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An examination of the resistors and challenges *in the NHS commissioner/provider relationship*

Abstract

Since 1991, the English National Health Service (NHS) has been subject to several control and management regimes that have often used market based approaches to enable the delivery of services. This paper uses survey based research to explore the resistors and challenges that impact on the development of effective relationships between commissioners and providers in delivering high quality patient care.

The study is part of a larger multi method study and although this paper focuses on the quantitative aspects it is the authors' intention to publish other aspects of the study in the future.

The findings highlight the key challenges as the short tenure of senior leaders, time limitations on organisational stability, prescriptive performance management frameworks, lack of innovation and conflict and tensions between commissioners and providers.

The paper enhances the understanding of the complexity of the commissioner-provider relationship and develops a model to assist the understanding of this complexity.

Key words: NHS, health, commissioners, providers, complexity

Introduction

Commissioners and providers working together within the NHS is not a new concept but was first seen through the introduction of the purchaser/provider split in 1991 to create a quasi-market for healthcare in England. As, however "the NHS faces one of its toughest ever periods financially" (King's Fund, 2010, p.1), the need for greater collaborative working across health and social care partners, and the emerging concept of multi-specialty providers and accountable care organisations (Department of Health, 2014), has intensified with an ageing population driving increased demand for services and high public expectation for improved quality of healthcare. These issues need to be addressed within the narrowing boundaries of public sector financial resources and represent what Prowle (1995) has described as the Health Service Dilemma. The aim of this paper, therefore, is to enhance the understanding of the factors that influence the success of the NHS commissioner-provider relationship focusing on the resistors and challenges that exist in the partnership.

The collaborative and individual challenges that commissioning and provider organisations face a good base knowledge of the ongoing challenges for NHS England, Clinical Commissioning Groups, Foundation Trusts and NHS Trusts. This paper, therefore, provides clarity on these challenges for the commissioner-provider relationship through survey-based research and the exploration and generalisation of the outcomes across the NHS as a whole has been provided in the conclusion section. The understanding and open recognition of these barriers is likely to enable NHS managers to focus on more effective methods for addressing the current and

future challenges together as a system.

Lessons from previous studies and concepts

The literature has been considered under three main themes to explore the issues examined in this study:

- The NHS as an organisation;
- Commissioner/provider relationships; and
- Knowledge Management.

The NHS as an organisation

This study takes a holistic approach to reviewing and researching the NHS means, which means a shift away from the approach of reviewing organisational form and hierarchies (Mannion et al, 2010). Complexity theory suggests that "organisations [are] living systems in which relationships and communication are much more important than processes and structures" (Battram, 1998, p.i) and "because complex systems have built-in unpredictability, the certainties of the 'command and control' approach to management no longer hold true" (Battram, 1998, p.11). This concept fits with the suggested cross-organisational boundary approach of multi-specialty providers (Department of Health, 2014).

Damanpour (1996, p.694) echoes Mannion et al's (2010) views highlighted above by stating that:

> *"structural complexity and organisational size…are important facets of organisational growth and complexity (Whetten, 1987) and are among the most important predictors of organisational innovation (Ettlie et al, 1984; Kimberly and Evanisko, 1981)".*

The importance of Damapour's (1996) association to organisational innovation is accentuated by the need of NHS organisations "to accelerate the speed and extent of the spread and adoption of innovation in order to deliver the cost savings required while improving the quality of care we deliver" (NHS Improving Quality, 2013). Damanpour (1996) adopts Blau's (1970) approach that formal structures are made up of four dimensions; spatial, occupational, hierarchical and functional and "the degree of structural complexity is often indicated by the extent of differentiation along these four dimensions (Hall, 1977)" (Damanpour, 1996, p.694).

Miller (1987) explores the relationship between organisational complexity, structures and strategy-making and concludes that;

- assertive strategy making is positively linked with structural integration and negatively linked to formalisation;
- complex organisations need more to time to adapt and need more time for decision making than organisations with simple structures, networks and environments;
- administrative tasks are complicated in large organisations inhibiting strategy making and innovation;
- the personalities of top executives have less influence in large organisations

compared to smaller organisations;

- the decisions on structures by CEOs greatly influence the future performance of the organisation; and
- the alignment of structural factors with analysis and future orientation are important for the performance of large, complex organisations.

The comparative and contrasting views above highlight the different perspectives on the NHS in England, however, a common thread throughout the literature suggests that the complexity of the system alone is a challenge, or what can be described as a Complex Adaptive System (CAS) (Plsek and Greenhalgh, 2001).

McKenzie (2014, p.1) states that a CAS "need leaders with humility, willing to draw upon the emergent and self-organising nature of complex adaptive systems through empowering others and continuous re-calibration", as well as "organisations that can keep up with the dynamic nature.....by being able to learn and adapt to changing circumstances [through].... taking risks, experimentation, and accepting failures." Connelly (2007, p.1246) states that "leadership is an important, if not critical, element in the success or failure of inter-organisational systems" and establishes the common themes of leaders working within a participative system as (Connelly, 2007, p.1248):

- "The need to establish common culture while not compromising the unique culture of each participating organisation
- The creation of a common vision/strategy with respect to the outcomes of the system
- A need for open communications
- The need for trust among all parties so as to maintain commitment from all participants
- Flexibility and an entrepreneurial outlook in terms of processes and in many cases final outcomes
- A belief that alliances/networks build alliances/networks"

This will be an important ingredient in the implementation of the Dalton Review's recommendations around multi-specialty providers (Department of Health, 2014) which is explored further in the next section.

Leadership and the commissioner/provider relationships

Leadership is a concept that is difficult to define (CIPFA, 2005b) and McKenna (1994 cited by CIPFA 2005b, p.153) attempts a definition as "Leadership is a force that creates a capacity among a group of people to do something that is better or different…Leadership is an agency of change, and could entail inspiring others to do more than they would otherwise have done, or were doing". Yet, the instability in leadership in the NHS is highlighted by Lynas (2009, p.1) as the "average tenure of a chief executive is said to be around two and a half years. And therein lies the problem". The creation of trust, a common culture and the building of alliances/networks

(Connelly, 2007) could therefore be inhibited by the short tenure of senior leaders across commissioners and providers (Lynas, 2009).

The leadership of the NHS provides a unique dynamic with leaders from commissioning and provider organisations but also across professional boundaries with clinical and managerial leaders. The latter can create tensions between the different groups of leaders with Good- win (1996) describing the clash between the professional perspectives of managers and clinicians as the Clinician-Manager Paradox. Williams (2010) confirms this relationship issue by stating that the main focus should be on medical ethics and clinical freedom, however, the ongoing conflict between politicians, managers and clinicians means "neither the medical profession nor the politicians" can demonstrate this as the top priority (Williams, 2010, p.18). It is clear that the clinician-manager paradox (Goodwin, 1996) exists in the NHS and yet there appears to be an acceptance of the nuances in the relationships that are created by the NHS market.

The relational conflict and tensions and the complexity of collaborative structures is a further point that must be considered before entering into such an arrangement as high- lighted by Cigno and Gore (1999 cited by National College for Leadership of Schools and Children's Services, 2008, p.15) with their inference "that effective collaboration requires both formal and informal structures of support, and the absence of either can have a negative impact on the overall effectiveness of the initiative". The complexity of NHS structures therefore supports Huxham and Vangen's (2006) advice that organisations should not collaborate unless they have to. Quayle et al (2013) stated their views that the commissioning relationship is often presented in a reductionist manner as a simple contracting relation- ship, but it is more complex therefore a genuine partnership is required between Clinical Commissioning Groups and providers. Johnston (1997) builds upon these views by sharing her experiences of collaboration in a more emotive manner and focusing on the complexity in decision making and the tensions that can arise in collaboration between Commissioners and Providers. Johnston (1997,) frames these tensions across three headings; relationship, structural and developmental. It could be argued that these tensions across commissioners and providers need to be managed in order for the NHS system to be effective but having partners with misaligned strategic objectives can often be the cause of many of the tensions identified above (Le Grand et al, 1998; Child et al, 2005).

One of the biggest challenges for NHS commissioners is the influencing of providers when the strategic intentions are markedly different (Le Grand et al, 1998). Child et al (2005) identify that when forming an alliance, network or collaboration there must be some strategic fit between partners with Miller (1987, p.27) suggesting that "organisations must ensure complementarity among elements of structure and strategy making". On the one hand, it could be argued that the strategies of NHS commissioners and providers do not align (Le Grand et al, 1998) while, on the other hand, the governmental control emplaced on commissioners and NHS Trusts drive adherence to national policy (Audit Commission, 1998) and therefore co-operative strategy (Child et al, 2005). Blake and Moulton (1964 cited by Child et al 2005, p.127) cited potential strategies to achieve market-driven strategic goals of which a collaborative approach is perceived as the optimum choice (Child et al, 2005). The creation of Foundation Trusts (FT) from 2004 and NHS England's aspirant view of multi-specialty providers (Department of Health, 2014) means this enforced co-operation will diminish. The collaborative strategy approach (Huxham and Vangen, 2006; Child et al, 2005; Blake and Moulten, 1964) will no longer be appropriate in the

NHS (Curtis, 2010) and therefore alternative motivations must be identified. With the continued role of GPs with key commissioning influence in Clinical Commissioning Groups and the continued FT autonomy, the aim for the commissioner would be to protect their own organisation's outcome, first and foremost, before assessing the impact on decisions across other stake- holders (Blake and Moulten, 1964 cited by Child et al, 2005). 'Game theory' suggests that in a competitive environment, stakeholders and competitors react to an organisation's own actions and decisions which then leads to that organisation reacting to the competitor, a dynamic relationship is therefore created (Saloner, 1991 cited by Johnson and Scholes, 1997). The strength of the leaders in making these hard but necessary decisions is therefore imperative (Porter, 1985) but restricted by the prescriptive performance management frame- work that NHS organisations are required to follow (Department of Health, 2009c).

Knowledge Management

Customer satisfaction in the NHS may fluctuate, but the customer and their knowledge rarely leaves as there is increasing demand for healthcare services (Gainsbury, 2009) but effective knowledge management can be an area that impacts across the commissioner-provider relationship. Knowledge management is explained by Bocij et al (2003, p.29) as a "term to describe a broad range of activities related to ensuring that an organisation makes the best use of its information resources".

There is a general acceptance of two types of knowledge and "different approaches can be used to disseminate this type of knowledge within an organisation" (Bocij et al, 2003, p.29):

- "Explicit – details of processes and procedures. Explicit knowledge can be readily de- tailed in procedural manuals and databases.

- Tacit – less tangible than explicit knowledge, this is experience on how to react to a situation when many different variables are involved. It is more difficult to encapsulate this knowledge, which often resides in the heads of employees. Techniques for sharing this knowledge include learning stories and histories."

(Bocij et al, 2003, p.29)

One use of knowledge management is, therefore, to turn tacit knowledge into explicit knowledge (Bocij et al, 2003). Davenport et al (1998) suggest four ways of approaching this task as; create knowledge repositories to enable tacit knowledge from individuals to be transferred and stored; improve knowledge access by finding the person that has the required knowledge and transferring it to another; enhance the knowledge environment by making it more conducive to the creation, transfer and use of knowledge; and manage knowledge as an asset by including it in the corporate strategy. On the other hand, "British Petroleum's ability to leverage knowledge is key to its competitive strategy. Rather than conducting its own basic research, British Petroleum learns from its partners and quickly spreads that knowledge through the company. It does this not by building a large electron- ic library of best practices, but by connecting people so they can think together" (McDermott, 1999, p.103). McDermott (1999) calls this a 'knowledge community' where information is introduced and then members of the community use that information creatively to develop a new knowledge base. This community is not

created without its challenges:

> *"The technical challenge is to design human and information systems that not only make information available, but help community members think together. The social challenge is to develop communities that share knowledge and still maintain enough diversity of thought to encourage thinking rather than sophisticated copying. The management challenge is to create an environment that truly values sharing knowledge. The personal challenge is to be open to the ideas of others, willing to share ideas, and maintain a thirst for new knowledge" (McDermott, 1999, p.116).*

Fahey and Prusak (1998) state that if organisations or networks do not detect or correct errors then the organisation's knowledge will deteriorate, become obsolete and bad decisions will then be made. They identify 'the eleven deadliest sins of knowledge management' that are common in failed strategy:

1. not developing a working definition of knowledge;
2. emphasising knowledge stock to the detriment of knowledge flow;
3. viewing knowledge as existing predominantly outside the heads of individuals;
4. not understanding that a fundamental intermediate purpose of managing knowledge is to create shared context;
5. paying little heed to the role and importance of tacit knowledge;
6. disentangling knowledge from its uses;
7. downplaying thinking and reasoning;
8. focusing on the past and the present not on the future;
9. failing to recognise the importance of experimentation;
10. substituting technological contact for human interface; and
11. seeking to develop direct measures of knowledge.

(Fahey and Prusak, 1998)

Associations have been identified, between culture (De Long and Fahey, 2000), geographical boundaries of an organisation (Alavi, 2001), leadership (Earl, 2001), strategy (Earl, 2001) and knowledge management. These links reflect the essence of the partnership working between NHS commissioners and providers, therefore the part that knowledge has to play in making this relationship more effective must be understood in the context of these partnerships. "By combining human and information systems, organisations can build a capacity for learning broader than the learning of any of the individuals within it" (McDermott, 1999, p.116): and the

ability of the holistic organisation to develop competitive intelligence (Bocij et al, 2003), and to enhance the understanding of the market (Department of Health, 2009c) will support the strategic objectives of commissioners and providers alike. The transfer of knowledge from PCTs to CCGs as part of the transformation of the NHS under the coalition government was essential to avoid a decline in service quality and maintaining continuity (Department of Health, 2010b). 'Was this achieved?' remains an unanswered question.

The above section has focused on the resistors and challenges of the NHS commissioner-provider relationship and the following is a conceptual framework to be tested through the primary research developed from the above review:

- Tenure of leaders
- Leadership
- Clinician-Manager tensions
- Innovation
- Complex organisations and adaptation
- Conflict and tension between partners
- Restrictive performance management frameworks
- Knowledge management

Research approach

This paper presents the quantitative aspect of a multi method study that examines aspects of the relationship between the main constituencies in the commissioning process. A quantitative survey approach has been adopted as it allows for the capture of views from a representative population of the various organisations involved in the commissioning process and the subsequent application of generalisations to the whole population. This approach provides population validity, however, it does not make claims to ecological validity (Gill and Johnson, 2010). This has been addressed in other aspects of the first author's initial study (Cross, 2012), which it is intended to be made available to a wider audience in the near future.

The study has adopted a deductive approach in that it follows a clear research cycle (Frankfort-Nachmias and Nachmias, 1996). The authors have taken a pragmatic, realist approach (Gill and Johnson, 2010) to ontological issues for this study. In the context of the nature of the study exploring the stated responses of participants and the quantitative nature of the method this is considered an appropriate ontological perspective.

- The questionnaire before distribution was tested on a small sample of persons with appropriate backgrounds. Changes were considered and, where

appropriate, made over a series of iterations.

- The survey was distributed, collected and analysed via a proprietary software tool purchased for the study.

- The sample for the survey was determined from the constituencies involved in the commissioning process. A total pool of potential participants of 337 was identified and a statistically valid sample of 119 responses calculated utilising Yamane's (1967 cited by Israel, 1992) formula. Responses to all survey questions achieved statistical validity (up to 163 responses from NHS managers and GPs).

Research Findings

The findings of the research are examined through the conceptual framework identified above.

Tenureofleaders

Alexander and Lee (1996) demonstrated the probability of organisational failure dependent on the tenure of the CEO. The short tenure of CEOs in the NHS is well known with the average tenure of a Chief Executive Officer (CEO) being two and a half years (Lynas, 2009) which may also link into the risk averse nature of the NHS. Qualitative research (Cross, 2011) also suggested that the short tenure of leaders in the NHS has an adverse effect on the ability of organisations to develop successful partnership working and deliver long term strategies.

The questionnaire survey also strongly suggests that the short tenure of leaders does adversely affect NHS organisations with 79% of respondents agreeing with this assertion. The margin of error (5%) for the sample size has no impact on the certainty of the outcome and therefore the short tenure of leaders can be confirmed as a challenge for the NHS.

By lengthening the tenure of CEOs, there may well be higher rewards and achievements for the NHS although the probability of organisational failure may also increase. The demanding nature of the challenges that lie ahead for the NHS will require the appropriate length of leadership for individual organisations which, in turn, will enhance the success of the commissioner-provider relationship.

GP Leadership

The development of GPs into leadership roles within the commissioning environment represented a fundamental principle for the creation of Clinical Commissioning Groups in 2013. The survey question focused on whether this innovative responsibility for GPs will address the issue of leadership stability. The results delivered a firm outcome with 71% of respondents stating that GP leaders were not the answer to this dilemma. The resolution to the problem highlighted by Lynas (2009) does not appear to have been found through the development of Clinical Commissioning Groups (Department of Health, 2010a). The commitment to longer term leadership may therefore create improvements in strategy development and delivery but the enhancement of the commissioner-provider partnership could also be a product of the prolonged existence and continuity of individual leaders.

Clinician-Manager tensions

Goodwin (1996) illustrated the tensions between clinicians and managers as a paradox where the professional perspectives of the two roles continually clash. The historical relationship between NHS organisations and GPs has, at times, been

fairly unstable with some GPs favouring clinical decisions over attainment of financial stability and, on the other hand, a leaning towards statutory targets and national policies by NHS managers (Cross, 2009).

The testing of these assumptions was undertaken through the questionnaire with a focus on the alignment of motivations and goals of clinicians and managers. The views of the respondents were inconclusive and broadly split between those who saw a worsening in relations and those who saw improvement as to whether the new model of healthcare pro- posed by the government, with GPs at the forefront of commissioning, would help address the divergence of clinician-manager objectives. Whilst it is not clear whether the long sought after alignment of motivations and goals between clinicians and managers would improve or worsen in the current NHS model, the different views of these groups were stark with 80% of GPs believing the introduction of CCGs would improve the alignment whereas only 39% of managers concurred with this view. This in itself demonstrates the disparity between clinicians and managers.

The uncertainty in the questionnaire outcomes suggests that further research should be undertaken to understand the clinician-manager tensions and how they should be ad- dressed. One response to the questionnaire suggested that "the only way to address this is to align their goals, and this is best done using health outcomes. So the introduction of the Outcomes Framework should go a long way to achieve this". This will represent an area of additional primary research that will need to be undertaken to gain clarity on how to improve the clinician-manager paradox within the English NHS.

Innovation

Damanpour (1996) expressed a view that innovation was more restricted in not-for-profit organisations in comparison to other sectors due to:

- Greater influence by external political and regulatory institutions;
- Constraints by external rules;
- Exposure to greater external scrutiny and accountability;
- Constraints on decision making through external control;
- Fewer risks taken in their strategic decisions; and
- Greater levels of centralisation, formalisation and standardisation of personnel procedures

These views, we are certain, will chime with observers of the NHS. The survey addressed the issue of innovation within workforces and the ability of leaders to empower their teams to be creative in supporting organisational objectives. The findings were a resounding neg- ative with 74% of respondents (106 out of 142 responses) confirming their views that inno- vation was in short supply across commissioning and provider workforces. The application of the confidence interval still provided the same results with a lower bound interval of 71% (101 respondents) and an upper bound interval of 78% (111 respondents), therefore the large majority from the sample still formed the view that innovation, and the empowerment of the NHS workforce to innovate, was very limited. The support for Damanpour's view (1996) is therefore clear in the outcomes.

The empowerment of front-line staff, in particular, is at the heart of the current NHS model (Department of Health, 2010), however, the ineffective delegation of power and decision making can only be counter-productive to these proposals and should therefore represent an area where leaders in the 'new NHS world' will need

to further enrich in order to gain the most benefit from the human resources in the system. This is further supported by Damanpour's (1996, p.694-696) observations that large organisations are unable to change and adapt quickly, have impersonal work environments and provide greater challenges. The enhancement of innovation across the workforce to deliver the organisational objectives should begin to address these factors.

The restriction of innovation in the NHS links to various other findings in this paper; partner tensions, expansive NHS principles, leadership turnover, performance management, limited financial resources and policy and politics. The breadth of this issue can be seen in the underlying issues outlined throughout many variables in this paper.

Complex organisations and adaptation

A comment has been made that "complex organisations need more time to adapt and need more time for decision making than organisations with simple structures, networks and environments" (Miller, 1987 cited by Cross, 2010, p.15-16).

Whether one perceives the NHS as a whole to be an organisation or whether the individual bodies are the constituent organisations that make up a complex network, it is clear that complexity is a common factor from all perspectives and thus the above comment will probably 'strike a chord' among those knowledgeable about the NHS.

The questionnaire addressed the issue of the adequacy of time for organisational development in the NHS and the results show a two-tone outcome with differences in results for commissioning and provider organisations. 78% of respondents expressed the view that commissioning organisations are not given enough time to evolve and 14% having the con- verse view. More granular detail for this question showed that the majority of respondents across commissioners and providers shared the same view that commissioning organisations were not given appropriate time to develop. In terms of providers, however, the views are fairly equal with 50% taking the view that provider organisations do not have sufficient time to evolve and 45% with the opposite view that NHS Trusts and Foundation Trusts have adequate time to demonstrate their success.

In summary, it can be seen that commissioning organisations have not been offered the conditions that Miller (1987) states are a prerequisite for the development of complex organisations whereas the evidence on provider organisations is less conclusive. Commissioners and providers are both large, complex organisations and therefore the government must alleviate the concerns expressed by Miller (1987) and Damanpour (1996) by proffering a longer term commitment to NHS organisations particularly the stabilisation of commissioning organisations by limiting structural and leadership change.

Conflict and tension between partners

This research also focused on the relationship between commissioners and providers and the causes of any tensions between the organisations. Johnston (1997) outlined three types of partner tensions; relationship, structural and developmental, and these are used to assess the commissioner-provider relationship and the level of conflict that exists.

When participants were asked about the relationship the modal answer was that there was a good relationship between commissioners and providers with 40%

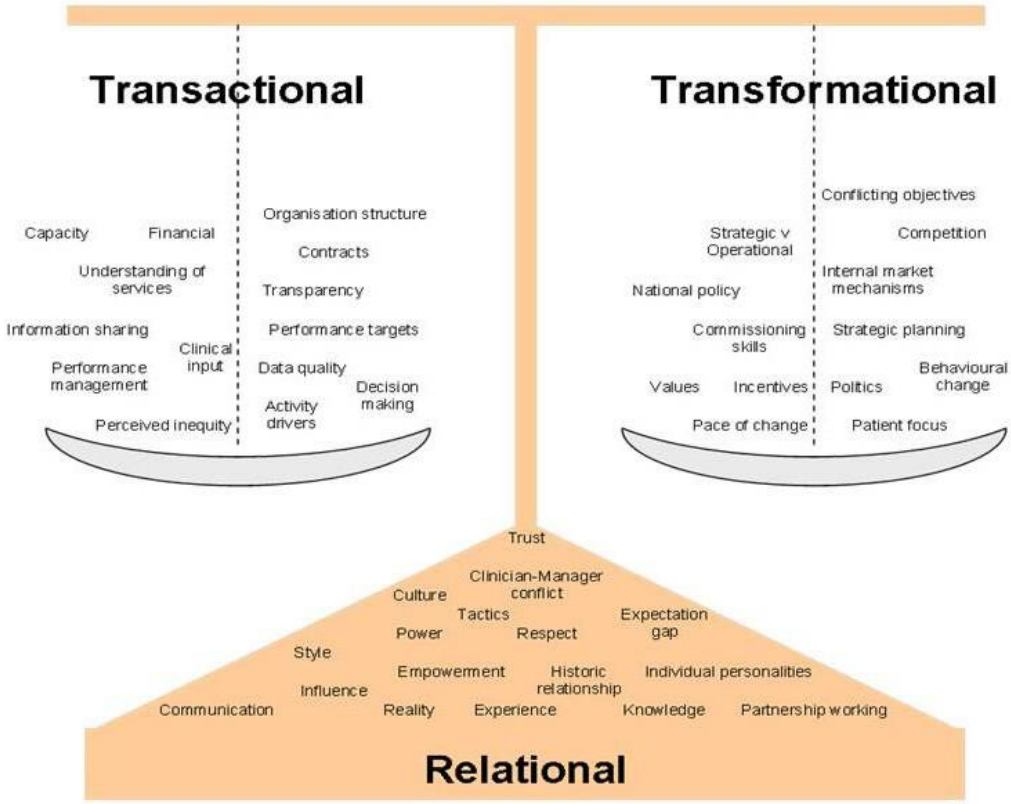
stating that a good relationship exists, 33% were undecided and 27% disagreed that a good relationship existed. This outcome may not be as unanimous as the results from other questions but a majority view suggests that a reasonably good relationship exists.

Even good relationships are not without their tensions (Johnston, 1997) and many causes of these tensions were identified. Altogether there were 51 different responses to this question (which shows the complexity that exists in the commissioner-provider relationships) but the most mentioned issues were financial matters (59%), conflicting objectives and priorities and contractual matters.

The answers, however, can be categorised into three broad headings; transactional, trans- formational and relational. This is a gradation of Johnston's (1997) categorisation of partner tensions as relationship, structural and developmental but has been developed based on the findings from a qualitative research paper by Cross (2011). An NHS Trust Director of Finance stated that one of the differences between commissioners and providers was that commissioners focus on the transformational aspects of the relationship and providers on the transactional elements - relational tensions therefore arise (Cross, 2011). The transactional category focuses on the operational mechanisms that exist in the NHS whereas the trans- formational items focus on the strategic and organisational changes and aspirations.

The mapping of the answers across these headings shows that transactional and relational issues override the number of transformational tensions and, yet, with significant organisational and system changes planned for the NHS, the focus should be on transforming the healthcare market. The complications arising from the transactional and relational tensions therefore may be diverting attention and resources away from the government's intentions and highlight the issues that really drive conflict between commissioning and provider organisations. This is diagrammatically presented in Figure 1.

Figure 1



The comparisons to Johnston's partnership tensions (1997) are clear to see, with transformational tensions aligning to developmental and relational tensions featuring in both concepts. However the main difference is Johnston's (1997) model features structural tensions whereas the concept developed in this paper focuses on transactional tensions. It is likely that not all of these tensions exist in one single partnership but commonality exists across the commissioner-provider collaborations. The complexity of the challenge that NHS leaders face in meeting the NHS principles has therefore been established. This complexity is not going to disappear from the NHS and therefore leaders must understand the individual challenges that exist for their partnerships before managing these complications.

These represent the challenges that must be overcome to improve the organisational relationships across the NHS. The ability of leaders to minimise and address the effects of these tensions links many of the factors in this paper, and the range of these answers suggests that these tensions could only be managed not fully resolved in line with the barriers of large, complex organisations (Miller, 1987; Damanpour, 1996) discussed earlier in this paper. This fits with the views of Plsek (2001) on complex adaptive systems that the complications driven by the relationships between agents within a system can be non-linear and unpredictable, which does not fit with the requirement to understand the cause of these tensions, but the difficulties in problem solving are evident in the breadth of the answers received.

Restrictiveperformancemanagementframeworks

NHS England establish the key priorities for the NHS through the issuing of technical and strategic guidance to commissioners which also provides the basis

for the performance management framework that NHS organisations are monitored on. The leaders in the NHS face the challenge of delivering these performance measures and top teams in organisations (commissioners and providers) are judged on their ability to demonstrate their success against nationally driven criteria (Wilson, 2009).

The original intention of the current healthcare model was to reduce the bureaucracy in the NHS and remove unnecessary, labour-intensive performance targets (Department of Health, 2010a). Part of the survey focused on the level of resources used in addressing performance targets. While 54% of respondents expressed the view that the level of resources utilised in demonstrating progress against targets was inappropriate, 32% suggested that the resources used were appropriate. The overall outcome of this question remains un- changed with the application of the 5% confidence intervals, therefore, a definitive view can be formed that the prescriptive performance framework does create a challenge for NHS organisations to overcome and therefore supports the Coalition Government's claims (Department of Health, 2010b) that this is an inhibitor for the development of the NHS. This outcome also remains unchanged in the sub-set analysis across GPs, corporate managers, commissioners and providers.

Knowledge Management

The challenge of knowledge management in organisations is depicted by McDermott (1999, p.116):

> *"The technical challenge is to design human and information systems that not only make in- formation available, but help community members think together".*

This view is also reinforced by other commentators (Fahey and Prusak 1988). The management of knowledge is an essential competence for commissioning organisations with the move to GP-led commissioning in 2013. In particular, the fluid sharing and transfer of knowledge between PCT managers and leaders was particularly important during the transitional period between PCTs and CCGs in order to reduce the risks of organisational memory loss and the potential for a wealth of NHS knowledge to leave the NHS in the form of PCT corporate managers.

The research for this paper attempted to elucidate from commissioners and providers what they saw as the key challenges in this area. The results are shown in Table 1.

There are consistencies between commissioners and providers on views around knowledge management and the only statement where there are opposing views is actually an expected outcome. Statement 5 focuses on awareness of PCT to CCG knowledge transfers and there would be little expectation that provider managers would have an informed view on the plans to transfer knowledge between previous commissioners and their successors. The challenges outlined in the overall results are therefore broadly the same throughout the categories identified within the sample.

Table 1

Ref	Statements on Knowledge Management	Commissioners	Providers
1	The sharing and transfer of knowledge is a priority for my organisation	✓	✓
2	There are formal systems for sharing and transferring knowledge across local NHS organisations and GP practices	✓	*
3	Knowledge freely flows between individual members of commissioning and provider organisations	X	X
4	I have the opportunities and freedom to share knowledge face-to-face with my colleagues	✓	✓
5	I was aware of plans to transfer knowledge between PCTs and CCGs	✓	X
6	My employer encourages innovation to support the creative development of knowledge	✓	✓
7	My employer actively seeks to identify skills and knowledge held by its employees that are not routinely used	X	*
8	I am regularly faced with the situation where a colleague has left the organisation and their knowledge of their work area has been lost at the same time	✓	✓

Conclusions

This paper has been developed and presented in a period of unprecedented change for
the NHS (Department of Health, 2010a; Central Government, 2014). Leaders are changing. Whole organisations have disappeared. Clinicians have an unorthodox role. However, the fundamental principles and aims of the NHS (NHS Choices, 2009) continue to be the com- mon factor between models of healthcare This paper suggests that the significant challenges for the commissioner-provider relationship are:

- Short tenure of leaders
- Time-limited development of NHS organisations due to the instability created by regular organisational restructuring
- Restrictions related to prescriptive performance management framework
- Innovation restricted in the NHS due to lack of empowerment by NHS leaders

- Conflict and tension between commissioning and provider organisations

The outcomes from the survey have supported this view as “the frequent changes in key leaders hinders addressing many of the cultural challenges the service face as changing culture is a long term process”. The aspiration of leaders to avoid organisational failure overrides the drive for organisational success (Alexander and Lee, 1996) creating a risk averse environment where the promulgation of innovation and creativity is inhibited. Cross, (2011b) identified that improved delivery of strategic objectives is achieved through encouraging innovation through the empowerment of the workforce.

Complex organisations must set forth a good enough vision and create a wide space for natural creativity to emerge from local actions within the system, and yet the research has proven that an innovative environment does not exist between commissioners and providers. McShane (2010a) said that this would only be developed if the unwritten office rules were ignored and individuals left to express themselves. A respondent to the questionnaire supported the view that “commissioners being clear on vision and requirements, using staff to develop change and not allow the Chief Executive to make all decisions” was essential to ensure the success of the collaboration between commissioners and providers. The linkage between the tenure of leaders, organisational success and the enrichment of workforce roles has been drawn out from this research as a challenge for the NHS to overcome.

It is also argued that complex organisations need more time to adapt to change and deliver organisational objectives. On the basis that NHS organisations are complex, the research has confirmed that commissioning organisations fit this theory whereas the evidence was less conclusive for provider organisations. In order to improve the relationship between commissioners and providers, the government must create conditions in which the system can evolve naturally over time rather than attempting to force credible outcomes within short timescales.

The first three bullet points above are unlikely to be resolved through localised action between commissioners and providers. It will require government-driven decisions applied consistently across the whole of the NHS to make some in-roads into addressing these challenges. The challenge around innovation highlights the failings of local NHS leaders in empowering their workforce to achieve specific objectives but may be partly driven by the risk of failure due to the level of challenges identified. The controllable nature of this issue, however, suggests that leaders do not currently recognise the risks of failing to empower teams and individuals. Qualitative research (Cross, 2011b) undertaken has outlined the importance of individual relationships to the overarching organisational relationships and therefore an innovative commissioner-provider relationship must be driven by the creativity of individuals working together not single, autocratic leaders.

A final outcome from this paper, and probably the most significant development, was the identification of a potentially new partnership model which is illustrated in Figure 1 on page 14. The complexity of the relationship between commissioners and providers is demonstrated by focusing on the transactional, transformational and relational tensions. Clearly, the quantity of the tensions suggests that they can only be managed not fully mitigated, therefore commissioning and provider organisations, in whatever guise that the future model of healthcare presents them

in, can only benefit from improved collaborative working.

The model shows the areas of contention between commissioners and providers which reflects the two-level objectives for NHS organisations; transformational and transactional. The ability of commissioners and providers to deliver the challenging and, in some cases, conflicting objectives is dependent on the management of relational tensions between the two parties. These relational tensions are driven by the professional relationships between individuals (Cross, 2011) and the resolution of those tensions is reliant on those same individuals who have formed the barriers. The nurturing of leaders, and leadership skills, to balance the relational challenges identified will enhance the probability of understanding, addressing and managing the different perspectives of commissioners (transformational) and providers (transactional). The partnership tensions model provides evidence of the complexity of the commissioner-provider relationship and it would be naive to suggest that these tensions could be fully mitigated. Plsek's (2001, p.313) view on complex adaptive systems therefore rings true with the NHS as "a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions changes the context for other agents". The organisational behaviours between commissioners and providers impact on the relational tensions and therefore the transactional and transformational outcomes for both parties.

"Provide simple rules and minimum specifications" was stated by Plsek (2001, p.28) as a design essential for complex adaptive systems. The NHS has not addressed this factor to the extent that the prescriptive performance framework has been proven as a challenge for the commissioner-provider relationship in this research paper aligning to the coalition government's published views (Department of Health, 2010a; Central Government, 2014). This issue is partly highlighted by an anonymous respondent to the questionnaire; "generally people on a personal level do work well together, however, financial resources, policy, frameworks and national priorities do tend to challenge this relationship". The frameworks and national priorities mentioned in this statement therefore provide further evidence of the restrictions being placed on commissioners and providers alike. If the NHS as a whole does not embrace the change required to address the relational and system challenges and recognise the influenceable characteristics of a complex adaptive system, then the longer term sustainability of the English NHS would truly be in doubt.

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