised on these features and exploited these opportunities in the second (‘performing’) phase of LHG development, to create distinctive organizational identities and capabilities by the third (‘evolving’) stage. These three ‘stages’ are artificially constructed, but they do appear to fit the data emerging from the interviews throughout the study.

10.2 Organizational Assets and Opportunities

From this longitudinal analysis, seven features stand out as differentiating the activity of these five LHGs. Three relate to organizational characteristics that were distinctive to each LHG from the outset: (1) the existing level of practice development; (2) the nature of the infrastructure and resources initially allocated to them; and (3) the level of instability in their local environments. Because they are specific to each individual LHG these are termed “assets”, or ‘assymetries’ in Miller’s et al’s (2002) terminology. In addition to capitalising on these distinctive existing organizational assets, these identified Chairmen also exploited four key opportunities presenting to them: (1) the formation and development of their Boards; (2) the
development of an over arching agenda focused on primary care development; (3) putting clinical governance at the centre of the LHG's agenda; and (4) applying a learning orientation towards their roles as Chairmen. These four opportunities were, of course, common to all twenty two Chairmen. Indeed, the first three are specifically noted in the Chair's Job Description detailed in Chapter 6. The distinguishing behaviours here, though, are the ways in which these identified Chairmen used these opportunities, to go on to create unique organizational identities locally, and, in so doing, to create organizations that were themselves receptive to change. The following sections of this chapter explain how this was accomplished for each of the assets and opportunities identified.

10.3 Leveraging Assymetries

When LHGs were first established, in April 1999, existing levels of practice development locally varied considerably across Wales. Against this backdrop, however, positive features noted by identified Chairmen included geographical spread, IT uptake, and previous experience of commissioning of services.

During the 'forming' stage, in each of the five selected LHGs, the existing level of practice development was embraced by the LHG Chairman as an asset, rather than a liability. In one LHG, where the
Chairman had personally facilitated the establishment of a local Out of Hours (OOH) cooperative in the face of a relatively lower level of practice development and a higher number of single-handed practices, this same relative weakness was articulated as a strength (009.1). Similarly, another strategically-aware Chairman, covering a rural area over which a large number of practices were dispersed, making physical contact with them time-consuming and difficult, nonetheless noted this as a strength:

"And the other thing as well in Xshire is that most of the practices are at the same sort of structural and organisational level." (005.1: 26.10.99)

Thus the willingness of these Chairmen to accept the existing level of practice organisation and development and build on it, rather than to term it an obstacle, was noteworthy in this study. In contrast, many other LHG Chairmen reported similar levels of practice development as problematic (e.g. 011.1; 004.1),

Similarly, identified Chairmen referred to the geography of their "patches" as an asset, particularly in relation to its impact on the spatial distribution of practices across the areas for which they were responsible for service provision.

"Well I think X...it's easier, and being relatively small, I think that's one big thing" (022.2: 10.08.00)

This Chairmen could rightly have complained about his relative isolation, but, instead, he noted that the small size of the area was
helpful in enabling him, physically, to get around to each practice, and thus to develop dialogue through personal contacts. In larger areas, this responsibility was sometimes delegated to the Clinical Governance Lead, bringing with it a more distant relationship to the Chairman.

The extent to which general practices were connected to Information Technology services, and were using this to generate data relevant to performance management, was also perceived as a real asset (e.g. 006.1), by these Chairmen, because it enabled an effective monitoring process to be conducted, giving feedback to practices on relative performance. This was especially useful for areas of concern, such as prescribing rates. Accessing up to date prescribing data across Wales was reported to be problematic throughout the first two years of the study, so being able to access and use locally generated data was a real bonus.

Finally, previous experience of commissioning local services was another aspect of the existing level of practice development that these identified Chairmen tended to view positively. They reported both their own, and their GP constituents' previous experience, whether of fundholding or of locality commissioning, as assets, providing a good springboard for future development activity. Other Chairmen,
however, tended to emphasise the negative aspects of such experience. For example, more operationally oriented Chairmen, especially former fundholders, emphasized the consequent loss of services, and of organisational and information management skills in the wake of fundholding's abolition:

“One of our problems is that because half of the practices in Xshire were fundholding, we have had the deterioration in our own practice administration in that we have had the redundancies and sackings in the various organisations so staff are demoralised, patients are not getting the service they used to get and so they wonder why; there is a bit more chaos in the waiting rooms – so there has been a deterioration in service” (004.1: 5.11.99)

Previous involvement in either form of commissioning, on the other hand, was perceived by these identified Chairmen as indicative of interest in and commitment to a broader quality improvement agenda, too:

“...we had locality commissioning groups for one...and we had the TPPs. So in a sense we are slightly head of the game in terms of the mutual trust between practices (005.1: 26.10.99)

From the outset, then, these features were referred to by Chairmen as indicative of local GPs' willingness to engage in the effort to change their way of practising and providing services to patients.

As they moved into the 'performing' stage, the second stage of LHG activity, the existing level of practice development was leveraged by those Chairmen who used any putative locality groups to construct two way communication channels with the LHG. These channels
then fed issues and views on needs directly to the LHG in bottom-up fashion. By definition, they enabled a wider constituency to be included in this process. In one LHG, by the end of the study, in the 'evolving' stage, this approach had become an integral part of the community development strategy:

"...we've actually put into being a structure right across Xshire with four locality steering groups, which reflect the...all the stakeholders, representatives of primary care, and varying members from primary care there's not a preponderance of one member...Their essential remit is to assist this dialogue between the community and the LHG" (010.3: 24.07.01)

This outcome, of course, was not accidental; it had proved to be an arduous and uncertain process to establish such extensive and comprehensive communication channels:

"It created far more difficulties achieving that than I originally thought...but we are achieving it! (010.3).

Despite the time and effort involved, this Chairman had shaped this existing channel into a useful tool for collecting a wider range of information on health needs from an increasingly broad spectrum of the community:

"Increasingly the agenda is coming together in terms of primary care development, clinical governance, local health action plans...[then] we had a formal launch...and we didn't let them go away until they'd begun to prioritise some early issues..." (010.3)

This excerpt shows that, by the third stage of LHG development, the 'evolving' stage, a local agenda was being articulated. This is a good example of the way in which an existing organizational asset, which though perceived as problematic by some Chairmen, was identified,
and shaped positively, and then leveraged to enable a unique organisational capability to be developed.

These identified Chairmen took similarly positive and proactive approaches to developing their infrastructures. In the ‘forming’ stage, as chapter 6 indicated, GP Chairmen’s day jobs as independent contractors gave them independence and autonomy, both in terms of how they worked and their personal priorities. This brought an element of history which complicated their relationships with health authorities. This background was initially problematic in ‘forming’ constructive working relationships with their General Managers. However, those Chairmen who were able to develop this key relationship over time were able to work more constructively to strengthen the LHGs’ sense of identity and purpose. LHG Chairmen who were content to accept the constraints imposed by their positions as sub-committees tended to accept premises and secretariat staff proposed by the health authorities. This often meant sharing premises within the health authorities’ own headquarters. Since the general managers were employees of the health authority and directly accountable to the Chief Executive, loyalties as well as responsibilities were blurred, as earlier chapters outlined. General Managers were under strong pressure to give their first loyalties to the health authorities. At the same time, General Practitioners, as a
group, were traditionally neither well understood nor regarded by the secondary sector management community. Yet each of these strategic Chairmen managed to wean their GMs away from these hierarchical and cultural pressures to conform to health authority interpretations, to work with them to create their own local organizational identities. Chairmen initially approached this key relationship with some misgivings, expressing concerns about both the recruitment process and skills levels of the newly appointed General Managers:

"Unfortunately there wasn't enough money given in the salary structure to get in people to General Manager jobs. Where they could stand up to executive directors at the health authority" (005.1: 26.10.99)

Strategically oriented LHG Chairmen were keen to build a unique vision for their LHGs; the divided loyalties of general managers imposed considerable constraints on their ability to support this. During the 'forming' stages of LHG activity, Chairmen, as we have seen earlier, adopted pragmatic and operational roles in order to get their LHGs functioning1. By the end of this period, however, many were beginning to question the wisdom of this approach, on grounds of both time commitment and expertise. Once they had successfully recruited General Managers, several Chairmen recognized the need to step back from the operational role. Those who reportedly

1 The researcher's field notes record the difficulties that most Chairmen had to operate within in terms of lack of LHG premises (many worked from their practice libraries, for example); lack of secretarial support (difficulty with locating papers was an inevitable consequence); and relative isolation.
accomplished this did so by a combination of reflection and negotiation.

In the 'performing' stage, these strategic Chairmen, despite their roots in – and expressed preferences for – rolling up their sleeves and getting their hands dirty – learned to step back from the day-to-day responsibility for running the office and implementing their agenda, and to concentrate on their own sphere of responsibility. They appeared to learn the need for, and the ability to, delegate effectively, and their General Managers responded by rising to the challenges given them. This enabled a more effective working relationship to develop, in which each partner was able to play to his and her own strengths:

"And then, I believe, you've got to delegate down from that, that the office should be run by the General Manager, and that the General Manager should make the [secretariat] appointments. *All this the Chairman needs to know about, but you have to ask that the responsibility be taken by the General Manager, and her immediate team; you have to allow the process to go on*" (007.1: 23.12.99)

"So, it comes down to... *it's very interesting what happens is that XX and I have to take a joint approach. She does the sort of trying to get around with, trying very hard to persuade everybody, and then she comes back to me and says, 'he won't let us spend this GMS money because he thinks that we ought to....'...[and then] *it is my job to try and persuade [them] that this is the right way to go forward. But, I mean, that, to me, is something that I'm easily trained for. I enjoy the sort of battles with the health authority...*" (005.1: 26.10.99).
In 2001, this latter Chairman looked back on the relationship and its evolution during the period of study, to describe how this change had taken place:

"I think the first of it is to realize that you have been criticized many times in the past of being far too much of an executive chairman, and that's true to a certain extent. I think, as the years have gone on, I've got much less at that. But at the start, when you're setting up something new, you want to be, you know, you want to be in there doing it all the time. And actually it's a matter of learning trust between yourself and your general manager, really, and allowing [her] to get on with it. And that's a relationship that's grown very well" (005.3: 30.08.01).

This Chairman identified the absence of a Chief Executive at health authority level as one of the features that had both aided the development of a joint approach between him and his GM, but also which had left his GM isolated and under-supported (005.3). The absence of the Chief Executive, however, also created space, which enabled this approach and relationship to develop beyond the constraints imposed by the existing structures, thus allowing a more effective working relationship to develop between Chair and GM.

In the final phase of the study, the 'evolving' phase, the general managers, as a group, had grown in sufficient confidence to decide to 'throw in their lot' with that of the LHG. This was, no doubt, further helped by the decision to remove the health authority tier, announced at the beginning of 2001. But it was the all Wales GMs Group that led the work on developing a “Futures” paper for the Assembly, detailing options for organizational structures for the
future. During this process, the Trusts emerged, re-energized, to put in counter proposals which would have seen LHGs become integrated into Trusts. Despite this, LHG GMs and their Chairmen worked effectively together to develop a more primary care oriented vision for the future, which, eventually, was implemented by the Assembly. It is perhaps a measure of these identified Chairmen's skills that they had managed to win such loyalty from their GMs, in the midst of a process dominated by health authority and Trust managers, and against the history of their respective backgrounds and experience.

Finally, identified Chairmen also stood out for the approaches they took to managing uncertainty. As Chapters 4 and 5 demonstrated, the health system in Wales was in considerable flux when LHGs were established, creating a unique set of opportunities and challenges for newly appointed LHG Chairmen. A number of senior posts changed hands during this period, creating numerous vacuums in authority. Those Chairmen with the ability to exploit this situation, to create freedom of action, tended to thrive in this environment. Others reported to find the lack of concrete direction a further hindrance to development activity. These vacuums were used as opportunities by all of the strategically-oriented Chairmen, but in different ways, depending on their local situations and contexts.
Strategically-aware Chairmen were frustrated by the strictures imposed by their Health Authority parent bodies but were rarely really constrained by them. These Chairmen implicitly recognised that real power resided in the Trusts and in the Assembly.

Consequently they tended to tailor their influencing strategies towards these key agencies, even during the initial ‘forming’ stage:

"The LHG arranged a meeting with Jane Hutt...and we had the Chair of Social Services there, the X Trust Chair, ourselves and the [health authority] chairman, and sort of presented our aims and objectives and our future direction. And basically got her to sign off that really this was the sort of thing she wanted to see..." (005.1: 26.10.99).

By the middle phase of LHG development, the ‘performing’ stage, some Chairmen had decided that the most effective strategy was to bypass the health authorities as much as possible, and work to align their stated aims to those of the Assembly, and in particular, the policies of the Health and Social Services Minister. This was not always a comfortable path however:

"I think there is total frustration [among the LHG Chairs] that there is no direction from the centre. Jane Hutt keeps coming out and saying Local Health Groups are the way forward and everything else, but I don't know what she tells the health authority...it's very difficult being in the position where you are getting the bricks thrown when you don't really know which...where you're going" (005.2: 12.06.00)

A smaller sub set of these Chairmen also carefully aligned their LHGs' agendas with that of the Assembly itself. Doing so proved to be a constant challenge, however, as the Assembly’s lack of clarity and direction was continually bemoaned by most of the Chairmen.
throughout the study. But by making concerted efforts to align their LHG’s policies with those of the Minister, and by continually checking that alignment, these five Chairmen gained confidence in their ability to progress their aims, despite the obfuscation of formal political pronouncements:

"Because I think for all of us in X Shire, I think the last six months have in a sense been quite frustrating in a way not knowing whether our vision and direction was what everybody was signed up to" (005.2: 12.06.00)

whereas securing Jane Hutt’s approval of their vision and direction had a real liberating effect: “and, I think, Jane Hutt’s meeting sort of just managed to do that. So, we felt quite released; after that I was able to say ‘Well, great, you know, we’ve got sign up from the Centre’” (005.2).

Here the combination of a vacuum at the top of the health authority, requiring the authority Chairman to play something of an executive role, together with the LHG Chairman’s strong commitment to integrated partnership working, which the LHG had adopted as their main aim, enabled a direct link between the LHG and the Minister to be created and subsequently exploited, to the LHG’s benefit. It is unlikely that this link would have been established without the Minister’s prior commitment to quarterly meetings with the all Wales LHG Chairs’ Group, but it proved to have been a useful and effective tool for this otherwise rather isolated LHG. Given the local Trust
Chairman’s close personal links with the Minister (005.3: 30.08.01), the LHG had to persist strongly and sensitively, during both the ‘performing’ and ‘evolving’ stages, in putting its case for further growth and development forward. Here again, LHG Chairmen were hampered by a lack of any training or development – and certainly of encouragement by their health authorities – to go down this route. And since the Assembly was such a new organization, there was no map or history of effective lobbying to use as a template. The three Chairmen who did use this approach, 007, 010 and 013, of identifying local needs and building community wide coalitions to address them, and carefully tailoring the expression of those local agendas to Assembly policy initiatives, also appeared to have engaged the Assembly’s interest and support by the end of the study.

These three assets: the existing level of practice development, the infrastructure within the new LHG, and the nature of the vacuum in authority prevailing locally, can all be termed as organizational “asymmetries”: features that were distinctive to the LHG in question, and that LHG Chairmen identified as such and then leveraged, or exploited, to build a distinctive organizational identity locally. The following sections take this argument a stage further, by examining the ways in which these same Chairmen exploited specific opportunities presenting themselves.
10.4 Exploiting Key Opportunities

The four opportunities listed in section 10.2 were, of course, common to all LHGs, as pointed out earlier. But these identified Chairmen used them in ways that enabled them to optimize their effects, and thus contributed to the development of unique local identity and purpose.

The first of these opportunities was noted by most Chairmen as a real challenge: the formation of a cohesive Board. Chairing a Board is generally regarded as a demanding leadership task (NLIAH 2006), usually allocated to individuals, at later stages of their careers, able to draw on credibility and authority gleaned from previous experience and seniority, usually also at Board level, from a variety of organisations. The ability to take a strategic view is a particular asset for the role. LHG Chairmen lacked that sort of experience, but were expected to create a cohesive group from a singularly disparate collection of individuals, including other professionals who were more experienced in working independently than collaboratively. Virtually no training was provided for this role, other than the Job Description noted in Chapter 4. Consequently, most expressed concerns about this aspect of the role:

"I felt the groups were too large and I wasn't clear what the roles of the other independent contractors are, why they had to be full members, so I was sceptical from the start [laughter] and I'm even more sceptical now! I'm still not sure that there is a clear role for each of the members. It is a
The excerpt above highlights two aspects of this challenge: the size and diversity of the Board membership. Any group of eighteen people presents challenges to the individuals responsible for facilitating or leading them. LHG Boards were larger than most corporate Boards, consisting of between 10-15 people. Belbin (1981) argues that nine is the optimal number of people who can work effectively as a team.

The size of the Board’s membership was compounded by the variety of backgrounds, knowledge and experience of health services possessed by the individual members of each Board. Although Boards had been constructed to represent the major stakeholder groups relevant to primary care service delivery, GPs had been given multiple voices, thus their views of the purpose and function of the LHG Board was likely to predominate. Medical expertise and experience was potentially more heavily weighted, and more highly valued, than that of other Board members, each with fewer votes. This disparity in experience was particularly pronounced in relation to lay members, and voluntary sector representatives, whose perspectives were not always equally valued by their Chairmen (e.g. 002; 004), as was demonstrated in Chapter 9.
But identified Chairmen stood out among the rest of their colleagues for the inclusivity of their approach to these problems, even during the initial ‘forming’ stage of LHG development. Each of these strategically oriented Chairmen was noteworthy for the intrinsic value they accorded to the views of all of their members, irrespective of background. Indeed, they positively embraced the diversity presented to them as being a source of legitimacy to speak on behalf of their local communities:

“Anyway I think in the bigger picture of the LHG the other thing that was interesting was having to sit round the table with other players – I thought that was quite funny particularly our group – amazing people, such a diversity of personality types and I’ve warmed to it, it has been a bit frustrating the velocity of it, but perhaps that’s wise that it hasn’t been very fast; we have made good relationships which didn’t exist before” (009.1: 20.08.99)

This Chairman capitalised on members’ individual commitment to improving services for their communities, to foster the notion of the LHG as a community-wide resource:

“One of the tricks we’ve been able to move towards is being seen as part of the localities, not as some kind of Big Brother” (009.2: 20.06.00).

Several Chairmen took this inclusivity a step further by using the CHC as a channel for eliciting the views of the local community, distributing baseline questionnaires for the HIP via supermarkets, or holding focus groups to discuss specific issues. These Chairmen embraced, from the beginning, the multiple perspectives brought by their Board members and leveraged them to legitimate the LHG’s position as the voice of the local community’s perspective on health.
care. Less strategically aware Chairmen viewed this multiplicity of representation as a negative feature, and yet another hurdle to be overcome, rather than as an opportunity.

GP Chairmen also lacked experience of inculcating corporate accountability. But, as noted in the Job Description, each Chairman was expected to develop a degree of corporacy amongst his LHG Board members. As Chapter 9 indicated, many Board members' views of what this meant varied tremendously (e.g. 019). Though all Chairmen struggled to generate a sense of corporate responsibility, more strategic Chairmen tended to do so by encouraging individual member's responsibilities from the start:

"So all these sub groups [were set up] and I made it quite clear I expected each and every Board member to be an active participant in one or more of these groups, so every single person, and actually, some are in two or three, but everybody is involved in the sub groups so they are actively working to some sort of direction which reflects the core work of the LHG" (010.1:16.08.99)

Clarifying individual roles and responsibilities appeared to foster members' commitment, from the outset. Board formation was further facilitated, by the more strategically aware Chairmen, by paying careful attention to the selection and appointment of sub group leads:

"We thought that there were people with skills who could lead those sub groups, perhaps to finish jobs going on and help keep up the pressure... So, we're happy that we have quality people to lead these groups from within the Group. I think it gives them identity, it gives them the responsibility and makes them feel more part of the Local Health Group" (007.1: 23.12.99)
Rather than relying on volunteers, this Chairman systematically matched skills of his members with the needs and remits of the different sub groups. This was seen as an important part of the Board development strategy by these Chairmen, and this impression solidified, as one reflected, looking back over the three-year period:

"We thought very carefully about the people who would be involved in the subsets [working groups of the LHG], and we thought that perhaps those were the people who would be best suited to become involved in those areas. We haven't been far out, I don't think" (007.3: 25.07.01)

This in turn helped to engender a feeling of shared responsibility and corporacy. And of course, as noted earlier, those Chairmen who used the shadow stage to facilitate members' articulation of a shared agenda fostered this sense of cohesion further.

Once formed into a more or less cohesive and corporately focused group, Board members needed further development in order to perform their roles effectively. But this was another area for which Chairmen received little formal preparation, training or resources. Chairmen referred to the skills needed to ensure equitable contributions from members, as well as the need to ensure that meetings were focused. But that limited definition gave no inkling of the sort of skills that would be required in the LHG Chairman's role. As might have been expected, the more operationally oriented Chairmen approached this task very pragmatically, many simply
'circling the wagons' by focusing on the GP community representatives and expressing the agenda in primary medical service delivery terms. But during the second stage of LHG activity, the 'performing' stage, more strategic Chairmen capitalized on the diversity of membership to create broader agendas:

"At the local basis I think we've managed to identify areas where there is, there are possibilities to move and I think we have, I think what we have managed to do between us is to identify those avenues where movement can happen...I think there's a new feeling about working together, for sure. Some of the professional barriers are beginning to weaken. There is greater acceptance of the need for change. I think there's greater awareness of the role that others can take part. I think people now understand that the interface areas, there's more to be gained than to be lost". (009.2: 20.06.00)

This Chairman's reflection on the success in building a cohesive local agenda, only 14 months into the process, illustrated his growing confidence in the approach he had taken. He went on to show how he intended to broaden the local coalition of interests further, to embrace secondary care clinicians:

"And we are leading on the formation of a new X Intermediate Care facility and also on the development of Y [area] in Community Care facilities. So we'll use them as vehicles to, if you like, pen everybody into the same ring! I have to say that Social Services in particular have been very encouraging...So the groups of people we're now working with, I don't think you call them, I think they are communities rather than voluntary bodies. And I think we're beginning to open the debate as well with community, problems specific to particular communities" (009.2).

This approach to building a jointly articulated vision from among the Board was common to strategically oriented Chairmen, but not their operationally oriented colleagues, who tended to take a more GMP-focused approach and to expect their non-medically trained colleagues to then "catch up" as best they could.
Also, during this 'performing' stage, several Chairmen noted that a two-tier structure was emerging, de facto, within the Board, which initial guidance on the Board's structures seemed to perpetuate:

"I think the non-execs, if you like, of the LHG Board feel that they're not as involved as they would like to be. ...Partly to address this lack of involvement, we're trying to get the non-execs involved in some Group work...I want them to form themselves into a little group that can, as I say, performance manage – or not performance manage, but look at the performance, monitor the performance of the LHG Board, who will basically hold the Executives to account, if you like." (005.2: 12.06.00)

Changes like this one reflected Chairmen's growing confidence in their roles and their ability to shape their resources to meet their own needs. Sub Committee structure had been stipulated in the initial guidance (Welsh Office 1998b), but by mid 2001 some LHG's Board members themselves were gaining in confidence, as the following excerpt indicates:

"The Public Participation [Sub] Group, which was set up, and with all kinds of airs and graces, and they gave it all kinds of airs and graces, and then the penny dropped that every sub group, everything the LHG did should have public participation. So having a [separate] Group seemed to isolate...so it reflected on that and then decided to disband itself, and it came to the conclusion that it should disband, and brought it back to the Board and said 'Although you said this is what we should be doing, we don't think we should be doing it. We think it would be best if everybody took it on as a responsibility'" (009.3: 31.08.01)

This was a fairly radical step to take but indicates the extent to which Board members felt engaged and empowered enough to trust their own interpretations of the LHG's remit.
By the beginning of the ‘evolving’ stage of LHG development, Board member frustration was a threat frequently cited by Chairmen. The “pace of change”, or the rate at which LHG Boards were ‘allowed’ to progress, coupled with the time that planned developments actually took to implement, worked together to “de-motivate” Board members, in many Chairmen’s eyes:

Well, the thing is, we can’t make a clear...you know, we’ve sorted out the primary care money, which is about the only thing we’ve had to sort out, and we’ve done that. So in that sense, we’ve had meetings, we’ve made decisions...but we’re very stuck on anything else, really, because nothing else is really coming through. So we are stalled. And I think, you know, after eighteen months we should be a lot further forward, in my opinion” (020.2: 14.08.00)

The Assembly’s continuing failure to articulate clear direction in terms of LHG development exacerbated the difficulty of keeping individual Board members engaged and actively participating in the LHG’s work, reportedly becoming progressively more challenging as the study progressed. But more strategic Chairmen worked closely with their Board members, taking them into their confidence about this issue and its impact:

“I don’t really have much need to gee them up. They wanted to change the world overnight. It was a matter of, I mean I’m frustrated enough by the pace. They were even more frustrated so you know I just had to take them on board in terms of what the difficulties were and try to get them to realize that this is part of a change which is going to take time to bed in and with a bit of luck in a year or two down the line we will be able to look back and think we made a lot of progress” (010.1: 16.08.99).

Those Chairmen, on the other hand, who did not adopt such an approach, became somewhat isolated, and reported feeling embattled. The extent to which Chairmen were comfortable taking
such a partnership approach to their Boards may well have been
determined by their own personal commitment to learning and
development. This is explored further in later sections of this
chapter.

It would appear, therefore, that Chairmen who regarded the size and
diversity of their Boards as obstacles, rather than as opportunities,
missed out on the opportunity to leverage them. Instead, their more
dismissive approach tended to breed dissent amongst members as
they increased the LHGs’ focus onto medical services. This, in turn,
had a negative effect on motivation and engagement of individual
members, which eventually became disaffection, as they progressed
through the subsequent stages of ‘performing’ and ‘evolving’. More
inclusive Chairmen, however, used their diverse Board membership
to create a wider agenda focussed around community needs, not
existing medical services. They used their lay members to support
this perspective by opening up channels of communication with a
broad group of constituents.

The Chairs’ Job Description (Chapter 4) clearly specified the
importance of clinical governance. And earlier chapters have
indicated that Chairmen viewed the implementation of clinical
governance as presenting particular challenges for both them and
their organisations. Despite initial fears among the general practitioner community that clinical governance would be used as a stick (Williams 2002), astute Chairmen used it to appeal to professional vanity, right from the start:

"And it really is a case of, you know, they're all saying 'well, we don't have enough money to do this and clinical governance and all the rest of it', and I said to them 'well, actually, you want to be in the forefront of primary care, don't you' and they said 'yes'. Well, this is really only just good clinical practice really" (005.1: 26.10.99).

"Yes I think it has been hard work, but I think we've tried to remove the threat, and the threat having gone I think people see, you know, they know that it's here, we have to work with it, and I think the threat of governance was everybody was going to take something away if we don't do. It's not that, it's about enabling people to go forward" (007.2: 24.08.00).

Both of these Chairmen exploited clinical governance further, to place the concept at the heart of the LHG's remit:

"...the whole clinical governance thing as the driver and everything else will fall out of that, and...once we start looking at outcomes we'll say, 'well hang on a minute, we could actually do that better in primary care'. And there's that ethos in X Shire anyway, is that you will only send it to secondary care if it's absolutely necessary....because most of the GPs who have come to X Shire actually come there because they want to be that sort of family doctor, who does as much as he can..." (005.1: 26.10.99)

This linking of professional quality improvement and increased scope for skills development, with the move towards more integrated care, appealed to local GPs, partly because it helped them to gain a feeling of increased control over the services they were providing. Where clinical governance was used as a vehicle for individual and practice development, during this initial 'forming' stage, it was effective in engaging the local professional community. Perhaps it was most
effective when it also embraced the other independent contractors, beyond GPs (022).

During the second stage of LHG development, the 'performing' stage, one Chairman further exploited this perceived opportunity by identifying specific local health service challenges as quality improvement issues. This redefinition of issues as key professional concerns, rather than as managerial responsibilities, was instrumental in helping them to wrest the agenda back into clinicians' sphere of influence and thus their control. It also enabled a developmental rather than a punitive approach to be taken, as this excerpt from the quote above emphasizes:

"...once we start looking at outcomes we'll say, 'well hang on a minute, we could actually do that better in primary care'" (005.2: 12.06.00)

Despite Chairmen's fears, putting Clinical Governance at the centre of the LHG's agenda eventually proved to be an effective tool for rallying professional support for their new organizations. These identified Chairmen were exemplary for the way in which they grasped this particular nettle. By the 'evolving' stage, the most successful approach appeared to have been to embrace the concept as central to the LHG's role. Whereas many other Chairmen remained intimidated by the challenge, or attempted to distance themselves from its implications, some even hiding behind their Clinical Governance Leads, these identified Chairmen used it as a
focal point and essential plank of the LHG's remit, redefining that remit in terms of quality improvement. This approach was insightful, reflecting a deeper awareness of the factors which motivate professionals, than some of their other colleagues demonstrated.

This insight may have been gleaned from experience as educators but not all those Chairmen with educational backgrounds adopted this line as strongly. The approach also seemed to be correlated with Chairmen's interest in community development as a strategy for the LHG, again illustrating the value of using these factors in combination to maximise leverage.

Common, too, to most of the strategically-aware Chairmen's agendas was a focus on health care and local needs, as opposed to health services. The articulation of a primary care-oriented agenda, right from the outset, in the 'forming' stage, immediately distinguished the LHGs' interests from those of the local Trusts. It enabled Chairmen to reach out to, and engage, a broad spectrum of support. This enabled them to stake a claim to important – and attractive – new territory. The words 'primary care' need a caveat because they denoted a broad and inclusive definition of local needs for care at the first point of contact, encompassing care needs traditionally met by community and social service providers. This contrasts with the
narrower definition more commonly adopted by general practitioners as a profession, denoting GMS services and/or people employed by the GP practice to provide care to the patients on their practice lists. This narrower definition limited both the thinking and the scope for action of the more operationally oriented Chairmen, as demonstrated in previous chapters. More strategically-aware Chairmen could tap into the broad church enveloped in the wider definition, cutting across employing organisations' boundaries, to create a unifying agenda, conceptually and practically. This agenda gave credence and legitimacy to the idea of reconfiguring services “on the ground” at local level. It was also, however, a bold approach, given that Acute Trusts had only just been restructured vertically in Wales, in 1998, to incorporate community services, a few months before the creation of LHGs.

The new territory carved out was distinctive to LHGs: no other organization could claim to represent the same interests with such legitimacy as an LHG:

I think we've made a cause majeure, and I think that in a way the health authorities must have been aware of this before, and there has been great resistance in the past to anything intrusive, whereas this is certainly locally owned and will be locally led...but I think we've - one of the tricks we have been able to move towards is being seen as part of the localities, not as some kind of big brother..." (009.2: 20.06.00)
The lack of a coherent strategy for public health at this point was another contributing contextual factor enabling LHGs to seize that agenda:

Yes, anybody who works here can realize that there is an odd mix between social care and health care and maintaining good health and...the way we supply services for the patients has been to fit them within localities...so my ideas had changed quite dramatically and it was quite interesting to see Public Health standing there not knowing where it was going and waiting for its green paper...(009.1: 20.08.99).

While public health professionals played a waiting game, and a 'feeling of inertia' emanated from the new Assembly's immaturity and uncertain leadership, savvy LHG Chairmen stepped in to "agitate the debate" (009.2; 007) to build "an increased understanding of the necessity to move on" (009.2):

"At the local basis, I think that we've managed to identify areas where there are possibilities to move and I think what we have managed to do between us is to identify those avenues where movement can happen...there's a new feeling of working together for sure. Some of the professional barriers are beginning to weaken. There is greater acceptance of the need for change. I think there's a greater awareness of the role that others can take part. I think people now understand that the interface areas are more - there's more to be gained than to be lost" (009.2).

This approach represented a perceptive reading of the Assembly's agenda. It was born out of the optimism that characterised these Chairmen's first few months in office. It was closely tied to their personal commitment to "developing primary care locally" which characterised most of the Chairmen's underlying motivations for taking up their roles in the first place. Again, as noted in Chapter 6, this 'inclusivity' was a second distinguishing characteristic of more strategically oriented Chairmen.
During the second phase of LHG life, the ‘performing’ phase, identified Chairmen took their primary care focus a step further, by identifying specific local health issues and using them as focal points for LHG activity. Such local developments provided key opportunities for LHGs. In one area, the Community Services Review was underway as LHGs went live, having started about a year earlier (005.1). Canny Chairmen used these tools to develop an additional strand of their agendas: involving the local community.

The local community had been perceived as playing a useful and constructive role in the Community Services review:

"...they had a panel of patients who looked at all of the issues...and when the LHG and the patients’ panel actually completely and utterly agreed with the certain direction, the local politicians didn’t know what to do. Because normally they’re in the situation when they can sort of do this in a dividing line and sort of playing one off against the other, but when the two of them got together, they couldn’t cope..." (005.1: 26.10.99)

This Chairman used this unexpected congruence of agendas to seize the initiative with local politicians, and then to begin building direct links with them, to bring them “on side” by helping them to understand and appreciate the role and function of LHGs. This LHG also built on their CHC link to inform the wider community directly about its aims, taking a regular slot on the CHC’s newsletters. This helped them to be seen as fitting into the organizational landscape in a complementary rather than competing fashion. In contrast, more operationally oriented Chairmen (e.g. 012) made efforts to create
links with CHCs, via shared premises for example, but failed to exploit the relationship’s potential beyond this level. Another LHG reached out to the wider constituency via its initial Questionnaire survey to inform the LHG’s contribution to the HIP:

“We constructed a Questionnaire which we hope will be sensitive, and that’s gone out, and we hope to get the returns from that to help us make prioritizing decisions on the Health Improvement Program. We’ve sent it to various groups because of course we’re trying to encourage local groups to sign up to our Compact, you know, the agreement with local voluntary service groups in this locality? We did this, and launched it last week; Alun Michael¹ came to launch it, and we have contacts through that and we’re using the network which is there. Because I think that people in the community, they’re comfortable with the way they can communicate their feelings whereas a big consultation exercise, very often, in our experience, it doesn’t work because you have two men and a dog turning up and that may not be representative...”(007.1: 23/12/99)

This Chairman’s strategic use of the voluntary sector agreement is in stark contrast to another, more operational, Chairman’s approach. That Chairman (016) was perhaps even more aware of the voluntary sector’s potential as a service provider having been linked to the formation and development of a local consortium of voluntary groups for many years as a local GP, but in that case, the link was never exploited or developed into any sort of two way dialogue.

In the ‘evolving’ stage, another Chairman used the area’s relatively high CHD mortality rates as a focal point around which to raise awareness of its impact among the wider community. Although not a new issue, the opportunity to use it as a community awareness

¹ Alun Michael MP for Cardiff South was also the First Minister of the Welsh Assembly Government at this time
raising tool presented itself by the congruence of two events. The first was the introduction, in England, of a new National Service Framework for Coronary Heart Disease (CHD); the second was an invitation to address the local council. This Chairman used the NSF to raise awareness of CHD’s impact, including social costs, at local level through a one off invitation. He further leveraged this opportunity to cement relationships with local politicians through ongoing dialogue, which in turn created a more supportive environment politically for the LHG. The examples noted above show the ways in which identified Chairmen managed to identify and capitalize on their focus on local health needs to raise awareness of these among the wider community, and in so doing, to highlight the LHG’s role and contribution to addressing them.

These initiatives became self-reinforcing, in terms of identified Chairmen’s growing awareness of their organizations’ increasing effectiveness locally. Despite the structural obstacles to their contributions, several Chairmen did report that they had managed to make an effective contribution to the health debate locally. The data appear to suggest that those Chairmen who adopted more facilitative management styles were most successful in generating broad inclusive agendas, which were also locally responsive. These Chairmen tended to have had backgrounds in educational work
amongst their GP communities, and appeared to apply principles of adult learning to their work as LHG leaders. They tended to speak of their LHG in the second person plural, and to have a strong orientation towards organisational learning:

"The difficulty is that people in the community wish to see things done now, we have noticed that you can't do things 'now' but you have to try and do things as quickly as possible but be open about it. Say 'well, OK, adopt, we'll take that on board, we'll look at it and come back to you, and if we think it's, the outcome is going to be positive for the future then we'll go ahead and make every effort to do so'. We've had one difficult public meeting...but we've learnt from that and we would hope that we can get the community to grow with us along some proposals which we are going to put to them" (007.2: 24.08.00)

This approach to problem solving, using the opportunity to learn as an organization, typified this Chairman’s approach to his role and the LHG’s work. He pointed to “the knowledge which has been obtained over the past two years” as one of the key forces driving the LHG forward by July 2001.

Reflecting further on this process, this Chairman recognized the strength of the facilitative approach he’d adopted:

“Well, we’ve done a lot of facilitating work together, we have taken a board development approach, we’ve been using that....We’ve taken time out to throw things around...we’ve sat down and talked about it and did that and we’ve asked them for what their needs are...so, you know, it’s been a very democratic process, it hasn’t been a one-sided thing” (007.3)

This emphasis on organizational learning became stronger as the period of study progressed. He explained his approach to generating
shared objectives among the professional provider community, using CPD as the vehicle:

"We are going to try and take half days out of practice, on a monthly basis, so that all practices have the opportunity to attend. Locums would be put in place so there is no excuse for people not attending. Go on the Doncaster model as an educational tool, and also an informative one" (007.2: )

This was the first LHG in Wales to adopt formalized CPD sessions, for the whole practice team, across the patch. The idea met opposition from some quarters (including his clinical governance lead) initially. This Chairman's response was to open up the debate further, to try to find solutions, rather than to impose his view as to what should happen:

"We're having to review some of the planning that we've put into that in order to make it more primary care friendly, I think...because there are misgivings about people giving up time and having to work harder the following day. And we are going to try and brainstorm that and work through it..." (007.3: 25.07.01).

During this 'evolving' stage, professional ownership of the quality improvement agenda was further enhanced by leveraging Clinical Governance as a central plank of the LHG's agenda, exploiting it further by using it as a tool for joint learning across practice teams (007.3). Even this approach was not without its detractors locally (007.3), but the Chairman's longer range vision, and his learning oriented style supported the eventual implementation of this initiative. This LHG's approach to implementing clinical governance remained consistently developmental and inclusive of the four independent contractor professions "so rather than impose, this is
the developmental thing, with the trainer doing it all...so we have a common aim” (007.3).

In terms of the Chairman’s role, too, the emphasis was on listening in order to learn:

“That you have to listen. You can’t be blinkered and you may have to accept things which you don’t agree with but the majority do [and] you have to run with that...You have to learn not to say too much and to allow others the time to say what they want...It’s a listening process and trying to pick out the threads of it all” (007.3)

This emphasis on the need to listen to the community was emphasized by all of the more strategically oriented Chairmen:

“Whoever chairs it needs to be able to motivate and facilitate, but most importantly, understand...” (009.3) and to enable others to understand by:

“Taking those filters off and making it safe. And being able to make it clear as to what is being discussed and its implications. Perhaps you yourself can’t do it but you can enable people on the board to get that...” (009.3: 31.08.01)

The Chairmen who used this facilitative style, and emphasized organizational learning, appeared to draw on their own previous educational skills and roles. They also appeared to demonstrate the ability to exploit this background courageously to enable consensus to emerge, rather than to try to impose their own views. This was not a management style prevalent among the career managers within NHS Wales at the time, nor was it one that was particularly encouraged by the increasing emphasis on performance management.
that was being introduced by the centre. Nor did the approach get much air time at all Wales Chairs' Group meetings. But, by using such an approach, these Chairmen did appear to effectively tap into the 'underlying value systems of their organizations' and to effectively influence the development of their organizations' power structures, control systems and paradigms (Miller et al 2002, p. 38) to build unique organizational identities which attracted and mobilized the engagement of their local communities. Interestingly now, some five years later, the relevance of organizational learning to performance, is becoming increasingly recognized, within NHS Wales, as a key organizational competence (Crompton et al 2003).

10.5 Summary

In this chapter, by taking a processual approach (Pettigrew 1990) to the analysis of activity reported by Chairmen, it has been possible to isolate distinctive organizational assets and opportunities that identified Chairmen selected and applied to the process of creating unique organizational identities. The combined effects of these organizational features, together with they ways in which these Chairmen identified and exploited them, enabled their LHGs to grow into organizations that were receptive to change. They had each developed unique capabilities and communication channels that
promoted dialogue with their constituents that in turn informed their strategies and their operational activity.

In the final phase of the study, the stage in which a large part of the LHG Chairmen's attention was dominated by anxieties and discussions about what LHGs would become in the wake of the decision to abolish health authorities, Chairmen were asked to identify some of the lessons they had learned from their work since 1999. In this 'evolving' stage, the identified Chairmen all expressed more confidence in themselves and their visions for the future as being "right" for the needs of the population, if less certain in structural terms. They pointed to the effectiveness of approaches which focussed on local problems and needs; the ability to understand and respect the differences in roles and contributions of the Chairman and the chief officer; the value of peer group learning and collaborative links across LHGs. Most of them also emphasised the value they continued to place on the contribution of each individual Board member. All five also expressed the wish to have had the confidence, in retrospect, to have exploited the uniqueness of their positions more strongly.

In each case, it was the Chairman's perception of the specific asset, or opportunity, as potentially beneficial that enabled him to leverage
it effectively. It is also worth noting that it is unlikely that any one of the specific characteristics noted would be sufficient, independently, to have a transformational effect. It appears to have been their combined effect which was most powerful. So it may also be that it was the Chairmen's abilities to apply these assets in combination which enabled them to be leveraged effectively. This ability to identify and then to build upon specific organizational features in such a way that new organizational capabilities are created may be similar to what Butler (2003) terms “implementation capacity”. This increased organizational capability, together with strategic vision, and the ability to manage institutional politics to build spheres of influence, despite decision making being located elsewhere in the system, appear to combine to create contexts receptive to change and growth (Miller et al 2002). These identified Chairmen reported these abilities more consistently over time than their colleagues; they also expressed a higher degree of enthusiasm for the future and confidence in the present than their more operational and inwardly-focused counterparts across Wales.

It could be argued that, given the nature and extent of the structural constraints within which LHGs emerged and evolved, it is not surprising that more LHGs did not develop into receptive/high change organisations. This analysis has indicated that relatively few
Chairmen succeeded in acquiring and consistently applying the behaviours needed to foster high change organisations. Those Chairmen who did adopt these behaviours appeared to do so by virtue of their commitment to organisational learning and continuing personal and professional development, rather than as a result of any externally provided Chair development activity. The training and development offered to Chairmen focussed on specific topics identified by the Assembly Government's Health Department civil servants, rather than on new skills which Chairmen might need to acquire. At no stage were skills relevant to influencing effectively in a political arena considered or addressed. Several Chairmen noted that they felt the need for more skills in managing a large Board, in dealing with the Press, in involving the public, and even in managing meetings more effectively. Many of these skills would normally be addressed in standard management development programmes. The assumption seems to have been that such skills would have been absorbed and acquired along the way - illustrating the gaps in understanding and expectations between the centre and the field at local level.
Chapter 11: Discussion, Recommendations and Directions for Further Research

11.1 Introduction

This study set out to identify and examine factors that influence organizational change in primary care, with reference to Local Health Groups in Wales between 1999 and 2001. The case study approach was selected as providing the most appropriate vehicle for studying the process of organizational change in primary care, prospectively, within a defined geographical area, and over a finite period of time, using the occurrence of the implementation of a specific policy: devolution of decision-making to local health professionals. The aim of the policy was the delivery of higher quality, more efficient and responsive primary care services to local communities (Welsh Office 1998a). The policy intentions were, thus, broadly sketched outlines, rather than detailed plans. As vehicles to implement this policy, 22 Local Health Groups (LHGs) were created across Wales. These new organizations provided a useful mechanism through which to explore the “processual” (Pettigrew et al 1992), as opposed to episodic, nature of organisational change. The study design enabled examination of the process of change over time, in parallel with the content of the changes taking place, and in light of the environment and context in which the changes were attempted (Butler 2003; McAuliffe and McKenzie, 2007).
LHG Chairmen were responsible for leading the formation and development of these new organizations, and for driving the change process locally. This study has, therefore, charted the experiences of the Chairmen of the 22 local primary health care organisations, from start-up in April, 1999 to the decision to reconfigure LHGs, taken at the end of 2001. This study explored the extent to which these Chairmen saw themselves as having created local organizations receptive to change and development. This study did not set out to measure organizational effectiveness or to evaluate the achievements of LHGs. Rather it set out to capture Chairmen's own views of their experience over time, in forming and developing new organizations capable of driving change locally. That some eventually described themselves as having acquired influence locally, and at Assembly level, emerged from the analysis as one of their own indicators of success.

The empirical data captured from three sets of interview cycles has been collated and analyzed to identify emerging themes relevant to issues of leadership, organizational relationships and influence within the primary care arena. The themes which have emerged help to build a picture of the factors which promote successful implementation of NHS policy, at local level, through the creation and development of organisations which are receptive to change. Therefore, the findings are pertinent to current
challenges facing the Welsh health system today, in the face of proposals for another round of organizational restructuring, announced in April 2008.

This chapter presents a brief overview of the findings, in Section 11.2 in relation to research questions 1 and 2. Section 11.3 explores the implications of the findings on leadership behaviours in relation to recent academic literature. Section 11.4 examines the implications of the findings in relation to recent literature on inter organizational relationships. Section 11.5 relates the findings to current issues in policy implementation literature. Section 11.6 discusses limitations to the present study. Section 11.7 offers recommendations arising from the lessons learned from this investigation, in line with research question 3. Section 11.8 concludes the dissertation by providing directions for further research.

11.2 Overview of the Main Findings

Research Question 1: What structural and organizational changes were made for the formation and development of LHGs?

As was shown in Chapters 4 and 5, the policy documents (Welsh Office 1998a; 1998b) articulated significant expectations on LHGs in terms of promoting change locally. Better integrated care would result from increased responsiveness, improved efficiencies, and closer alignment of clinical and financial responsibilities at local
local (Welsh Office 1998a). However it can be argued that there are inherent contradictions in these policy intentions, between, for example, responsiveness and efficiency, and demand and need. Local primary care organizations were intended to “rationalise” service delivery according to evidence of local need. This would indicate that service efficiency was a primary policy goal. But at the same time LHGs were meant to increase public involvement, to promote more responsiveness, thus implying giving local demand a high priority.

These policy contradictions may have contributed to the wide variations in the range of experiences reported, both over time, and across the twenty two LHGs. In addition, the structural arrangements created LHGs as sub committees of “parent” health authorities. The guidance document (Welsh Office 1998b) indicated that this would be a temporary connection from which LHGs would quickly move towards independence. And it could be said that therein lay the root of many of the subsequent problems. At no time during the entire lifespan of LHGs was a clear developmental pathway ever articulated or proposed (though some discussion about using King’s Fund standards was briefly mooted and quickly discarded, according to Chairmen’s reports). Chapters 4 and 5 explored the impact of the constraints this structural relationship imposed on LHGs’ abilities to create independent identities and to build more effective vertical working
relationships. They demonstrated the extent to which health authorities were able to retain dominance over all aspects of LHGs' operations throughout the study period, and thus, in large measure, to define the terms of the agenda for primary care development. The large multidisciplinary LHG Board was meant to broaden representation and promote increased responsiveness locally, but the health authorities were given few incentives to change the way they worked: responsibility for commissioning, frequently promised, was never devolved. Public health physicians, who might have helped to bridge the gap between health authorities and LHGs, continued to prioritise the demands of their health authority employers, over the needs of their new colleagues. Moreover, omitting Trusts from representation on the LHG Boards did more to embed separation than to foster integration between primary and secondary services. The Assembly responded by putting a statutory duty of partnership in place and enacting legislation to enable easier pooling of budgets. But when new monies came into the system through the Labour government's injection of additional cash in June 2000, the lion's share went to health authorities and Trusts.

Looking horizontally, coterminosity with unitary authority boundaries was intended to foster closer integration of health and social service delivery. But these policy intentions were undermined by the practical effects of reshuffling within Welsh
local authorities during the years under study, as Chapters 5 and 8 showed. Just as structures acted more to constrain than to facilitate change at organizational level, delays in decision-making at both Assembly and health authority level impeded LHGs’ efforts to provide incentives to effect behaviour change at individual and practice level during the years under study here. Thus, the structural arrangements for setting up LHGs could be said to have created a form of path dependency (Wilsford 1994), acting more to re-enforce than to change the existing distribution of power and influence within the health system across Wales. But, as Ferlie et al (1996) pointed out:

“...the adoption of a new organizational structure may be seen as a legitimating device to maintain outside support and funding...” (p.228)

In that sense, then, the setting up of LHGs was congruent with centrally determined, UK-wide policies of devolution and decentralisation. Ferlie et al and Wilsford (1994) before him, are, however, pointing to the success of the centrally imposed reform project in the UK public sector. Ferlie et al (1996 p.230) go on to identify key elements that have promoted the implementation of such efforts, notably a broad vision rather than a blueprint for implementation, a proactive communications policy to sell the reforms, and the selection and appointment of key figures at Board level. In this case, the then Minister for Health and Social Care could be said to have had the requisite “broad vision” especially in the sense of partnership working for integrated
service delivery, enshrined in the composition of the new LHGs. But very little in the way of a proactive communications policy could be discerned during the time under study. This study’s findings suggest that the environmental context may well have demanded stronger measures, in any case.

The literature indicated that the environmental context in which organisational change is attempted can play a determining role in the outcome of the change process. This study’s findings have extended this view. The context in which the inauguration of LHGs took place was highly complex. It was further complicated by the high degree of instability prevailing within it, especially throughout late 1999 and most of 2000. Pettigrew, Ferlie and McKee (1992, p.278) point to a need for both continuity and stability in the effective management of strategic change. However, this study has indicated that it is not the environmental instability or complexity itself that is influential, but rather, it is the way that the ensuing, or accompanying, ambiguity is perceived and used by different change agents that may be predictive of organisational “success” or, conversely, of a failure to thrive. In other words, the political and leadership skills of some of the key actors proved to be critical in this study.
Research Question 2: what leadership behaviours did the selected health professionals apply to their roles as Chairmen?

This study's data suggested that power vacuums and policy gaps could be exploited positively by skilled leaders confident enough to do so. Thus it emerged that it is how the different Chairmen reacted to, and exploited, this vacuum that explains much of the variability in the ensuing formation and development of LHGs as organizations, across Wales, between 1999 and 2001. As Pettigrew et al (1992) and Butler (2003) have indicated, it is the interplay of context, leadership, and relationships that helps to determine organizational receptivity to change. Butler (2003) points to the need for organizational leaders to have clear ideological vision, and the ability to negotiate institutional politics by forming effective working relationships. However, Butler's study looked at situations in which decision-making power had actually been devolved. This study has explored the way ideological vision and strategic thinking has been necessary attributes in a context in which power is contested. It has also shown the challenges involved in firstly, forming effective horizontal relationships, and secondly, in the continuous effort required to re-shape and realign emerging visions with the centre's overarching policy aims. Miller et al (2002) have pointed, additionally, to the need for skills in leveraging asymmetries to build organizational capacity. The findings indicate that, despite an inauspicious context, some Chairmen demonstrated these abilities.
For LHG Chairmen, those individuals selected to lead the new organizations, their three years at the helm could be said to have been roller coaster rides: they entered their new roles with high hopes; these were repeatedly dashed by the realities of the obstacles and impediments they faced. These setbacks were frequently interspersed with brief surges of optimism: the promise of new resources in June 2000, and the repeated promises by health authorities that budgets would be devolved. Chairmen dealt with these challenges differently, both in terms of the sense they made of their new situations, and the approach they took to their roles.

The findings identified the competing perspectives, and wide differences in understanding, of the policy aims and processes, prevailing among the key actors in this study. The Chairmen, all clinically trained health service professionals, brought a strong personal motivation to effect change and development in primary care to their roles as leaders of the newly forming primary health care organizations. But many were hampered by their views of the policy making process, which could be termed those of “naïve rationalists” (Russell et al 2008), in that they assumed a linear progression for their organizations in terms of development and autonomy. This somewhat simplistic view of their environment does not match the reality of the modern policy making process.
Some writers have characterised this process as a "soup", a complex mix of a wide variety of influences, the outcome of the coming-together of which is rarely based on evidence or rational planning. Health authorities, of course, colluded with this line of thinking, in effect, through the nature of the controls they imposed on LHGs' activity and development, and the nature of the work they delegated, geared more to "the furtherance of their own organizations", in the words of one Chairman, than to the development of autonomous new organizations.

Thus the selection of GPs to be lead figures (Chairmen) of the newly formed Local Health Groups was interesting in itself. GPs, as health professionals, work as independent contractors, and therefore, as self employed heads of small to medium-sized businesses. Their leadership development would have been largely experiential and self directed, often tailored to meet the demands of their CME requirements.

But implicit in the central UK government's policy aim to devolve decision-making to local health professionals, was the underlying assumption that these people were those best placed to understand local needs and to engage other local health professionals. Local Health Groups were structured so that GPs' views would have the most weight, since they held 6 places out of the 18 on the multidisciplinary Board. But evidence that GP-led
commissioning, or even purchasing, had achieved much in the way of significant change in the configuration of secondary care services was weak (Smith et al, 2004). Nonetheless, at the beginning of the study, most GP Chairmen reported that one of their key strengths was indeed their own local knowledge, and their understanding of patients' needs based on their experience at the coalface.

The key strengths that emerged from the data, however, tell a different story. The data indicated that those Chairmen who instinctively embraced a community development approach in their roles as leaders were the most successful in terms of creating and maintaining a unique agenda for their LHGs. Their approach was both strategic and inclusive of the broader community. These Chairmen tended to focus on creating new communication channels to promote listening to the community’s views of its needs, and developing structures and feedback channels to enable professionals to work towards delivering services differently to meet those needs.

These Chairmen tended, also, to exercise astute political skills in influencing upper tiers in the system, notably the Welsh Assembly Government and their parent health authorities. In addition, their commitment to community needs and focus enabled them to transcend the health authorities’ more operational views of LHGs’
roles as their internal sub committees, and thus to create their own unique agendas and power bases. These Chairmen exhibited skills in exploiting the authority vacuums and ensuing uncertainty that prevailed during the early stages of their work towards establishing their LHGs. In many ways, then, for these strategically skilled Chairmen, the absence of direction, from both the WAG and the health authorities, freed them up to develop and implement their own visions for the future, and thus, ultimately, to report more satisfaction with their achievements than did more operationally focused Chairmen. This may equate to Butler's (2003) ideological vision as a key leadership element in creating organizations receptive to change. However, these Chairmen's abilities to exploit the prevailing ambiguity were an essential prerequisite to developing this vision in the first place. Thus this finding extends Butler's (2003) concept of ideological vision by highlighting the importance of context and the effectiveness of the ability to both interpret and exploit it to meet organizational needs. This finding thus extends the earlier work by Pettigrew et al (1992), who noted the importance of a stable organizational context. This study's findings point to the ability to tolerate uncertainty and environmental ambiguity as more critical in turbulent working environments as section 11.7 will argue, highlighting again the importance of focussing analytical attention on the interplay of context, leadership and relationships.
The variation in strategic vision among the 22 Chairmen emerged over the course of the study. Those Chairmen who adopted wide ranging and ‘inclusive’ definitions of their constituents, coupled with a community development focus for their organizations, were able to effectively exploit the absence of clear direction at the assembly government level. From this perspective, moreover, they were able to identify distinctive features within their organizations and then lead their staff to work to combine those resources in new ways that, in turn, gave their organizations unique identities and capabilities (Miller et al 2002).

Many of the more operationally focussed Chairmen, on the other hand, tended to try to develop their LHGs according to the model they had perceived as most successful in their own experience, GP Fundholding. They expected their LHGs to be able to work in a similar, but broadened, fashion, reducing variations in services by focussing on their local populations’ needs, rather than on those of their smaller, separate practice populations, but with the same degree of flexibility and alacrity implicit in holding their own budgets.

At the same time, many of these more operationally oriented Chairmen were suspicious of more formal techniques, such as health needs assessment, and saw little point in devoting resources to such processes. They felt that the instincts they had
built up during their experience as practising GPs gave them
intimate familiarity with the needs of their patients, and that they
could extrapolate from these across their extended LHG areas.
This failure to realise the gap between individual experience and
broader, more holistic, needs assessment was symptomatic of the
difference between themselves and their more strategically
oriented colleagues.

These Chairmen also tended to express more disappointment by
the end of the study period, in relation to their perceived control
over money or budgets. Since very few budgets were actually
devolved to LHGs, and those which were had largely been
previously allocated, these Chairmen were almost bound to be
disappointed and tended to express frustration more frequently.

These operationally oriented Chairmen frequently emphasised
money and information as key tools to ‘unlock’ the system, but at
the same time, they found it increasingly difficult to influence
their health authorities effectively. Their own underlying
assumptions seemed to imprison them within a game whose rules
kept changing; when the goalposts also changed they became even
less sure of the way forward: they expressed bewilderment and
ultimately disenchantment. Their efforts to try to read the ‘script’
for GPFH, with which the health authorities appeared to collude,
in terms of their own discourse, led them to focus increasingly on
operational detail at the expense of overall strategy. This narrower focus also served to isolate them further from other potential sources of support in the wider community.

These more operationally-oriented Chairmen also tended to focus on ‘the rules’, and soon became bogged down in procedural detail. This concern with rules and procedures may well have suited their ‘parent’ health authorities. Health authorities had steered discussions with their LHGs, from the outset, around the physical structure and composition of the new bodies rather than focussing on fostering new organizational orders (Pettigrew et al 1992, p265). Moreover, the authorities, using the sort of managerial discourse bounded in rationality (Green and Thorogood, 1998), effectively steered the content of negotiations with these LHGs (Pettigrew et al, 1992, p. 266). They bolstered this linear view of the world through a variety of command and control mechanisms such as performance agreements. They legitimated their resistance to devolving budgets through the language of corporate accountability and fiscal responsibility. This approach tended, over time, to render the more operationally focussed LHG Chairmen increasingly powerless.

In contrast, however, their community development-oriented and more strategic colleagues ‘rewrote their scripts’, and thereby succeeded in working around the obstacles the health authorities
presented. Their approach supports Senge's dictum (cited in Iles and Sutherland 2001) for effecting change: when resistance is strong, work to reduce the resisting forces rather than to strengthen your own efforts in opposition. This ability to circumvent obstacles appeared to be an important feature, subsequently enabling them to report satisfaction with their progress.

Thus the leadership skills evidenced in this study included the expected abilities to create a shared vision, persuasion and influencing ability, but coupled with a broad political awareness, and, more particularly, the ability to tolerate and exploit ambiguities in the prevailing power structures. This finding corroborates Pettigrew et al (1992, p. 279) who highlighted the effectiveness of "leadership exercised in a subtle and pluralist fashion" and the power of the combined abilities of planning, opportunism, and good timing in effectively managing "incoherence". The data from this study extends Pettigrew et al's thesis by highlighting the importance of this ability to tolerate and exploit uncertainty as a key leadership skill in building new organizations, especially in situations where power and decision-making have not actually been devolved in practice.

The ability to build effective organisational relationships emerged as another key leadership skill, and a significant factor in
enabling the newly-formed LHGs to establish themselves within a
crowded, and somewhat hostile, organisational landscape.

Pettigrew et al (1992, p.265) point to the central role that inter-
organizational networks play in terms of a change project’s
success. And although relationship building alone was not
predictive of success, most LHG Chairmen, throughout the three
years of the study, pointed to their newly forged relationships as
their most solid achievement, in terms of building power and
influence locally.

Chairmen frequently referred to this relationship-building activity
as a struggle – an “uphill battle” – for which there were few
tangible prizes. And the data showed the extent to which previous
organizational relationships and history added to these
difficulties. In fact, those Chairmen who viewed relationship-
building as a means of influencing the distribution of resources
were frequently disappointed by their inability to overturn the
prevailing power imbalances. Indeed, “getting a seat at the
tripartite table” seemed to have been a pyrrhic sort of victory when
the Trusts and health authorities reportedly paid little attention to
their new partners. Here, too, there was a correlation between
those Chairmen who worked to become accepted as equal players,
with a voice in the distribution of the other players’ assets, and a
perceived failure to influence the agenda.
The more strategic Chairmen, however, addressed relationship-building differently, by stimulating the formation of new coalitions across the spectrum of primary and social care provider organisations and users. This bottom up approach helped them to build broad visions based on “services not hospitals”. This broad based approach also helped to build new shared understandings and thus to reduce the destructive power of the prevailing “local histories, group ideologies and power relations” illustrated by this study and reported by Pettigrew et al (1992, p.266) as significant negative factors in terms of developing change-receptive organizations.

In contrast, those who attempted to get a firmer grip on the vertical relationship ladder found it dangerously slippery and unstable. These vertical relationships were relatively easy to obstruct, as Trusts and health authorities continued to negotiate together in tried and tested fashion and opportunities to build the trust necessary to cement budding new relationships were often derailed by historic and structural work patterns.

The ability to build relationships to support a broad vision seemed to be more effective, in terms of building power and influence locally, than focusing on operational detail. This may have been because of the degree of threat perceived by potential partners, whose control of resources would have been negatively affected,
perhaps too early in the process. Those Chairmen with an orientation towards community development tended to foster relationships across organisations with a view to creating service configurations which could attract new sources of funds or external development monies. This approach enabled them to build horizontal partnerships, as well as to strengthen the local community’s sense of identity. In these sorts of relationships, the LHG became the source of support and strength for new organisational groupings. Knight et al (2001 p. 140, 146) point to the size of the challenge in making such collaborative working a reality ‘on the ground’ and the value of approaches that aimed to create a common sense of purpose, whilst at the same time embedding them within the institutional context to legitimate them further.

Those Chairmen who could then proceed to align their LHGs’ visions with those of the Assembly found themselves empowered even further. For example, we saw in Chapter 5 that one Chairman referred to testing his LHG’s vision for community based services at a forum specially convened for that purpose with the Minister for Health and Social Care. Her approbation emboldened him further, to the point where he used the Community Services Review process to strengthen ties with the local community and to oppose the Trust’s views, which local politicians were then supporting. By year three of the study, these
Chairmen had reported their delight in seeing their agendas progressing – and at the impact they saw themselves as having had on the Assembly’s strategic aims for health and social care delivery.

The data from this study, therefore, emphasizes the importance of building relationships and networking skills, in constructing new organizations and in developing the web of links that served to embed them in the wider community. Thus, abilities to exploit ambiguity, to work strategically to build new organizational agendas, then to weave a network of organizational relationships in support of those agendas, and then to align those agendas with those of the Assembly, have been shown to be important leadership skills in this study, in terms of strengthening their spheres of influence locally. But these data also point to the value of another set of leadership skills: the ability to recognise and effectively exploit an organization’s distinctive features.

In addition, some Chairmen displayed an ability to identify tacit skills and knowledge from within their new organisations, and to tap into this to build unique organisational capabilities. “Leveraging” these “asymmetries” (Miller et al 2002) in this way enabled some Chairmen to differentiate their LHGs’ products from those of other organisations in the area and to be seen to be offering something new and uniquely valuable to potential
customers and clients. The findings of this study thus corroborate Butler's (2003) conclusion that the ability to leverage asymmetries is a critically important leadership quality in terms of building implementation capacity and thus facilitating receptivity to change:

The ability of a sub-set of Chairmen to, firstly, accept the existing state of practice organization as an asset and then to build on this to create broad communication channels across the wider community enabled them to build a primary care focussed rather than medical service led agenda for their LHGs. In addition, some Chairmen developed their infrastructures in such a way that they were able to build organizational capability to deliver that agenda. For example, those Chairmen who were able to build effective working relationships with their General Managers also reported higher levels of satisfaction with their achievements. At the outset of the study, the majority of Chairmen bemoaned the recruitment and selection processes applied to these key appointments. Moreover, the General Managers were viewed by Chairmen (and saw themselves) as employees of the health authorities, to whom they were both accountable, and culturally and historically oriented towards. Strategically aware Chairmen learned to value this 'alien' experience and to respect it. They evolved complementary working relationships and soon weaned their GMs away from their health authority orientation to work as full
partners towards a different set of goals. This relationship
transformation was by no means universal. More operationally
focussed Chairmen never really managed to change their
perspectives on this crucial relationship. Their failure to build a
more trusting working relationship with their chief officer tended,
in turn, to mirror their relationships with their health authorities
throughout the study period.

Ferlie et al (1996) pointed out the critical role that an effective
Board could play in developing an organization’s competence,
noting the importance of Board development in this respect, both
individually and collectively. But as this study has shown, LHG
Chairmen were given very few resources or guidance in relation to
the development of their Boards. Some Chairmen embraced the
diversity presented by their 18 Board members, and engaged their
commitment by giving them central roles and responsibilities in
developing and shaping the LHGs’ agendas, and helping to solve
problems arising. These Chairmen stood out from their
colleagues, who saw the Board as more problematic. In addition,
Chairmen who applied a learning orientation to their role were
more likely to value this diversity and to use it constructively.

Similarly, those Chairmen who seized the clinical governance
agenda as an opportunity rather than as a threat, and placed it at
the centre of the LHG’s agenda, created a unifying force, both
among their clinical constituents and their local client and user communities. This service quality orientation, couched in the language of clinical governance, became an effective tool for engaging social service and voluntary sector provider colleagues too. In the event, clinical quality improvement became an effective rallying point for local clinicians, and a useful bridge uniting primary and secondary sector based clinicians.

Focussing on specific local health issues also proved to be an effective tactic for engaging both local clinicians and the wider community. In these instances, the definition of local health needs tended to be informed by evidence rather than individual experience. Such an approach differentiated the LHG from local hospital trusts, for example, and enabled them to build coalitions aimed at stimulating service provision rather than protecting existing structures and buildings. This approach also facilitated the engagement of local business leaders and local politicians, raising the community’s awareness of health needs relevant to their interests. This increased awareness was adroitly turned into broad based support over time.

One of the most striking aspects of the Chairmen’s struggles, however, is that the harder some of them tried, the more difficult it became, and the further away they appeared to be, from succeeding. Lewin’s (1951 cited in Iles and Sutherland 2001)
Force Field Analysis may help to explain this perversity, postulating that, when meeting forces resistant to change, the most effective strategy is to work to reduce the strength of the resistance, rather than to strengthen arguments favouring the proposed change. Those Chairmen's efforts to strengthen their case for more resources only served to unite and strengthen health authorities' resisting forces. The consultation process on re-structuring initiated by the new Director of NHS Wales in 2001 gave those resisting forces an ideal platform to come together as a united front. And as we have seen, the consultation process itself disadvantaged GP Chairmen as players, hampering their ability to present their case. As a result, the Assembly's decision to remove the health authority tier was the only way forward for LHGs.

The new statutory status subsequently conferred gave the LHGs (as LHBs) the opportunity to “cross the boundary” of organisational politics, and to “become co-creators of the new reality” (Webster 2004) of NHS Wales. Whether this was to prove to be the blessing it appeared to be would have to be the subject of a future study.

11.3 Implications of the findings in relation to recent literature on leadership. The leadership behaviours identified in this study differ from those usually referred to in classical leadership texts at the time the study commenced. They were
certainly not noted in any of the developmental workshops provided to Chairmen at the outset of the study. But as Chapter 2 argued, the context in which public sector organizations are operating has been changing rapidly over the past twenty years. Sandfort and Milward (2008) point to the “hollowing out of the state”, sparked by the drive to improve productivity, and increasing reliance on private markets to achieve public ends, leading to increased decentralisation and organizational fragmentation. They also point towards a parallel increase in service orientation and more emphasis on tactics to enhance accountability for results (p.147). These competing drivers have been further complicated by growing awareness of the limitations of individual agencies to tackle presenting public problems, prompting calls for more ‘cross cutting’ approaches, requiring collaborative working arrangements, particularly in relation to public service delivery. In such contexts, emphasis has turned to shared provision of services. Such contexts also imply shared resources and power. But, as Sandfort and Milward point out (p.151), shared does not mean equal.

And, as was noted in Chapter 2, organizational responses included more partnership working, more networking and horizontal linkages replacing more traditional vertical or hierarchical relationships. Pettigrew and Fenton (2000) pointed out that these new organizational forms gave rise to new dualities
and tensions. Managing such challenges effectively would require different sorts of leaderships skills and behaviours than those predicated in the hierarchical and market models prevailing in the 1980's and 1990's. Alimo-Metcalf and Alban-Metcalf (2006) refer to the emerging model of leadership as "nearby" in contrast to the more remote and 'heroic' individualist leader models of these earlier decades (pp. 295-6). Their 14 leadership constructs include a mixture of traits and behaviours, derived from their own empirical studies, which combine to portray transformational leadership (p. 299). This model purports to build on Greenleaf's concept of the "servant leader" to extend it to "leadership in partnership" but still seems to be more relevant to those working within more traditional, albeit complex, public sector organizations, with its emphasis on team building, thoughtful and sensitive delegation, etc. Grint (2001) highlighted the importance of leadership which takes account of stakeholders, emphasising the positive value of diversity, especially in relation to informational and societal contributions to leadership effectiveness. Grint's Review for the Cabinet Office (2001) also picked up the servant/partnership theme, but highlighted the potential impact of the maturity of followers in contributing to leadership effectiveness. He also pointed to the importance of negotiation and persuasiveness skills in securing agreement to put collective needs above individual wants, and the ability of leaders to negotiate their way through multiple accountabilities.
and conflicting demands, harking back to Pettigrew's and Fenton's (2000) prescription. Pedersen and Hartley (2008), noting the impact of the disintegration of traditional hierarchies of roles and procedures, extend Grint's (2001) work by pointing to the emerging need for leaders who can both create decision-space and recognise mutual interests. They call this the ability to:

establish an independent platform from which the manager can become an accountable part in positioning and creating frameworks...for relations with stakeholders, users and employees (p. 336).

In essence such leaders have to negotiate both their own legitimacy and power bases, almost on an issue-by-issue basis. Perhaps it is this latter aspect at which the more transformational LHG Chairmen showed themselves to be most adept. They worked continuously to reshape their working contexts but in addition they then continually adapted their emerging priorities to align them with central planks of the WAG's own overarching agenda. The ability to read the political priorities and to then reinterpret and express them cogently in ways that multiple stakeholders could embrace was critical to their success in building supportive organizational relationships. In addition these Chairmen showed an astute capacity for engendering learning across their organizations. This emphasis on facilitating collective learning from their emerging experience may have contributed to strengthening their organizations' capacity and resilience (Stewart and O'Donnell 2006). Oddly, however, the ability, noted by Miller et al (2002), to build capacity by identifying and strengthening
tacit organizational assets is absent from these more recent academic studies of leadership, though Hartley's review, commissioned by the NCCSDO and not yet in print, may well address this gap. This study noted the ability to identify tacit organizational assets and to build on them to create new organizational capacity as a key leadership behaviour. The importance of context has been noted by more recent literature. Vangen and Huxham (2003) have pointed to the need for leadership and management that is "embracing, empower[ing], involving and mobilising" in order to build and sustain effective collaborative arrangements locally. Again this model recognises implicitly the need for continuous re-negotiation of legitimacy and authority. Hartley (2008) calls for more recognition of "public value outcomes" in relation to leadership and proposes a multidimensional model which incorporates such longer term consequences equally alongside context, concepts, characteristics, capabilities and challenges in seeking to define and measure leadership effectiveness. Since this study did not test or measure leadership qualities, more empirical research to test this model in practice is needed now.

11.4 Implications of the findings in relation to recent work on inter organizational relationships LHG Chairmen themselves pointed to organizational relationship building as one of their most important if difficult achievements. Recent research in the
field of inter-organizational relationships illustrates the complex and multifaceted nature of this task (Cropper et al 2008).

Chairmen's efforts to forge horizontal relationships exemplified the underlying need to negotiate legitimacy and decision-space (Hartley 2008) with each of their stakeholders, again on an ongoing and case-by-case basis throughout their tenure in office. That this came as something of a surprise to these Chairmen is probably an understatement. Yeung (2008) refers to the way in which the concept of power has had to be reinterpreted and expressed to fit new organizational realities across collaborative arrangements. In these new contexts, power emerges as the ability to influence a wider variety of other actors, and thus is a mediating behaviour, rather than an asset vested in position or resources (p. 484). Another difference in these collaborative working contexts is the need for continuous renegotiation of legitimacy.

Within the emerging field of inter-organizational relations, this study could be said to be set within a social psychological approach, in that it looks at "real organizations' and their interactions...relevant histories, and future perspectives...and the dynamics occurring at various system levels" (Cropper et al, p.726). But in doing so this study is only a beginning: the short lifespan of the LHGs as organizations emphasizes the time
consuming and lengthy processes involved in building effective organizational relationships.

In a context where organizational restructuring is the norm not the exception, there is rapid turnover of (often the same) personnel within short periods of time. This study has highlighted the importance of history as a relational dimension. Experience has shown that changing ‘hats’ does not erase previous organizational or personal history in a small geographical region. Previous history, at individual and collective level, has been shown to impact on trust and may play a stronger role at the early stages of relationship formation, than at later stages.

Schulter’s and Lee’s (1993) typology proved to be a useful analytical device in so far as it provided a range of relational dimensions along which to consider and understand complex relationship quality issues. It may be that it is most useful for examining the early stages of forging partnerships and collaborative working arrangements. It highlights issues to be considered and their potential impact. Issues of how power and influence are developed at this formation stage may well be different from how power is maintained at later stages in the partnership’s evolution. Thus, at later stages, when collaborative arrangements are more firmly established, attention can turn to what Lotia and Hardy (2008) term “collaborative and resource
dependencies”: how the partnership itself works to enable member organizations to increase their collective power by increasing their ability to access resources and “manage dependencies” (p. 368).

11.5 Implications of the findings on policy implementation

This study’s findings have identified the roles which individual LHG Chairmen and their LHGs have had at a micro level in terms of policy implementation. While the study period has been relatively short, some tentative conclusions have emerged in terms of policy implementation. We have seen that the immaturity of the newly formed Welsh Assembly Government did not help them to provide clarity or consistency of direction. Nor did it help them to anticipate the numerous challenges to be faced in ensuring implementation or reducing local variation. At the same time, the challenges presenting, especially in terms of changing power relations locally, were proving particularly intractable. The structural changes introduced had had little effect on the dynamics prevailing within the health system across Wales. In such circumstances the Minister’s decision to meet regularly with her LHG Chairs could be seen as creating a useful feedback mechanism on policy implementation aspects. Her decision to further restructure by abolishing HAs, and making LHGs into statutory organizations could be seen as responding appropriately to the collective complaints of LHG Chairmen. The problem was
that it didn't go far enough to have an impact on the real powerhouses in the system, the combined Trusts. This highlights again the complexity of the issues presenting and the difficulty of using a structural mechanism to address them (Walshe and Rundall 2001).

Moreover, the policy aims themselves were unclear. Exworthy et al (2001), among others, note that competing policy objectives impact negatively on local implementation. The policy aims in this case were further clouded by failure to articulate any clear developmental pathway or criteria for the new organizations. This meant that their parent organizations were free to create their own definitions of progress, and associated performance measures, thus muddying the already murky waters further. Smith & Goodwin (2006) note that lack of clear and appropriate performance measures for PCOs in England is part of a larger international problem, claiming that policy makers have been overly influenced by process, in terms of setting up primary care organizations based on models used in different countries and health systems. They call for more attention to be paid to the effect of different models on health outcomes (p.194). Again the constraints imposed by context need more attention.

In such circumstances Cropper et al (2007) call for mechanisms that promote more “policy learning” through more interactive
policy making, including piloting and testing, that would in turn encourage wider forms of learning (p. 41). The LHG Chairs Group might well have been an appropriate vehicle for developing that sort of dialogue had it not been hijacked by more powerful players and the announcement of another structural change.

11.6 Strengths and Weaknesses of the Present Study

The study has followed the fortunes of all 22 of the key actors selected at the outset of the study. This represents 100 per cent compliance throughout the two and a half year study period. It also includes, in three cases, the Chairmen who replaced those who left the role before the end of the study in the final tranche of interviews, (and, in one case, includes the retiring Chairman as well). This willingness of subjects to participate throughout such a demanding and turbulent period of their own professional lives is both unusual and highly gratifying. As noted in Chapter 3, it may indicate that Chairmen attached some degree of value to the process, in that participation afforded them rare opportunities for personal reflection. It may also point towards the isolation and loneliness of the Chairmen's positions in the organizational landscape throughout the study period. At any rate, this compliance provided a uniquely rich set of data. This richness was strengthened by the fact that the study covered virtually the whole organizational life cycle of LHGs. This was not the intention at the outset, because at that point there was no indication that
the LHG life cycle would be so short. It could be argued that it is only because so few concrete steps were taken to develop and strengthen these new organizations, beyond the sub committee status that they were originally given, that such a major statutory transformation was eventually required. But announcement of this structural change did mean that Chairmen were amenable to reflecting upon the lessons learned during their tenure in office, and onto advice they might give to their successors. Looking back over the period as a whole helped increase their awareness of what they had achieved as well as of all the challenges still ahead. However, the depth of exploration, analysis and understanding achieved by the study design may have been at the expense of more roundedness of experience. Individual paradigms, decisions and actions could be given a gloss that triangulating with LHG Board Minutes and other grey literature could not remove. An alternative study design incorporating the use of a smaller number of case studies, say five to give one per HA area, would have incorporated the viewpoints of more actors, possibly the whole Board, or the Executive Committee. Arguably this would have provided a more rounded picture of the fortunes of the LHGs. However the commitment levels and contribution of individual Board members is inevitably variable, especially over time. And Executive Committees in English PCOs have been criticised for being overly dominant (Smith and Goodwin 2006, p. 209). Moreover, none of the Board members held the degree of personal
accountability or responsibility that the Chairmen held. Finally, since the aim of the study was to capture the experience of leadership, the focus on the responsible individual was preferable to a more diffuse study of a broader number of participants. Had the aim been to evaluate effectiveness, or progress, however, then the broader case study approach might well have been preferable. As it happens, and in the circumstances prevailing, the decision to focus on the experiences of the selected key actors has provided a rich collection of data, filtered by individual reflection that also afforded a degree of distance, whilst still retaining temporal immediacy.

Another possible weakness of the study is that it deliberately avoided any attempt to evaluate achievements. The decision not to evaluate was taken because of the peculiar circumstances of the researcher and the prevailing culture within NHS Wales throughout the period under study. As pointed out in Chapter 3, the researcher’s ‘insider’ role as an academic within the regional medical school helped facilitate access to participants, acceptability of research aims and credibility of research process. But her role as a senior employee of Wales’ NHS management development agency brought significant constraints. Care needed to be taken to avoid any hint of acting in concert with the Welsh Assembly Government, or as its agent, as that would have seriously compromised the researcher’s credibility in the eyes of
the study participants. In this role, the researcher was constrained by additional political considerations: her Chief Executive was keen to ensure that the research “did not embarrass the Welsh Assembly Government”.¹ This meant that a somewhat awkward balancing act was needed to distance the researcher sufficiently from the centre and its directives and, at the same time, to demonstrate awareness of the prevailing organizational context and the policy pronouncements emanating from the centre.

Furthermore, boundaries imposed by the structural relationship of LHGs to HAs had to be respected. Whilst LHG Chairmen were happy to participate as subjects, there was every indication that they had not asked permission from their HA Chief Executives to do so, and several indications that, had they done so, permission would not have been granted. As noted earlier (see Chapter 2, section 2.12, p. 48 and Chapter 4, section 4.4, p.130) HA Chief Executives reacted furiously and speedily to overturn an initial WAG agreement to fund an evaluative study proposed by the researcher and colleagues, on the stated grounds that permission to study their sub committees should first have been sought from them, and that these LHG sub committees were, in their view, already ‘over-researched’. These sensitivities made it impossible to carry out more evaluative studies. As a result the only outcome

¹ Personal verbal communication July 1999
measures applied were “soft” ones, based on LHG Chairmen’s own
descriptions of themselves. These included a focus on “progress”
which meant increased autonomy. Another implicit indicator was
the extent to which the WAG appeared to respond to their local
agendas. Whilst this might be considered a weakness in one
sense, the resulting study has provided a rich picture of the
experience and process of policy implementation, in all its
variability, within one relatively small and unified geographical
area. As such it goes some way to further understanding of the
factors contributing to variations in policy implementation. The
findings thus add to earlier work in this area, notably by Exworthy

Finally, comments are in order in relation to key conceptual
frameworks employed in this study. Schulter’s and Lee’s (1993)
relationship typology was especially useful in terms of
understanding the often seemingly contradictory data in
Chairmen’s reports. It was also helpful as a reporting device,
because it enabled material to be organized thematically, and
discussed longitudinally. However, because Schulter and Lee
(1993, as adapted by Meads (2001) did not fully differentiate their
categories in sufficient detail, some domains appeared to overlap
with others. This limits the typology’s usefulness as a measuring
device.
The concept of organizational receptivity to change proved pivotal to the analysis in this study. Pettigrew et al’s (1992) empirical study of how organisations react to strategic changes within the NHS identified eight factors that need to be in place to enable organizations to react positively to policy changes. Butler (2003) subsumes these eight factors down to four in his empirical study of local authorities’ reactions to a new policy imperative. Butler’s study also linked receptivity to capacity building. This study differs from the earlier studies in that it focuses on newly forming, rather than existing, organizations. Secondly, in both earlier studies, decision-making authority had actually been devolved, so that attention was able to be focussed on implementation. That was not the case in this study. But the earlier works did provide robust frameworks for analysis. The frameworks also provided crucial links to organizational theory and change management literature. They gave useful structure to the emerging data analysis, enabling deeper testing and comparison of concepts, within a unified and tested theory. This study’s findings add to these earlier works in terms of specific leadership behaviours identified. The analysis has shown not only what behaviours were effective, but how they impacted, over time.

In terms of leadership qualities per se, however, the study might have been further strengthened by incorporating quantitative measures of leadership traits or competences. Whilst such an
approach might have given greater clarity to the findings, it might also have limited the focus of attention on to those dimensions of leadership then extant; and this might have made it more difficult to identify and isolate the behaviours which differed from earlier concepts that emerged from this study. No 360 degree appraisal systems were in use within NHS Wales at this level during the study period. The Minister for Health and Social Care was responsible for appraising Chairmen and it is possible that incorporating her views of leadership effectiveness into the study would have helped to corroborate findings. It is debatable whether such an element of personal evaluation would have been acceptable to Chairmen. The lack of clarity in role and expectations would have made this an interesting exercise.

Notwithstanding these limitations, it is fair to say that the study has achieved its aims in that it has provided a unique picture of the challenges and opportunities faced by those responsible for leading the implementation of a major policy initiative locally, over a defined period of time and within a bounded geographical area. The study's findings are, of course, peculiar to this context. But they may also have resonance for similar contexts across Europe, where regional governments have responsibility for policy initiatives and implementation, especially in relation to health and social care delivery. The insights provided by those 'at the sharp' end help us to see the startling gaps between rhetoric, intention
and reality with fresh clarity. The prospective nature of the study means that a reasonably complete picture has been possible, of implementation challenges over time, and throughout an organizational life cycle. This "processual" (Pettigrew 1973) approach has also enabled a clear picture of leadership behaviours to emerge and to be clarified over time, as having been effective in identifying and capitalising on opportunities for facilitating organizational change and development, within a turbulent policy environment in which decision-making was never really devolved.

11.7 Recommendations Arising from the Study

Research Question 3: What lessons can be learned for leadership, and policy implementation at local level?

Recommendation 1: Leadership Development Programmes, especially those aimed at clinicians, or at building organizations receptive to change, need to foster the development of the skills shown in this study to be effective in creating change promoting organizations. More focus on political skills in getting round structural constraints, the 'how' of change, rather than on the content and structures themselves, or the 'what' of change, would be helpful in such programmes. The contested nature of power and influence in collaborative working arrangements also needs to
be highlighted in development programmes, together with effective strategies for securing and maintaining "decision-space".

The isolation experienced by clinical leaders is another area for attention. Clinical leaders in particular would benefit from more individual coaching and mentoring support. Peer support groups, properly facilitated to encourage structured reflection, could address this need.

In addition, clinical leadership development initiatives need to incorporate elements which prompt participants’ to challenge their assumptions about policy making, and the myriad influences which impact on the policy process, to enable them to work more effectively within the complex health sector environment. In particular clinical leaders need to learn the limitations of so-called "evidence-based policy making" and how it differs crucially from evidence-based medicine. Blackler et al (1999) note the potential for using ‘activity theory’ to promote clearer understanding of "perspective-making...and shaping processes and their relationships" to this end. Leadership Development programmes also need to support the acquisition of the ability to understand this environmental complexity and exploit uncertainty effectively. McAuliffe and McKenzie (2007, p. 208) suggest use of "retrospective policy analyses" as a useful step towards achieving this goal.
Recommendation 2: Inter-organizational Relationship Building and Community Development approaches

The value of adopting broad based approaches to the wider community and creating opportunities for continuing dialogue with stakeholders needs to be emphasized in leadership and organizational development programmes, especially when the object of the exercise is to promote change and innovation. Because institutional politics emerged as so important in this study, such programmes could usefully include analysis of how factors that promote effective working relationships among stakeholder agencies work in different contexts. Maintaining collaborative relationships over time and changing circumstances also needs addressing in such programmes.

Recommendation 3: Organizational Learning has increasingly been recognised as a core competence of effective organizations (Senge 1990; Easterby-Smith et al 1998; Crompton et al 2003, Cropper et al 2007). It appears from this study that those Chairmen who applied such an approach to their LHG’s development expressed more satisfaction with their progress, than their counterparts who did not do so. Many of the Chairmen who spoke most frequently of the need to learn, and supported their organizations in doing so, had held previous educational roles, often as CME Tutors, for example. But it was their emphasis on facilitating others'
learning, both within the LHG and across their geographical areas that had the most impact, as Chapter 10 showed. The Chairmen's Group was originally set up, at the end of their initial preparatory development programme, in July 1999, to foster this sort of shared learning among the Chairmen, as peers. But, by 2001, this Group's focus had become dominated by discussions about future structures and models. This meant that the Group no longer functioned as a means of sharing learning and new approaches to common problems. The members' own agendas could be said to have been hijacked by the centre's concerns by this time.

The opportunity cost of this was the shared learning foregone, as attention focussed around ways to influence the future shape of LHGs. Sucked into playing the political game they professed to detest, many of the Chairmen became embroiled in it, and thus were distracted from what might have become one of their core strengths - the ability to share learning and experiences. Again, however, this core competence of a high performing organisation was never discussed during their initial training.

More use of structured reflection as a learning tool would also help in this respect. The Chairmen appeared to welcome the opportunity to discuss their perceptions over time, but the role of the researcher in this study made it impossible to adopt a facilitator role in that respect. Yet arguably the most powerful
learning might well have been achieved through such facilitated structured reflection, either on an individual basis or through action learning sets. Smith and Goodwin (2006) call for more active involvement of PCOs in organizational research, to aid understanding of how different organizational models and governance frameworks impact on service quality and health outcomes locally. Miller et al (2002, p.50) acknowledging the difficulties of engendering competences in leveraging assymetries note the value of continuous action, experimentation and reflection in order to identify, develop and embed new organizational capabilities over time. Given the importance of this area in building receptive organizational contexts, more attention to funding facilitated learning across PCOs is needed.

Recommendation 4: improving policy implementation at local level: Confusion about policy aims hampered implementation in this study. This enabled disputes about boundaries and authority to flourish. Smith and Goodwin (2006) point to the tendency of policy makers to adopt managed care models from other contexts, paying insufficient attention to the importance of contexts. The negative effects of this might be lessened by more action research in this area.

The value of on-going dialogue between policy makers and implementers has been shown, in this study, through the
Chairmen's efforts to hold quarterly meetings with the Minister. It may be that building similar continuous feedback loops into the process of policy implementation would help policy makers to identify unintended consequences early on in the process, and to take avoiding action where possible or desirable. Adopting Cropper et al's (2007) proposals for building interactive learning into the implementation process would enable both policy makers and policy implementers to increase their own reflective capacity, as well as that of their PCOs.

Additionally, policy makers need to recognize the length of time it takes for new organizational structures to form and then become operational. Chairmen, in this study, frequently pushed back the time frames of their expectations, pointing to the fact their emergent organizations were still forming, well into the second year of the study, and their LHGs' life spans. This mirrors the experience of PCOs in England (Smith and Goodwin 2006).

Policymakers also need to acquire a better understanding of the conditions needed for facilitating intersectoral collaboration in general, and organizational relationships, in particular. This study has highlighted the impact of history as being particularly important. Again time is an important factor because of the lengthy period of time it takes to build trust among key players.
and organizational leads. Such trust is of course a prerequisite for any form of risk sharing to be attempted.

Finally, although this study did not set out to measure effectiveness, the findings suggest that innovation can be stimulated and supported within a publicly funded sector provided that attention is devoted to ensuring that the requisite skills are in place and appropriate strategies pursued. The requirements of sustainability may conflict with the realities of short term central funding, in a politically led service, but this issue needs to be resolved. Therefore the current interest in social entrepreneurship has to be buttressed with skills in spreading, embedding and sustaining innovative services if social gain is to be realised. In this sense, paying more attention to the development needs of those charged with responsibility for implementation is a key challenge for policy makers and educators alike.

11.8 Directions for Further Research

Supporting and Sustaining Collaborative Working

The community development and learning oriented approaches applied by the more strategically oriented Chairmen in this study indicate the effectiveness of such approaches in fostering local engagement and ownership in the process of developing service delivery partnerships. Perhaps the real question remaining, then,
is the extent to which such new partnerships can best be supported over the longer term, given the constraints of short term and non recurring funding patterns.

**Leadership Behaviours**

Further research is needed to test the leadership behaviours identified in this study. The analysis has shown that the factors which helped LHG Chairmen to grow their organisations are similar to, but not identical to, those identified by Butler (2003), Miller et al (2002) and Pettigrew et al (1992). And it is clear from this study that none of these behaviours would have been enough by itself. Whether this combination is sufficient in terms of specific outcome measures, and in different contexts than that studied here, need further research.

**Organizational Research**

The study's findings highlight the importance of conducting research into organizations within the health sector, as well as the time consuming and expensive nature of such research in addressing the really interesting questions about the relationships between policy changes, organizational responses and leadership behaviour, and their effects.

In the case of LHGs in Wales, the opportunity to assess the effects of their co-optation into the mainstream by becoming Local Health
Boards with statutory powers for commissioning has now been lost since they are to be restructured afresh. But new questions arise from the current restructuring proposals. What impact might the new structures have on their ability to innovate, for example? More research into organizational models that promote changes in service delivery is needed, alongside strategies to sustain such collaborative service delivery partnerships. Studies into the amount of “decision space” (Bossert 1996; Exworthy 2008) created by structural change, and the resulting impacts on organizational effectiveness and health gain could also be valuable research streams, in view of the findings from this study.

Clearly another key question arising from this study is the effect that setting up LHGs had on the range and quality of local service provision. There is a need for further research into the effects of structural and organisational change on the quality and quantity of service provision. Such studies are needed at all levels of the health and social care system: regionally, across the four countries of the UK; sub-regionally, within PCTs/LHBs and across sub-groupings, particularly as new commissioning arrangements begin to bite; and more locally, to compare and contrast the effects of structures in the post industrial areas of the Welsh valleys with those of market towns and urban areas.
Finally, this study’s findings have demonstrated that, while structural changes are important levers for change, they are not the end of the story but the beginning. In this study it was the leadership behaviours and political skills of key actors that were most influential in creating organizations receptive to change and promoting change locally. And, at the end of the study, it is salutary to remember, and to contrast, the Chairmen’s own modesty, via their descriptions of themselves, as leaders (Chapter 6), with the nature of their achievements in this role. None would have used the management labels applied here to describe their efforts. But it is only through eliciting their stories, as this study has, that it has been possible to dissect and uncover the leadership styles and behaviours that ‘worked’ in this context, and why.
Post Script

This study has covered the period from January 1999 to December 2001. It thus begins at the point at which LHGs became operational in shadow form. The study ends after the point at which the decision had been taken to abolish the HA tier, and to strengthen the organizations at primary care level. By the time the study ended, consultation on the form that the organizational restructuring would take had been completed.

Local Health Boards were duly constituted as statutory organizations on 1st April 2003. The composition of the Boards remained largely unchanged, but they were expanded to include additional lay representation. The chief officer post was strengthened to reflect the increased responsibilities at this level, becoming Chief Executive rather than General Manager. Remaining staff at HA level were largely absorbed by the new organizations, in an effort to provide increased capacity especially in relation to new commissioning responsibilities. Another significant change in the system occurred at the same time, impacting on capacity at primary care level. Public Health professionals became independent in that they were employed by, and accountable to, a newly created but separate agency, the National Public Health Service. This move enhanced the profile of public health as a profession but, arguably, created further problems in terms of conflicting responsibilities and accountabilities. Each LHB was entitled to specialised public health support through named individual Directors,
but these individuals were, at the same time, accountable to the newly appointed Director of Public Health for Wales, who was, in turn, accountable to the Welsh Assembly Government.

It is fair to say that the new restructuring plans for NHS Wales announced in the autumn of 2008 were aimed at addressing system imbalances still remaining in the wake of the 2003 restructuring. Anecdotally, LHB Finance Directors have complained of inadequate capacity to effect changes in service delivery locally, and the hoped-for benefits from LHB commissioning have not materialised. Consequently the Welsh Assembly Government Minister for Health and Social Care, Edwina Hart, announced the abolition of the internal market in health and social care across Wales in June 2008, and consultation on the new organizational structure to implement this policy has just been completed (end September 2008). A new National Advisory Board will be created. A separate Delivery Board, to oversee day-to-day operations, will also be established, chaired by the Chief Executive of NHS Wales. Seven newly vertically integrated Trusts will be responsible for providing health services across Wales. The role of the body responsible for the commissioning of specialist services is still under review at the time of writing, as is the structure of the soon-to-be formed Unified Public Health organization. Present proposals indicate that executive responsibility for public health will reside with the new Trusts, but that this responsibility will be shared at national level. There will also be a new public health presence within local government.
References


Bate, P. 2004. The Role of Stories and Story Telling in Organisational Change Efforts: the anthropology of an intervention within a
UK hospital. *Intervention, International Journal on Culture, Organization and Management, 1:1*


by the National Coordinating Centre for NHS Service, Delivery and Organization Research and Development.


http://www.ournhs.nhs.uk/


National Assembly for Wales 2001b Structural Change Newsletters Series, Newsletter No 2, August 2001. Cardiff: NAW The Assembly's Organizational Chart showed that LHG representation on each Task and Finish Group averaged about 10% of the membership.


Pedersen, D., and Hartley, J. 2008. The changing context of public leadership and management: implications for roles and


Roland, M. and Smith, J. 2003. The Role and Contribution of Primary Care Trusts in Quality Improvement, Ch 13 in Leatherman, S. and Sutherland, K, eds *The Quest for Quality in the NHS: A Mid Term Evaluation of the Ten Year Quality


Personal Communications and Observations

Personal observation of debate between LHG Chairmen and Director and Assistant Director of Social Services, presenting the launch document for Local Health Alliances across Wales, 2 July 1999, Study Block 3 of the NHS Staff College Wales Development Programme for LHG Chairmen. Caer Beris Manor, Builth, Wales.

Personal communication (verbal) to researcher from (then) line manager, NHS Staff College Wales, Hensol Hospital, Pontyclun, Wales, July 1999.

Personal communication from GM 003 to researcher during a telephone conversation to arrange next interview with Chairman, August 2000.

Personal observation of the proceedings of the Health and Social Services Committee meeting held on 25 October 2000, Committee Room 2, National Assembly for Wales. Agenda Item HSS-18-00. Recorded by researcher in own field notes and corroborated by Minutes published subsequently.

Personal communication to the researcher from an Independent Medical Advisor to the Chief Medical Officer of the Welsh Assembly Government, during a meeting held for another purpose. 15 August 2001. Notes recorded in researcher's field notes made immediately following the meeting.

Personal letter from HA Chief Executive to researcher arguing against proposed research into LHGs January 2001.

Personal communication to researcher from Director, NHS Wales in which the need for caution in dealing with Social Services colleagues was emphasized, in particular, the importance of avoiding any action or initiative that might imply NHS dominance over Social Services activity. September 2002.
Appendix A Invitation and Consent Letter

Letter A – distribution list attached

Please reply to Ext 3770
Email: Williamssa@cardiff.ac.uk

Dear «Salutation»

It was a pleasure to meet you on Friday during the last Module of the LHG Chairs Commissioning Course at Caer Beris Manor.

When we met, I asked whether you would be willing to participate in a research project on Local Health Groups. You kindly indicated interest, and I agreed to write to you with more details, so that you could make a decision after time for reflection.

The attached flyer outlines the aims of the research. Basically, the establishment of LHGs provides a unique opportunity to learn valuable lessons about the management of change within primary care. I would like to carry out a qualitative study based on the perceptions of the key players: the LHG Chairmen themselves. In order to do this, I would like to arrange an initial meeting with each Chairman in the next couple of months, followed by a series of telephone interviews at quarterly intervals, culminating in a final interview in about 18 months time. The first and final meetings might last up to an hour; interim conversations might take half an hour or so.

I am hoping that the process will be an enjoyable one for participants, and that the opportunity to reflect on the previous months’ activity afforded by the telephone interviews will be valuable in itself.

I would be very grateful for your agreement to participate in this study. I think there is real potential for NHS Wales to learn some important lessons about policy development and implementation from the results.

Would you kindly complete and return the form attached to indicate whether or not you are willing to participate in the study? I would be grateful for a reply by the end of July. If you would like any further information about the study before making a decision, please do not hesitate to contact me.
Thank you very much for considering this.

With best wishes

Yours sincerely

Stephanie Williams
Lecturer Health Service Management

Enc
Primary Care Development Study of the formation of Local Health Groups

1. I am willing to participate in the above study. I understand that you will be contacting me in mid September to arrange an initial meeting.

I am not willing to participate in this study because:

Name:

Address:

Telephone:

Email:

Signed:

Please return this form to:

Stephanie Williams
Lecturer Health Service Management
Department of Medical Education
School of Postgraduate Medical & Dental Education
UWCM, Heath Park
Cardiff CF14 4XN

By 30 July 1999
PRIMARY CARE DEVELOPMENT RESEARCH

Background: Setting up Local Health Groups is an important landmark in the development and evolution of the NHS in Wales. It presents a unique opportunity for research into factors relevant to the development of primary care. Studying the opportunities and constraints inherent in the process can help us to learn key lessons, both for policymakers, and for educators.

What? This project aims to capture learning points as they are emerging from the natural process of setting up and establishing Local Health Groups.

How? I am proposing to undertake a qualitative study of the viewpoints of the central figures in this process – LHG Chairmen.

Process: The study would involve a series of interviews with each Chairman over a period of 18 months. The interviews could be carried out mainly by telephone, at times to suit each individual, at approximately 3 month intervals. The initial and final interviews would ideally be face-to-face. The first and last interviews would take up to about an hour; subsequent interviews would last about half an hour. All information would be treated in strictest confidence; only aggregated anonymised data would be used in any reports. If possible some participant observation of peer group support meetings will be included as a means of triangulating data collected from interviews.

Outcomes:

For participants:
♦ Regular opportunities to reflect on activity
♦ An independent listening ear
♦ The potential for development activities to be created to meet emerging needs

For NHS Wales:
♦ A deeper understanding of the context in which primary care works
♦ Feedback on the implementation process for policymakers, hopefully helping to reduce the gap between rhetoric of policy and the real world of practitioners

Next Steps:
1. To meet potential study participants informally during the July workshop, to discuss the proposal.
2. To write formally to each LHG Chairman to invite participation in the study.
3. To schedule a series of initial interviews for September/October 1999.

I will be in Builth Wells on Friday 2nd July; I look forward to seeing you then.

Steffi Williams  Dept of Medical Education, School of PG Studies  UWCM
Appendix B: Exemplar Interview Summary Int 1: Dr XYZ 018.1 11.8.99

Chairman’s Motivation & Role:

- See role as extension of fundholding, and national level committee work, GPFH Consortium
- “Direction” from HA, via selection to help with Development Programme
- Not a lot of competition in some areas
- Enjoy the management issues & cut & thrust of politics
- Chairman as political figure: independence from HA to speak more freely (cf GM)
- Need for neutrality & openness to everyone’s points of view
- Political action: taking agenda forward via Jane Hutt

Developing the Board:

- GPs & Director of Social Services already knew each other well, and GM so Board gelled very quickly
- 2 Day Time Out scheduled for Sept, to focus on HIP: “No game playing”!

Set up Tasks:

- Time taken to get established: Seeing Year 1 “as lost cause”: 4 out of 6 posts now authorised but only GM and PA actually in post

Relationships with other agencies:

- **Health Authority:**
  - Changing CEO—not really an issue
  - Regular forums with CEO and Chairman, fortnightly meetings with HA Exec Team
  - Shared resources: Finance, Public Health support
- **Trust:**
  - Need to find ways to bring them on board, share the agenda
- **Local GPs:** role as representative of profession cf representative of community
  - Round of visits to each practice completed by GM
  - Data Validity exercise re local services & resources to produce solid, accurate database
  - Some suspicion re “this new interfering body”
  - Potential for conflict between different professions' views of needs
- **Public:** using rep as focal point for communication
- **Politicians:**
  - Creating an association with local press,
  - Agreement to get regular slot in local paper following each Board meeting, which LHG will produce
- **National Assembly:**
  - Local AM invited to all meetings but has never attended;
  - Limited organisational capacity: NA members have limited experience & steep learning curve “more like Council members”
  - Hope to get NA to see LHG as a source of information and change

LHG Priorities:

- To establish the Group
- Build credibility with field as a decision-making body
- Create more autonomy
- Concentrate on cross boundary issues, eg hospital discharges, and things which bring agencies together, linking processes
Opportunities:
- Involve NA members at a local level
- To get debate about rationing into public arena, involve people to allay suspicions
- To assess and prioritise needs
- To keep regional population focus
- To dis-invest & re-invest in priority areas: LHG as catalyst for this
- To merge budgets to tackle joint problems

Challenges:
- Involving the public
  - Scale of task: one individual to link to the general public
- Balancing need for HIP to be inclusive with need for focus
- HA leading the HIP process, LHG to then tease out it's own “mini-HIP”
- Clinical Governance developing along separate parallel track,
- CG: Having to learn from scratch, work “by the seat of the pants”
- Current structures don't facilitate joined up working, eg difficult to get Trust representatives on board

Supports/Tools:
- Good site: independent and accessible
- Being focus for the Contractor Services elements of the budget
- Chair's Group: getting together to share experiences, and re new requirements eg health needs assessment techniques
- Chairs Group: stepping stone and direct channel to National Assembly, skipping Welsh office layer
- Familiarity with the culture of the HA, and Welsh Office approach
- Project management skills within Trust, HA
- Having a good team
- Chairs group
- Climate of collaboration not competition unlike GPFH

Constraints:
- IT: GPFH systems tapered off over last few years, all using different systems
- Most practices collecting practice not contracting-type data
- Lack of money for training & development:
  - CESU encouragement to attend events cf lack of money (CG/MAAG money used up on putting staff in post)
  - Need to find and pay for locum cover for practice-wide events, pay for loss of earnings for other contractors
  - Costs of skilled facilitation
  - Little protected time
- HA unwilling/unable to delegate power
- Funding not been clarified yet : should’ve been by end 1998 to go live from 1.4.99
- Conflict between needs of practice and demands of Chairman’s role: “Could do this job fulltime”
- Making progress on priority areas is constrained by lack of available monies, and HA’s deficit

Steffi Williams
<table>
<thead>
<tr>
<th>Year</th>
<th>Key Decisions &amp; Events</th>
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</table>
| 1997 | Welsh Office Putting Patients First  
NHS (Primary Care) Act provision for  
↑ flexibilities in service provision, salaried GPs, pilot schemes |
| 1998 | Establishing Local Health Groups  
Corporate Governance Framework for NHS Wales  
end October |
| 1999 | January  
Feb 1 & 2 |
|      | 1st April |

**Key Decisions & Events**

- **1997**: Welsh Office Putting Patients First  
NHS (Primary Care) Act provision for  
↑ flexibilities in service provision, salaried GPs, pilot schemes

- **1998**: Establishing Local Health Groups  
Corporate Governance Framework for NHS Wales  
end October

- **1999**: LMC elections of LHG reps & Chairs  
LMGs contrib. -> interim HIP; consider proposed  
Agreements betw HAs/Ts re post April’99 services

- **1999**: LMGs go live: set up premises/develop Boards/training  
for Chairs/select GMs & tms/ divide into Working Grps  
monitor service quality; implement HIP; bid partnerships by  
carrying out baseline assessments; sign up -> perf agreements;  
develop risk sharing policies; agree practice-level incentive  
schemes w/ HAs; play key role in LHAs

- **1999**: HA CEXs: Bro Taf CEO removed  
XY acts up (DCS)
1st July
Sec'y of State for Wales devolved powers to new National Assembly; powers to develop & implement policy health & h. servs, local gov't, social servs etc

August
Jane Hutt calls for primary care dev priorities:
Consultation closes 16 Sept

October
JH spells out priorities for primary care: (H&SS Cte)
1. ↑ flexibility in service provision via p.c. pilots
2. enc LHGs->more responsibility & give more development
3. encourage joint planning & working
4. introduce pooled budgets h & las
5. extend roles of nurses & nurse Rx
6. enc extension of °care servs ->reduce 2°care work
7. focus on inequal & needs of minority grps
8. reduce inequal of access & health status
9. enc indiv responsibility for health
10. increase responsiveness of services provided

November 2
Merger of UHW, Llandough & Cardiff Community

Nov 5
Health & Well-Being Policy Board set up
->promote joined up strategy & policy
LHG Responsible Officers acting up til

July '99
GMs recruited (Cardiff-no one in post...)
Focus on process & infrastructure/staffing
securing premises, developing remit/focus
Baseline assessments due; HIPs due
2000

January  
Cardiff & Vale NHS T becomes operational  
"seamless service admission-> discharge"

24 Jan  
A Better Wales consultation launched: 100 targets  
"most significant document since the White Paper on devolution"  
Western Mail 24 Jan Front Page-promised "new approach to primary care" & 'tighter efficiency effectiveness & financial mngt of h & ss servs'

March  
HE CEOs: revolving doors  
Gwent HA- Graham Coomber in post  
IMH: JW takes up post  
Dyfed Powys CEO removed & Chair takes up executive role  
Director Performance & Director Finance leave DPHA  
NWHA: CEO leaves Interim CEO takes up post later in year

June 2000  
UK Gov't announces cash input to NHS:  
Wales: £99m 2000/01 financial yr:  
£86m=HA & central priorities  
£40m=waiting list/times & demand mngt emergency care  
£6.7m (approx) recurring re vol sector & LA partnership projects
July 2000

*Access & Excellence* published
Audit Commission Briefing re LHGs in Wales Yr1:

"need for more powers & clearer sense of direction" *HSJ*
6/7/00 p8

NHS Plan (England) produced 27/7/00

Sept 2000

Modernization Board set up to lead reforms
NHS Chief Executive TBA
New Concordat TBA between NHS, vol sector & private sector
1° care access targets: 24 hrs/48hrs for GP access;
integration of OH & NHS Direct
VFM; ↑patient experience; outcome focus; £stability via 3 yr allocat’ns

2001

Jan

Joint GMs/Chairs paper re development of LHGs:
Called for clear development pathway

PMS Pilot deadline 31.01.01

Feb

*Improving Health in Wales* produced
NHS Plan (Wales) issued & HAs to go 1.04.03
SoSHSC confirms full role for LHGs

1° March workshop planned

BTHA- new CEO takes up post:
Caerphilly GM sent to Cardiff
Bridgend GM to Caerphilly
District Audit Review underway re "Fitness for Purpose"

Feb 21st
Jane Hutt & LHG Chairs Meeting

JH agrees commissioning role for LHGs -> be Developed asap

Consultation on Primary Care Development launched

March 5
HA Allocations letter from WAG

JH asks for proposals from HAs & Ts (in consult’n with LHGs) fpr devolving indicative budgets for community services ->LHGs ->enable them to Assume more direct commission respons’bty For these services during 2001/2 (AL/CLR/03/003) Tighter mechanisms for investment/spending controls-AL personal approval needed Imminent new mngt arrangements for NHSSCW TBA, top slice for current yr only

1st April
Gwent HA-BH replaces GC as CEX
NAW makes £3 available for Inequalities in Health (£3m=CHD)

May
NHSSCW becomes CHL with re-launch

June
1st Health Plan Newsletter from AL re IHW

Implementation Plan: set up Steering Group JH=Chair; set up Implementation Grp AL= Chair; H&WBS&PTm Mike P leading management of Process; 9 Task & Finish Grps ALL chaired by HA Chairmen & NAW officers

Sept
All Wales Chairs Grp sends response to NHS Plan
12/13 July  
LHG Chairs Leadership Dev prog session 1:  
Leadership skills & personal audit  
Beverley Alamo Metcalf (SW facil)  
10 monthly sessions planned

19 July  
Jane Hutt letter to Paul H CHL  
1°Care Strategy launched as consult’n

end July  
*Shifting the Balance of Power within the NHS: securing delivery* published in England  
*LHGs develop prg (signals step change in skills required; Bard members can stay til 31/03/03 achieve full service integration (note changing structures not enuf-lesson fr England!))  
↑patient time with GP; develop 1°Care Resource Centres; invest in staff & OD; raise profile of 1Care as career; 10 yr Strategy->Action Plan by April’02

*Structural Change in the NHS in Wales*  
Consultation doc published  
2 more T&F Grps (HR & Info)

15 August  
Structural Chnge Newsletter #2  
Suzanne Penny’s letter re HR employment structure options-confidential discussion paper  
Org chart of 10 T&F grps: 2 LHG reps in each;  
# of members=17->>32 (0 on PublHealth Review)  
possibility of single NHS Wales as employer mooted
Oct

- Closing date for consultation on 1st Care Strategy
- NHS Confederation event on NHS Plan Structures paper

Nov

- Structural Change Newsletter #3
- Primary Care Action Plan sub-group set up -> advise
  - Re implementation of 1st Care Strategy
- T&F Group members changing: fewer LHG reps IMT, Perf Mgmt & H Challs

Nov 7

- H&SSCte Mtg: JH announces structural changes -> Plenary Session of NAW
- 22 LHBs = LA areas = 'blow' block: statutory bodies
  - Stat duty of partnership via specific Welsh clauses
  - In NHS Reform Bill: joint assessment of need & investment strategies; 18 mo all Wales Dev Prg;
  - Widen Board membership re Public Health; integrated commissioning H&CHS
  - Pathfinder projects re Comm Servs provision
  - 3 regular WAG offices -> visible local presence of NHSSCDirectorate: 10-12 Local H Partnerships
  - All Wales LHB & Partnership Dev Tm
  - Specialist Health Service Commission for Wales: tertiary commissioning & advice re 2nd comms

Nov 15

- AL letter: Local Health Board & Partnership Team
- Public Health organised all Wales acc -> CMO

5 Dec

- H&SSCte Mtg HSS-17-01 Health Legislation
- Confirmation of Welsh-specific clauses: not to go for 1st Care Trust model -> give patients 'voice'!
  - Welsh H&Well Being approach; est LHBs, decide funding at NAW level; joint planning Las re H&W
  - Broad participation & influence; joint planning Las re H&W
  - New structures for NHS D; arra -> redistribute HA
  - Functions; redesign Prof Adv mech; OD of LHBs & NHS D; (review NHSSCW); OD to be commissioned
<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
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<tbody>
<tr>
<td>2002</td>
<td>New structures announced: 22 LHBs, coterminous LA + Community CI reps</td>
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<td>WAG Programme Team set up to oversee Structural Change and Reform progress (Bryan Mitchell parachuted in)</td>
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<td>April</td>
<td>Primary Care Action Plan Team set up 5 LHB Chairs announced</td>
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<td>June</td>
<td>Task &amp; Finish Groups wound up</td>
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<td>July</td>
<td>Action Plan for Future of Primary Care announced</td>
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<td>Aug-Oct</td>
<td>LHBs to be set up in shadow form</td>
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<td>September</td>
<td>12 LHB CEOs appointed</td>
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<tr>
<td>Nov</td>
<td>3 Regional Directors appointed (Acting up)</td>
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<tr>
<td>Dec</td>
<td>LHB Chairs Development 2 day Study Block</td>
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<tr>
<td>2003</td>
<td>1st April: LHBs go live</td>
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</tbody>
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