RESPONSIVENESS

PERSPECTIVES ON POLICY IN GENERAL PRACTICE

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Abstract

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Responsiveness: perspectives on policy in general practice

Meeting the needs of patients in general practice is complex, and responsiveness is seen as a way to meet these needs and preferences. Policies have been published advocating responsiveness, but its meaning is multi-faceted. Little is known about how initiatives to improve responsiveness to patients interact with the values of the people and organisations trying to implement them. This qualitative study aimed to explore how responsiveness has been espoused in policy and it has been viewed and responded to in practice, with a focus on whether or not it is a useful concept in supporting quality management and improvement in primary care.

The research design includes analysis of English national policies about responsiveness in primary care, and interviews with elite policy-makers, and strategic and frontline staff. Analysis of policies took a thematic and longitudinal approach to investigate how responsiveness emerged as an aspiration in general practice and changed over time. Thematic analysis of interviews examined how the meaning of and response to responsiveness at the macro-, meso- and micro-levels has changed with the shifting political and social climate.

Findings indicate that responsiveness is considered a way to attain goals aligned with the core values of general practice but that there are tensions when balancing the needs of the many and the needs of the few, especially in times of financial austerity. For responsiveness to become successfully enacted, the goals of responsiveness need to be ‘amplified’ such that they become a priority, and these goals need to be aligned with the values of those attempting to prioritise them. Findings suggest that value amplification and values alignment can be helpful when making difficult choices between competing priorities in a context of restricted finances and prolific targets.
Acknowledgements

Many people have helped me on my journey to produce this thesis. First and foremost, a thank you to my supervisors, Carolyn Tarrant, Richard Baker and Graham Martin for their encouragement and critique. Carolyn and Richard were also part of the linked NIHR study during the first three years of my registration, again providing help and inspiration. The SAPPHIRE group has provided a fertile and supportive environment in which to conduct a PhD part-time, with colleagues offering helpful critique on draft chapters. I owe a debt of gratitude to the Department of Health Sciences for waiving my fees, and the NIHR, for the first three years, for allowing me time during working hours.

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### Abbreviations and terminology

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<th>Description</th>
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<tbody>
<tr>
<td>APMS</td>
<td>Alternative Provider Medical Services</td>
</tr>
<tr>
<td>BME</td>
<td>Black and minority ethnic</td>
</tr>
<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical commissioning group</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>CT</td>
<td>Carolyn Tarrant</td>
</tr>
<tr>
<td>DES</td>
<td>Directed Enhanced Service</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>GMS</td>
<td>General Medical Services</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>HCP</td>
<td>Healthcare practitioner</td>
</tr>
<tr>
<td>HS&amp;DR</td>
<td>Health Services &amp; Delivery Research</td>
</tr>
<tr>
<td>HSR</td>
<td>Health services research</td>
</tr>
<tr>
<td>IMD</td>
<td>Index of Multiple Deprivation</td>
</tr>
<tr>
<td>LES</td>
<td>Local Enhanced Service</td>
</tr>
<tr>
<td>NAPP</td>
<td>National Association for Patient Participation</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NIHR</td>
<td>National Institute for Health Research</td>
</tr>
<tr>
<td>NIHR study</td>
<td>The NIHR HS&amp;DR-funded work to develop a patient-report measure of responsiveness in primary care</td>
</tr>
<tr>
<td>NIT</td>
<td>National Improvement Team</td>
</tr>
<tr>
<td>PBC</td>
<td>Practice-based commissioning</td>
</tr>
<tr>
<td>PCC</td>
<td>Primary Care Commissioning</td>
</tr>
<tr>
<td>PCO</td>
<td>Primary care organisation</td>
</tr>
<tr>
<td>PCRN-EMSY</td>
<td>Primary Care Research Network for the East Midlands and South Yorkshire</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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<tr>
<td>PCSF</td>
<td>Primary Care Services Framework</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary care trust</td>
</tr>
<tr>
<td>PPG</td>
<td>Patient participation group</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality and Outcomes Framework</td>
</tr>
<tr>
<td>RCGP</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>SAPPHIRE</td>
<td>Social Science Applied to Healthcare Improvement Research</td>
</tr>
<tr>
<td>SHA</td>
<td>Strategic health authority</td>
</tr>
<tr>
<td>Thesis, doctoral study</td>
<td>Elements of my work that contributed solely to this thesis</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>USSR</td>
<td>Union of Soviet Socialist Republics (Soviet Union)</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Preface

I conducted the first half of my PhD studies alongside a large study funded by the National Institute for Health Research Health Services and Delivery Research (NIHR HS&DR) programme to develop a patient-report measure of responsiveness in primary care (Tarrant et al. 2014). The aim of the NIHR study was to seek patient and primary care staff perspectives on what makes a responsive primary care service and to develop a way of measuring this through a questionnaire. The project involved interviewing patients and staff from a range of primary care providers (GP practices, a walk-in centre, a GP service for homeless patients, a large Health and Social Care Centre, and pharmacies) and other organisations (to reach seldom-heard groups such as non-English speakers, travellers, and people with mental health problems).

Interviews aimed to find out what issues were important to patients and to ensure that our measure incorporated these aspects of responsiveness, and that the measure would be acceptable to staff and patients.

The NIHR study was primarily focused on the patient perspective. My doctoral study incorporated general practice staff interview data from the NIHR study (27 interviews were conducted in total across the different types of primary care provider, and I draw on 21 of these (of which I conducted eleven) in Chapter 6), and for the purposes of this thesis, I conducted secondary in-depth analysis of staff experiences of, and attitudes towards, delivering responsive general practice services. I also conducted additional data collection and analysis, including the selection and analysis of responsiveness policy documents (Chapter 2), conducting and analysing 17 interviews with policy-makers (Chapter 4), and conducting and analysing interviews with 12 staff in strategic roles in general practices, and local commissioning and public health organisations (Chapter 5).

Where I draw on the output from the NIHR study (in Section 1.3.1), I describe my involvement and contribution explicitly.
1 Introduction

In the UK, around 90% of patient interaction is with primary care services (NHS Digital 2016). Primary care is usually a patient’s first point of contact with the National Health Service (NHS). Primary care covers general practitioners’ (GP) practices, walk-in and urgent care centres, dental practices, community pharmacies and high street optometrists (NHS Choices 2016). The aim of primary care is to provide easy access to care, whatever the patient’s problem; it is based on caring for people rather than specific diseases. This means that primary care healthcare practitioners (HCPs) are generalists dealing with a broad range of physical, psychological and social problems rather than specialists in any particular disease area (Centre for Academic Primary Care 2016).

Primary care is undergoing a period of unprecedented change, with rising demand which is not matched by growth in either funding or workforce (Baird et al. 2016). In general practice, work is also becoming more complex and more intense, due to an ageing population, increasing numbers of people with complex and chronic conditions, initiatives to move some services from hospitals into the community, and rising public expectations (Baird et al. 2016). As well as trying to keep up with demand, altering working practices to deal with a changing patient population and structural change, GP practices also have to manage a high bureaucratic workload, for instance inspections from the Care Quality Commission (CQC) (Care Quality Commission 2016a) and complex relationships between primary and secondary care (Baird et al. 2016).

Responsiveness has been highlighted as fundamental to providing good primary care, and since the mid-2000s there has been a drive to improve responsiveness in primary care. The most recent definition of responsiveness is:

“Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care. [...] There is a proactive approach to understanding the needs of different groups of people...”
Definitions of responsiveness encompass key, core values of primary care. By studying the emergence of responsiveness in policy, and efforts to drive improvement in responsiveness in primary care in England, I aim to characterise the merits of conceptualising responsiveness as a tactic to implement policy goals aligned with values, identify the challenges to implementing responsiveness, and draw out some wider lessons about realising values in healthcare.

1.1 The value of values

The framework for this thesis is values in primary care. Values can be defined as “modes of conduct or states of existence that are thought to be worthy of protection and promotion” (Rokeach 1968, Turner & Killian 1972) and as serving two functions: “First, they are the primary driver of motivation and, secondly, they provide a standard against which actions are evaluated” (Sullivan et al. 2001). In this thesis I argue that responsiveness is way to achieve goals aligned with core values of primary care.

However, as noted by Dose (1997), values research is fragmented, with theorists focusing on specific domains without considering the relationships between these domains. Researchers also use different terminology (for instance, work values, moral values, personal values, social consensus values, preferences, etc.), and formulate their own lists of values and associated definitions. Comparison across studies is therefore difficult (Dose 1997), as is a comprehensive scholarly review of the subject.

Here, I review some of the key concepts in the values literature. In particular I examine values in public sector organisations, the NHS and general practice, where I consider various values models in general practice. I introduce responsiveness and its various definitions in the literature and in policy, and I argue that responsiveness can be viewed as a tactic to achieve goals aligned with values. I introduce the concepts of value amplification and alignment and discuss their importance in relation to behaviour and decision-making. I introduce the literature on the implementation of
policy goals aligned with values in the public sector and I end this chapter with my research questions.

1.1.1 Human values
Seminal work in the 1970s formed the basis for much values research in the following years. Rokeach (1973) built on his earlier work (Rokeach 1968) to present a value as “an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or existence” (p5). Rokeach suggests that values cannot be ever-lasting (allowing for individual and social change) but do tend to endure over time (allowing for continuity of human personality and society). ¹

Williams (1979) insists that “the core phenomenon [of values] is the presence of criteria or standards of preference. [...] When most explicit and fully conceptualized, values become criteria for judgement, preference and choice” (p16). Rokeach (1973) takes account of how values may interact with each other and states that “A value system is an enduring organization of beliefs concerning preferable modes of conduct or end-state existence along a continuum of relative importance” (p5). Whilst some values may take priority over others and they can be re-ordered, the total value system remains relatively stable over time. Thus values are standards that guide activity and motivate action (Schwartz 2012, Sullivan et al. 2001), and value systems are general plans that help to resolve conflicts (for example between competing values) and make decisions. Indeed, individuals subscribe to a range of values that vary in the degree to which they are compatible and attainable, and values are normally arrayed in a hierarchy such that some have greater salience than others (Snow et al. 1986). The ordering of values within a hierarchical system is crucial in helping people to determine what is most important and thus what to prioritise, which might be helpful, for example, for general practice staff working in times of austerity (Tarrant et al. 2014). The terminology of ‘standards’ is often used in the definitions of values as they can

¹ This, and the definition given earlier in Section 1.1, are in close alignment to other definitions in the literature. Indeed, the work of Rokeach and Williams is cited in much of this literature and provides the foundation for other authors’ research.
guide behaviour in a variety of ways. For instance they: lead us to take particular positions on social issues or to evaluate and judge; and are employed to persuade or influence others, to tell us which beliefs, attitudes and actions of others are worth challenging or trying to influence or change (Rokeach 1973, Schwartz 2012). Indeed, values and standards are similar in many ways and they are most powerful when they are declared and they act as guiding principles. But there are important differences: values state what is important (e.g. access to a GP) whereas standards state what is good or acceptable (e.g. access to a GP within 48 hours); values tend not to vary, whereas standards (both the current standards that have been achieved, and standards that are regarded as acceptable) may vary over time (Pendleton & King 2002). I will return to the concept of standards in Section 1.1.4.

Drawing on some of the key literature on social norms, it is possible to identify fundamental ways in which values differ from the concept of social norms. Social norms refer only to modes of behaviour (the ways in which people conduct themselves) whereas values refer to both modes of behaviour and end-states of existence (also termed ‘terminal values’) (Rokeach 1973). Norms can be considered as specific obligatory demands or rules, whereas values are the criteria of desirability (Williams 1979). According to Schwartz (2012), norms do not transcend specific situations, whereas values apply to all situations: for instance the values of obedience and honesty may be relevant in the workplace or school, in business or politics, and with friends or strangers; whereas norms usually refer to specific actions, objects, or situations. Norms are not hierarchical, whereas value systems assist with prioritisation (Béland 2009, Schwartz 2012). Norms tend to be consensual and tacit, and are based in ‘folklore’ and a historical understanding and acceptance of ‘how we do things around here’ whereas values can be explicitly expressed and defended (Pascale 1985, Bessant et al. 2001). Norms are consensual and tacit; values can be shared by members of a group but they can also differ from person to person. Finally norms are standards or rules that tell members of a group or society how they should behave, whereas values are a choice (Schwartz 2012). Norms vary on a scale of how much we agree or disagree that people should act in a specific way whereas our values affect whether we accept or reject particular norms. Thus, norms are patterns that become established and
accepted in every day practice, which may or may not reflect values. In general practice, many staff may share a value, such as accessible care, but they may struggle to put it into practice, which results in staff and patient dissatisfaction.

1.1.2 Organisational values, collaboration and values alignment

According to Schwartz (2012), values are grounded in one or more of three universal requirements of human existence with which they help to cope: the goals of biological survival; the demand for social interaction; and social and institutional demands for group welfare. The vocabulary of values is of key importance in organisations as values drive behaviour; there are strong arguments that values should not be compromised for financial gain or short-term expediency (Sullivan et al. 2001, Kidder 2005). Indeed Rona Lynn Fitzpatrick (2007) proposes that values are the foundation on which organisational systems are built. It is suggested that the foundations of organisational alignment (a commonality of purpose, shared vision, and harmonisation of energy towards achieving organisational goals) are built on values that have been clearly identified, examined, prioritised and translated into specific behavioural terms (Lynn Fitzpatrick 2007).

As Dose (1997) and others have suggested, there is a lack of agreement about definitions and conceptualisation around organisational values; however Bourne and Jenkins (2013) have attempted to set out some essential characteristics. They take the position that organisational values embody those general values that guide organisational members in their selection or evaluation of behaviour, and that these values represent a form of consensus regarding the values that a social group or organisation consider important for its aims and collective welfare (Bourne & Jenkins 2013, Williams 1970, Schwartz & Bilsky 1990).

According to Bourne and Jenkins (2013), organisational values can be of four forms: espoused, aspirational, shared, or attributed (summarised in Table 1, overleaf). The authors claim that these partial but related forms can be used to reveal the dynamic nature of organisational values. Taken as a whole, these forms offer a construct that provides scholars and practitioners the potential to explore further their influence and evolution (Bourne & Jenkins 2013) and I return to them repeatedly through this thesis.
<table>
<thead>
<tr>
<th>Organisational value form</th>
<th>Description</th>
<th>Demonstrated by…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Espoused</td>
<td>Values formally espoused and sanctioned by top managers</td>
<td>Explicit statements on organisational websites, in annual reports or other corporate documents: they clearly represent the value consensus among an organisation’s senior leaders and managers</td>
</tr>
<tr>
<td>Attributed</td>
<td>Values attributed by the organisation’s members that characterise their organisation through the patterns they observe in day-to-day actions; the context of organisational identity as though it was an individual</td>
<td>Members’ descriptions of their organisation’s values that are generally representative of the organisation, often based in history of past decisions, but are not necessarily espoused by managers, shared by members, or aspirational for the future</td>
</tr>
<tr>
<td>Shared</td>
<td>Values that are an aggregation of the values of the organisation’s members forming an organisational value system, its breadth measured by the proportion of members who share the values, and its intensity by the importance with which a value is held in relation to other shared values</td>
<td>Members’ descriptions of the values that they share, especially within their immediate workgroups based upon the assumption that members’ personal values can be shaped or subsumed through socialisation, and that divergence of interests can be minimised</td>
</tr>
<tr>
<td>Aspirational</td>
<td>Values members believe their organisation should adopt if it is to thrive in the longer term</td>
<td>Members’ descriptions of what the organisation’s values ought to be, not necessarily based on historical values or endorsed by top managers but may be similar to shared personal values of those individuals promoting them, but different from shared values in that they emphasise intention: what ought to be, rather than what is</td>
</tr>
</tbody>
</table>

Table 1: Four forms of organisational value according to Bourne & Jenkins (2013)

The relationship between these value forms is important for collaboration, according to Lynn Fitzpatrick (2007), which is key for general practice where multi-disciplinary teams work across professional and organisational boundaries. Although not referring to the forms explicitly, she says: “...it seems unlikely that values can be predetermined...”
and dictated to organizational members, if it [the organisation] does not take into account the values and beliefs members already possess. In other words, to achieve collaborative practices (create common agreements), one must act collaboratively” (Lynn Fitzpatrick 2007).

Some practitioner-oriented reviews have suggested that in successful values-based organisations, values need to be declared, but discovered rather than created – values should have meaning and be credible (Lee et al. 2005). Values have to be embodied in the very fabric of the organisation, in its systems, processes, practices, and rewards, not just in its annual report (Collins & Porras 1994). Such organisations do not explicitly seek to prioritise their values: instead they aim to function in such a way that all their values are shown (Collins & Porras 1994), and they work hard to resolve clashes of values. In this way they build trust, motivation, and commitment, hence increasing the likelihood of effective collaboration between internal employees and also with external stakeholders (Collins & Porras 1996, Pendleton & King 2002).

For collaboration to be successful and for a positive organisational environment, alignment between employees’ personal values and the values of the organisation is helpful. When values are aligned, it is claimed that all relationships (between one person and another, the present and the future, a customer and a product, a team and its goals, a leader and a vision) are strengthened (Branson 2008). It is especially helpful when values are explicitly defined and embodied by all employees as there is therefore less need for overt management and control (Branson 2008). Values alignment (see Section 1.3.4.1 for further discussion of values alignment) is an ongoing and deliberate process of building a cohesive working environment which helps an organisation to manage change effectively, according to Branson (2008). Such an environment guides people to work together towards a common goal because they have a deep desire to contribute towards the organisation (Lynn Fitzpatrick 2007). On the other hand, when values are misaligned, this can lead to conflict and inefficiency (Paarlberg & Perry 2007, Lynn Fitzpatrick 2007, Sullivan et al. 2001).
1.1.3 Values in the public sector

Given the context of this thesis, primary care in England, I turn now to literature on public sector values. According to Kernaghan (2003), the total field of public sector values can be divided into four categories: ethical values, such as integrity and fairness; democratic values, such as the rule of law and representativeness; professional values, such as efficiency and innovation; and people values, such as caring and compassion. \(^2\) (Tait 1997) These categories are conceptually different to the framework proposed by Bourne & Jenkins (2013) as they relate to the character of a given value rather than to its origin and ownership. However, in a similar way to that suggested by Bourne & Jenkins, Kernaghan also claims that values can conflict, both within and between the four categories of values. However, whilst it is claimed that this conflict is a pervasive feature of public administration, reference to ethical values can help to resolve conflict between such democratic values as accountability and legality and between a democratic value such as accountability and a professional value such as innovation (Kernaghan 2003). Thus ethical values are an adjudicating set of values that helps to make sense of and mediate conflict between the others. In addition, values-centred leadership is important for integrating values into public services (Kernaghan 2003, Grojean et al. 2004). For such leadership to be successful, leaders “must serve not only as exemplary models of values-based behavior, but also as skilful practitioners of the art of values management” (Kernaghan 2003). However, research has suggested that in times of turbulence and change, it is the employees who govern the success or failure of new values rather than leadership inculcating them (Larson & Pepper 2003, Paarlberg & Perry 2007); Paarlberg & Perry (2007) suggests that these findings have particular relevance to public service employees, within the context of traditional bureaucratic and hierarchical structures, which is certainly the case for general practice in England (Care Quality Commission 2016b). The authors claim that for organisations where employees increasingly operate under complex expectations of networks and enterprise, where traditional models of administration based on

\(^2\) Although cited in Kernaghan (2003) as a way of categorising public sector values, to shape these categories, the author drew on a Canadian taskforce report (not available online, but summarised in ).
hierarchically imposed rules and procedures are challenged, values management may offer an additional and complementary method of coordinating diverse and often competing belief systems (Paarlberg & Perry 2007).

1.1.4 Values in the NHS

Historically, values have been widespread in the NHS (through medical bodies such as the General Medical Council), but standards have tended to be emphasised (Pendleton & King 2002). This terminology of standards differs to that used in definitions of values (Section 1.1.1), as it helps to specify measures in order to see whether a value has been achieved. Thus values and standards (in this sense) perform different roles: values encompass what is important whereas standards specify what is good, acceptable, or required in terms of performance or service delivery. Such standards are very explicit and (generally speaking) externally imposed, and necessarily common across a group or organisation (although they are heavily context-dependent so may vary between organisations) at a given point in time. In addition, values are considered to be stable whereas standards often vary over time, for instance they may change in line with the politics of a new government or in response to new research evidence.

Shared organisational values are important for all the reasons discussed in previous sections, but are especially important for employees in the NHS at this time, when it is claimed that morale is low and staff are expected to work in ways that may conflict with their personal values (e.g. by working to externally-imposed standards rather than by enacting their personal values), which cause distress, which in turn can affect recruitment and retention (Pendleton & King 2002). In Spring 2008, staff, patients, carers, and members of the public came together across the country to develop a national statement of values for the NHS. This work was based on the premise that values are beneficial for organisations in terms of organisational performance, staff engagement, and quality and patient experience (NHS Institute for Innovation and Improvement 2009). The output from this exercise was an Institute for Innovation and Improvement (2009) report Living the values: the value of values and associated guidance documents. The values developed were: working together for patients; respect and dignity; commitment to quality of care; compassion; improving lives; and everyone counts (NHS Institute for Innovation and Improvement 2009). This work
demonstrates that the NHS was taking values seriously and that the importance of values for organisational effectiveness was being recognised from within.

Whereas the behaviour changes advocated in many NHS and Department of Health (DH) reports are based on government ideology and/or partial evidence grounded solely in consultations with stakeholders, the *Living the values* report was unusual as it included a lengthy literature review providing evidence for how values can bring benefits to organisations, staff, and patients. In particular it provided evidence for the links between values and organisational performance, values and behaviour, values and staff engagement, values and customer experience, and values and enabling organisational change. It also considered literature to evidence key contextual factors that enable values to contribute to organisational effectiveness: leadership; deep embedding of values within the culture of the organisation; strong alignment between ‘espoused’ values (analogous to Bourne and Jenkins’ (2013) conceptualisation of ‘espoused’ values) and ‘lived’ values (the behaviour of the organisation); and sympathetic organisational processes – especially human resources processes such as those suggested by O’Reilly & Pfeffer (2000) and Kelly et al. (2005), for instance recruitment and induction, and reward and recognition (NHS Institute for Innovation and Improvement 2009).

Another unusual feature of the report was that the authors (the NHS Institute) set out to use a social movements approach to the values work (as advocated by Snow et al. (1986)). This approach gives further credence to the report authors’ argument that values are important and should be ‘discovered’ rather than imposed (Lee et al. 2005, Collins & Porras 1996). Taken together, these approaches indicate a desire to move away from DH-dictated top-down policy towards a co-design and collaborative approach which aims to affect heart and minds, and hence behaviour. I am not suggesting that the most effective way to affect behaviour is by appealing to hearts and minds – indeed there is good evidence that standards and targets are very effective at changing behaviour – but that there is a desire from within to move towards this approach. As will be seen throughout this thesis, the tensions between ‘hearts and minds’ and ‘harder’ incentives such as targets (which were (and indeed
are) still prevalent at the time the NHS Institute’s report was written) can cause difficulties when individuals and organisations attempt to enact change.

In March 2011, the DH published the *NHS Constitution* which sets out the guiding principles of the NHS (NHS Choices 2015). Similar to the NHS Institute’s work two years earlier, these expressions of values were also developed by patients, the public and staff – values that inspire passion in the NHS, and that should underpin everything it does: “Individual organisations will develop and build upon these values, tailoring them to their local needs. The NHS values provide common ground for cooperation to achieve shared aspirations, at all levels of the NHS” (NHS Choices 2015). Box 1 (overleaf) displays the values and their explanations verbatim.

### 1.2 Values in general practice

In this thesis I am concerned with GP practices – doctors’ surgeries staffed by GPs, practice and community nurses, and reception and administrative staff. Practices are usually owned by the GP partners, sometimes with additional GPs being salaried employees. The majority of a practice’s income is derived from contracts with the NHS, of which typically 75% comes from capitation, 20% from pay-for-performance under the Quality and Outcomes Framework (QOF), and 5% from Enhanced Services contracts for specialist care (e.g. for substance misuse) (Peckham 2007). GPs can employ additional staff (salaried GPs, nurses, administrative staff) as they see fit, and their take-home pay comes from the practice’s profit (Roland et al. 2012). There is no fixed structure for staffing and services, thus there is variation in the services available across general practice, although federating is becoming more common, whereby practices team up to share good practice and provide for back-room services. Some practices are owned privately by companies – these employ salaried staff only and usually work to a hub-and-spoke model, with a central head office, regional staff, and practices that, according to advocates of the model, benefit from centralised policies with the ability to be flexible according to the needs of local the population (Tarrant et al. 2014).
Working together for patients
The value of "working together for patients" is a central tenet guiding service provision in the NHS and other organisations providing health services. Patients must come first in everything the NHS does. All parts of the NHS system should act and collaborate in the interests of patients, always putting patient interest before institutional interest, even when that involves admitting mistakes. As well as working with each other, health service organisations and providers should also involve staff, patients, carers and local communities to ensure they are providing services tailored to local needs.

Respect and dignity
Every individual who comes into contact with the NHS and organisations providing health services should always be treated with respect and dignity, regardless of whether they are a patient, carer or member of staff. This value seeks to ensure that organisations value and respect different needs, aspirations and priorities, and take them into account when designing and delivering services. The NHS aims to foster a spirit of candour and a culture of humility, openness and honesty, where staff communicate clearly and openly with patients, relatives and carers.

Commitment to quality of care
The NHS aspires to the highest standards of excellence and professionalism in the provision of high-quality care that is safe, effective and focused on patient experience. Quality should not be compromised – the relentless pursuit of safe, compassionate care for every person who uses and relies on services is a collective endeavour, requiring collective effort and collaboration at every level of the system. The delivery of high-quality care is dependent on feedback: organisations that welcome feedback from patients and staff are able to identify and drive areas for improvement.

Compassion
Compassionate care ties closely with respect and dignity in that individual patients, carers and relatives must be treated with sensitivity and kindness. The business of the NHS extends beyond providing clinical care and includes alleviating pain, distress, and making people feel valued and that their concerns are important.

Improving lives
The core function of the NHS is emphasised in this value – the NHS seeks to improve the health and wellbeing of patients, communities and its staff through professionalism, innovation and excellence in care. This value also recognises that to really improve lives the NHS needs to be helping people and their communities take responsibility for living healthier lives.

Everyone counts
We have a responsibility to maximise the benefits we obtain from NHS resources, ensuring they are distributed fairly to those most in need. Nobody should be discriminated or disadvantaged, and everyone should be treated with equal respect and importance.

Box 1: NHS values (NHS Choices 2015). Italicised text indicates expressions of values that will be referred to throughout this thesis.
Increasingly, the role of HCPs in general practice is to care for patients with multiple health problems. Care for these patients requires advocacy and coordination of care, which requires effective collaboration within the multidisciplinary team, and with other providers outside of the organisation (Branson 2008); values alignment, particularly within the organisation is important for supporting effective collaboration (through strengthened relationships) and a shared vision and approach to patient care (Section 1.1.2). Continuity of care over extended time periods is also important for patients both with and without long-term conditions, thus the doctor-patient relationship is seen as key to both HCPs and patients (Roland et al. 2012).

In response to rising demand, the issue of access and patients’ satisfaction with access remains a subject of debate within and beyond the NHS, with innovative models of care being called for by politicians, commissioned by CCGs, and delivered by practices, sometimes working with social enterprises (Sykes 2016) or limited companies (Lord 2016) to adopt new processes. Organisations exist to support general practices to share ideas for dealing with the demand crisis in primary care (Dayan et al. 2014, Ware & Mawby 2015, Rosen 2015, National Association of Primary Care 2016a, British Medical Association 2016). The NHS England report, General practice forward view, promised investment to enable a larger workforce, support for GP burnout and cutting inappropriate demand, improvements to infrastructure, and care redesign (NHS England 2016a, NHS England 2016b). However, other recent reports suggest that getting this money to where it is needed most is not straightforward (Matthews-King 2016a, Matthews-King 2016b, Williams 2016).

As discussed in Section 1.1.4, the NHS Constitution articulated the values of the modern NHS. Over the years, various values have been advocated specifically in relation to primary care and general practice. There have been several attempts to classify the values of general practice, each with slightly different emphases but with clear overlap. As explained in Section 1.1.2, other terms have, historically, been used interchangeably with values, such as norms, amongst others (Rokeach 1973, Lynn Fitzpatrick 2007, Schwartz 2012, Kernaghan 2003) and this interchangeability is also evident in the primary care literature. For instance, there are references to values,

As explored in the following sections, I argue that, although the terms and definitions are different, the issues explored in the general practice literature that I identify are values-centred. The literature speaks in terms of what should be important (normative, espoused and attributed or aspirational values, but which are not necessarily provided), as well as what is currently evident in practice or is reflected in usual day-to-day routines. Thus for the purposes of this review, and throughout this thesis, I use ‘values’ to capture the multiple terms.

Some key publications classifying the values of general practice are considered here, and are summarised in Table 2 (page 20), after I have discussed each value in detail. I have chosen these publications because: (a) they cover the time period of interest (late 1990s through to the 2010s, see Section 2.1.2 in Chapter 2); (b) they are mostly UK-based (I am interested in general practice in England); (c) they are not confined to the doctor-patient consultation but rather consider the whole system of general practice; (d) they are of mixed provenance (academic papers, opinion pieces, commissioned reports, and they therefore provide different perspectives); and (e) they include a seminal text (Starfield et al. 2005), which, whilst not UK-based, is widely cited in the literature about general practice in England. Together, this literature speaks of values in general practice as features that are considered to have universal merit, and as important positive attributes that affect behaviour. For instance, if ‘access to a GP’ is considered to be a value of general practice, the behaviour of those designing general practice systems should be affected, such that access can be delivered by the system. Other literature could have been included (World Health Organization 2008, Howie et al. 2004, Dutch College of General Practitioners 2011, Porter 2010), but it did not meet the above criteria.

The BMJ series of papers in 1998 (McWhinney 1998), adapted from Mike Pringle’s book on core values (Pringle 1998), summarised the importance of values in general practice. The main message from this series was that core values should be protected from erosion due to externally driven change:
“All key relationships in primary care with patients, with colleagues in practices and in the wider health service, and with local communities are underpinned by basic, core values passed down by tradition. Primary care practitioners must guard these values, recognising that values may be affected by evolution in health care and its delivery. Primary care must, however, ensure that this is a conscious and explicit evolution, rather than an erosion left too late to remedy.” (McWhinney 1998)

Thus, McWhinney (1998) appeared to take the view that having values, and ensuring they are shared and enacted as well as espoused (Bourne & Jenkins 2013), is a crucial component of ensuring that organisations such as general practices are positive and effective environments, similar to my argument in Section 1.1.2 (Collins & Porras 1996, O'Reilly & Pfeffer 2000, Branson 2008, Lynn Fitzpatrick 2007).

This BMJ publication identified six core values to which the authors subscribed (McWhinney 1998). Similarly, in 2005, Starfield et al. introduced “four main features of primary care services” (Starfield et al. 2005) and in 2007, prior to a time of austerity, the RCGP presented a roadmap to guide GPs, which included five values of ‘new general practice’ (Lakhani et al. 2007). Even during a time of plenty in the NHS, during which general practice had enjoyed considerable investment, the RCGP still recognised that “our aspiration will require considerable investment, reform and support for implementation but feel that it is a much needed and achievable model to improve patient care” (Lakhani et al. 2007). Marshall took a different approach in 2009, suggesting just three core values with an additional three ‘tactics’ to help ‘deliver’ the core values (Marshall 2009). More recently, several reports have been published reminding us of these values and their longevity: a KPMG report in 2013 (in which the identified ‘design principles’ (how primary care can be designed to embody the values) (Edwards et al. 2013) were near-identical to Pringle’s values, articulated 15

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3 These principles were adapted by KPMG from the US Agency for Healthcare Research and Quality (AHRQ) Primary Care Medical Home model (https://www.pcmh.ahrq.gov/page/defining-pcmh).
years prior (Table 2), and a recent review article (O’Malley et al. 2015), which refers to ‘features’ and ‘elements’ of general practice.

I now outline the various values suggested by these authors, identifying components that are common across different authors’ descriptions, as well as those specific to certain frameworks. The findings are summarised in Table 2 on page 20.

1.2.1 Patient-centred care
According to Pringle, patient-centred care was the first value, described as “the commitment of the generalist practitioner [...] to the person, not to ‘the person with a certain disease.’ General practice defines itself in terms of relationships, not in terms of diseases or technologies” (McWhinney 1998). Similarly, Starfield drew attention to “long-term person- (not disease) focused care” (Starfield et al. 2005) and the RCGP adopted ‘patient-centred professionalism’, and ‘trust and confidentiality’, which both relate closely to patient-centred care (Lakhani et al. 2007). Likewise, the KPMG report (Edwards et al. 2013) cited ‘person-centredness’, and Marshall (2009) and O’Malley et al. (2015) cited ‘whole-person care’.

1.2.2 Continuity of care
The second value, according to Pringle, related to continuity of care, which “builds trust, creates a context for healing, and increases the practitioner’s knowledge of the patient, much of it at the tacit level” (McWhinney 1998). Starfield’s (2005) second feature, “long-term person- (not disease) focused care”, described above in terms of patient-centredness, included this element of long-term continuity. Similarly, the RCGP advocated the ‘doctor-patient relationship’ (Lakhani et al. 2007), KPMG cited ‘comprehensiveness’ (which included continuity) (Edwards et al. 2013), and O’Malley et al. (2015) spoke of ‘continuous care’. In contrast, Marshall viewed continuity not as a core value but as one of several “traditional values” that:

“...must not be lost or designed out of the system, but perhaps can be better seen as ‘tactics’ that help deliver the three core values, rather than as core values in themselves. Tactics that should be used whenever appropriate but not essential elements of general practice, which if you aren’t able to use then you
would end up being judged by your peers to be ‘not a proper GP.’” (Marshall 2009)

Thus continuity is not absent from Marshall’s categorisation, but instead is seen as a way to deliver values rather than as a value in and of itself. Thus it could be argued that whilst patient-centred care is a value, continuity is a tactic (the way that patient-centred care can be built and sustained) that is in decline in English general practice.

1.2.3 Comprehensiveness

The value of “comprehensive care for most health needs”, which keeps most of the care in the community and prevents hospital admissions, was introduced by Starfield et al. (2005) and was also included in the values put forward by Edwards et al. (2013) and O’Malley et al. (2015). Pringle used the term ‘clinical freedom’, which allowed clinicians “the freedom to practice in accordance with the highest standards” using the fewest resources necessary to achieve this (McWhinney 1998). This allows practitioners the flexibility to make difficult choices between competing priorities and helped to keep care in the community. Marshall opted for the term ‘excellent generalism’ (Marshall 2009). The RCGP roadmap did not include this value (Lakhani et al. 2007).

1.2.4 Coordination

Starfield et al. (2015) introduced a fourth value of “coordinated care when it must be sought elsewhere”, which encourages primary and secondary care to work together to enable a smooth journey of care for the patient, as well as encouraging multi-disciplinary teamwork within practices. KMPG (Edwards et al. 2013) and O’Malley et al. (2015) used similar terms. Coordination also bears similarities to Pringle’s definitions of ‘teamwork’ and ‘effective relationships’, which involved “a change in traditional professional values” (McWhinney 1998). At a time when the general practice team was expanding to include, for example, social workers, psychologists, counsellors, physiotherapists, and pharmacists, it was seen as important to respect and learn about different perspectives where leadership was open to any practitioner in a team. Marshall chose the term ‘committed advocacy’ (Marshall 2009). As with
comprehensiveness, the RCGP roadmap did not include coordination as a value (Lakhani et al. 2007).

1.2.5 Population perspective
A population perspective was Pringle’s fifth value, “ensuring that the services of the practice are made available to the whole practice population” (McWhinney 1998). Starfield et al. spoke of “an orientation toward family and community” (Starfield et al. 2005, Starfield 1998), which they claimed may account for the beneficial impact of primary care on population health, such as a greater access to needed services, including access to health services for relatively deprived population groups. The RCGP also advocated care for ‘registered populations’ (Lakhani et al. 2007), and KPMG put forward ‘population orientation’ (Edwards et al. 2013), but O’Malley et al. (2015) did not. As was the case for continuity, Marshall (2009) suggested that the population perspective be used as a tactic rather than being given the status of a value.

1.2.6 Access
Pringle’s sixth value of accessibility, which encourages care provided in small units close to patients’ homes “avoiding the anonymity and intimidating atmosphere that tends to go with larger institutions” (McWhinney 1998), was also evident in the publications from Starfield et al.(2005), KPMG (Edwards et al. 2013) and O’Malley et al. (2015). Marshall (2009) suggested that access be used as a tactic, as he did for continuity and the population perspective. Like comprehensiveness and coordination, the RCGP report did not speak of access (Lakhani et al. 2007).

1.2.7 Patient-centred self-care skills
Only the RCGP report espoused the importance of ensuring that patients take responsibility for self-care (Lakhani et al. 2007). As the purpose of the report was to provide guidance for the ‘new general practice’, perhaps this was seen as an important addition in times when efficiency was being carefully monitored.

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4 This may also explain why some of the more traditional values, such as access and comprehensiveness were not included in the RCGP report, as they may have been taken for granted, and hence did not need highlighting as necessary for the ‘new’ era.
1.2.8 Quality and safety

Two publications (Edwards et al. 2013, O’Malley et al. 2015) spoke of quality and safety. Both these papers were published in the post-Francis report era, when safety became a prominent concern to both policy-makers and the public (Francis 2013).

Table 2 (overleaf) summarises these values in tabular form to show the overlaps between the publications. The first column indicates the section headings used above.
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<tbody>
<tr>
<td>Patient-centred care</td>
<td>Patient-centred care</td>
<td>Long-term person-(not disease) focused care</td>
<td>Patient-centred professionalism</td>
<td>Whole-person care</td>
<td>Person-centredness</td>
<td>Accountable whole-person care</td>
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<tr>
<td>Continuity of care</td>
<td>Continuity of care</td>
<td></td>
<td>Doctor-patient relationship</td>
<td>CONTINUITY AS TACTIC</td>
<td>Comprehensiveness</td>
<td>Continuous care</td>
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<tr>
<td>Comprehensiveness</td>
<td>Clinical freedom</td>
<td>Comprehensive care for most needs</td>
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<td>Excellent generalism</td>
<td>Comprehensiveness</td>
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<td>Teamwork</td>
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<td>Quality and safety</td>
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<td></td>
<td>N/A</td>
<td>N/A</td>
<td>Safe and high quality</td>
<td>Safety</td>
</tr>
</tbody>
</table>

Table 2: Summary of the values of general practice.

'Section heading' refers to the headings of Sections 1.2.1-1.2.8. Terms in [square brackets] represent the nomenclature of each paper.
1.3 Responsiveness in general practice

I turn now to responsiveness in general practice in England. First I discuss the literature on responsiveness and how it relates to general practice. Second I briefly consider how responsiveness has been described in policy (Chapter 2 provides an in-depth review). I end this section with a discussion of how responsiveness can be viewed as a tactic to deliver goals aligned with primary care values.

1.3.1 Responsiveness in the literature

Here, I introduce the concept of responsiveness and how it has been described in the literature, based on a literature review conducted by myself and colleagues as part of a NIHR HS&DR project to develop a patient-report measure of responsiveness in primary care (Tarrant et al. 2014). The literature review included systematic searches (conducted by an information librarian) of Medline and Web of Knowledge databases for international papers, written in English, relating to the meaning and measurement of responsiveness within both the public and private sectors. This initial search was supplemented with searches of the internet and of reference lists of identified reports and papers, to locate relevant grey literature. My first supervisor (principal investigator for the NIHR study, Carolyn Tarrant (CT)) and I screened the identified abstracts for relevance. I summarised the papers and reports into a chart which was used to generate an overview of the range and nature of work on this concept, and collaborated with CT to interpret and write up the findings. The search strategy and methods for review and analysis are described in Appendix 2 of the project report (Tarrant et al. 2014).

The findings from the literature review indicated that responsiveness is a rather fuzzy concept with a range of meanings and definitions evident across different fields of the literature. We (CT and I) identified three distinct but overlapping conceptualisations of responsiveness in the literature, corresponding to service quality, inequalities and the needs of diverse groups (in health or other services), and consumerism and patient involvement.
1.3.1.1 Service quality

Responsiveness has a long history of being considered a core feature of service quality (Parasuraman et al. 1985). Service quality has been defined as the ability of an organisation to meet or exceed customer expectations (Parasuraman et al. 1988). Parasuraman and colleagues’ widely-accepted model of service quality includes five key dimensions: tangibles (features of the service environment); reliability; responsiveness; assurance (the extent to which the organisation and its employees are perceived as credible and trustworthy); and empathy. Within this context, responsiveness has been defined as an organisation’s employees’ “willingness to help customers and provide prompt service” (Parasuraman et al. 1988).

Service quality is seen as important for customer-serving organisations in marketing (Brand et al. 1998), achieving success and profitability through helping to attract and retain customers (Zeithaml et al. 1996), and promoting customer satisfaction. Responsiveness is recognised as particularly important to the public image of customer-serving organisations; in the UK, the Institute of Customer Service makes a high-profile annual People’s Choice award for most responsive organisation (Institute of Customer Service 2016).

The notion of responsiveness as an element of service quality also features in the health literature. Several papers speak of responsiveness as part of a high-quality service, and as a feature of customer service or interactions between staff and patients. For instance in a qualitative study of patients’ expectations and experiences of public and private providers, patients were found to expect more responsiveness and better quality of care and to be willing to pay for it (Pongsupap & Lerberghe 2006). A study of predictors of hospital patient satisfaction ratings in the United States (US) found that nursing staff communication with patients had an important bearing on perceived responsiveness (Elliott et al. 2009).

The conceptualisation of responsiveness as an element of service quality has several key implications. First, responsiveness is tied to customer service – the quality and promptness of interactions between employees and customers (or between staff and patients). Second, the notion of service quality focuses on improving customer
experience, exceeding expectations, increasing satisfaction, and even delighting (Oliver et al. 1997) the customer. It is seen as a route to attracting and retaining customers and increasing market share. Within this literature responsiveness is not seen as a ‘duty’ or essential feature of an organisation, but as a ‘value adding’ feature of a service. Third, the focus is not on diverse or disadvantaged groups but on improving the experience of all customers or patients.

1.3.1.2 Inequalities and the needs of diverse groups

The concept of responsiveness is also prominent in the field of work relating to health inequalities. Seminal work undertaken by the World Health Organization (WHO) in the late 1990s and early 2000s identified responsiveness as one of the three intrinsic goals of health systems, along with good health and fair financing (World Health Organization 2000). Responsiveness involves health systems meeting the needs of the patients they serve and is based on the idea that there are fundamental needs or basic human rights that health systems should meet for all patients. These needs are seen as relating to the non-clinical domains of health service provision. Responsiveness is defined as: “how well the health system meets the legitimate expectations of the population for the non-health enhancing aspects of the health system. It includes seven elements: dignity, confidentiality, autonomy, prompt attention, social support, basic amenities, and choice of provider” (Darby et al. 2000). It is suggested that if a health system is responsive, the interactions that people have within the health system may improve their well-being, irrespective of improvements to their health (Hodge Jr & Valentine 2003).

The WHO argues that the measurement of responsiveness is essential to assessing the performance of health systems, and importantly, involves measuring “both the overall level of achievement (average over the whole population) as well as the distribution (equitable spread of this achievement to all segments of the population)” (Darby et al. 2000). It is clear that this conceptualisation of responsiveness involves fairness and avoiding inequalities across the patient population.

The WHO work focuses on responsiveness of health systems, rather than individual providers such as GP practices. The WHO definition was adapted for primary care by
Canadian researchers to produce a definition of responsiveness as the “ability of the primary care unit to provide care that meets the non-health expectations of users in terms of dignity, privacy, promptness, and quality of basic amenities” (Haggerty et al. 2007). They argued that the operationalisation of responsiveness was problematic due to lack of distinctness from other concepts such as whole-person care.

As discussed earlier, arguments for the need to promote responsiveness in primary care tend to draw heavily on the inequalities agenda with a recognition that responding to specific groups’ needs might help to reduce inequalities (Box 2008). However, needs are framed in a slightly different way from the notion of universal legitimate expectations that is central to the WHO work. Instead the focus is on the diverse needs of different patient groups and ensuring that individual patient needs are met through individualised and proactive care. Alignment with the needs of different patient groups is seen to be important and there has been particular focus on the need for cultural alignment with minority groups. Research has shown how cultural self-reflection and self-awareness on the part of staff can be helpful, and how developing a reciprocal understanding of needs can lead to a flexible responsive service (Cross et al. 2006).

With responsiveness defined as an approach to reducing inequalities, the onus is on providers to ensure they understand their practice populations and can segment them based on need (NHS Primary Care Contracting 2008a, Department of Health 2008c). There is also an emphasis on finding proactive ways to reach out to marginalised groups who may find it difficult to access healthcare (Smith 2003, Department of Health 2003).

One challenge raised within this field relates to the nature of needs, expectations and demands. A distinction has been made between needs and demands in the context of health needs assessment, and this distinction may be useful in conceptualising needs in relation to non-clinical aspects of care. Under this framework needs have been described as areas in which there is capacity to benefit, and as ‘normative’, i.e. they should be met (Wright et al. 1998). Demands are what patients ask for, and implicit in this is the notion that it may or may not be appropriate for providers to respond to
demands. One study, exploring the views of staff about needs and demands in relation to public services, concluded that responsiveness related to identifying unmet needs (with a focus on cultural needs) and finding the right balance of managing needs and demands (Sheaff et al. 2002). The authors define needs as rational demands (consistent and evidence-based) as opposed to ‘desires’. They argue that public services should try to meet users’ demands but that other forms of demand management may be required to realign these demands with users’ needs. They suggest that practical demand management in needs-based public service requires: knowledge of users’ demand for services; content analyses of users’ demands to identify any misinformed demands; conversion of any misinformed demands into evidence-based specifications of needs; and formulating coherent evidence-based demands on behalf of users who cannot do so themselves. The authors acknowledge the tension inherent in needs assessment being professionally controlled rather than responsive to users (Sheaff et al. 2002).

An alternative but overlapping classification is that of Bradshaw et al. (2013) who define normative needs as needs that “the expert or professional, administrator or social scientist defines as need in any given situation”. Thus, in the case of responsiveness, an element of judgement is required on behalf of the practice staff – akin to distinguishing rational demands from desires, as above (Sheaff et al. 2002). Bradshaw et al.’s taxonomy includes ‘felt need’, which “is equated with want. When assessing need for a service, the population is asked whether they feel they need it”. Further, ‘expressed need’ (similar to demands (Wright et al. 1998) to which it may or may not be appropriate for providers to respond) is “felt need turned into action. Under this definition total need is defined as the need of those people who demand a service”. When providing for needs of patients in general practice in an equitable way, the definition of ‘comparative need’ is also pertinent (Bradshaw et al. 2013). Here, “a measure of need is obtained by studying the characteristics of the population in receipt of a service. If there are people with similar characteristics not in receipt of a service, then they are in need”.

The key implications of considering responsiveness as relating to inequalities include, first, that responsiveness relates to a broad set of non-clinical features of service
organisation and delivery. Second, responsiveness is seen as a core duty of an organisation – providing a level of service that meets patients’ needs fairly across all patient groups (although there are some differences in emphasis in relation to whether this refers to basic universal needs or specific needs of different patient groups or individual patients, and a recognition that responsiveness may involve managing demands). Third, the focus is on diverse groups and ensuring that no patient groups are disadvantaged in their experiences of receiving services. Under this definition, achieving responsiveness requires more than just good customer service; it requires an understanding of population characteristics and proactive planning to meet needs and avoid disadvantage.

1.3.1.3 Consumerism and patient involvement

Responsiveness has been linked with the shift towards consumerism and consumer demand for services that are tailored to individual needs. Responsiveness is seen as a way of bringing the NHS in line with other services, such as retail and banking, which are geared towards being adaptable to individual needs and offering more convenience, choice and flexibility. Fundamental to this shift is the idea that services should be geared to the interests of users rather than the convenience of producers (Clarke et al. 2007). Increasing user participation is described as core to this; an advisory document reporting on group discussions and a citizens’ forum found that:

“Overall, people think that a responsive public service is one that: provides easy and appropriate access to services; encourages the individual to use and shape services in ways that suit them; actively seeks to learn from public involvement and develop services accordingly.” (Opinion Leader Research 2005)

People’s ideas on how public services could be made more responsive included making communication simple and obvious, keeping people informed throughout, involving people as early as possible, and shared responsibilities and shared outcomes (Opinion Leader Research 2005). This concept is quite distinct from patient involvement in shaping services in the responsiveness literature (see below). User choice and voice are also seen critical in the literature: exit and voice (communicating user demands)
have been described as recuperation mechanisms for making organisations responsive (Pickard et al. 2006).

Responsiveness in primary care has been defined as synonymous with patient participation, engagement and involvement (National Association for Patient Participation 2009). The National Association for Patient Participation (NAPP) suggests that being responsive requires GP practices to engage with patients, that patient experience is a key part of a responsive practice, and that improved communication and responsiveness are needed for a successful practice and Patient Participation Group (PPG) (National Association for Patient Participation 2009). A discussion piece summarising the meaning of responsiveness included involving patients with service planning (Smith 2003). The authors found two ways that this was enacted. First, some seek to involve patients in the planning of care. Second, others make attempts to reach out to groups who find it difficult to access healthcare. A Scottish study of Local Health Care Co-operatives highlighted the need to engage patients and local communities, and defined responsiveness in terms of proactively engaging patients in planning services (Simoens & Scott 2003).

The close link between responsiveness and patient engagement is highlighted by the inclusion in a Directed Enhanced Service (DES) Framework on responsiveness of eligibility criteria relating to engagement with patients, as the report states:

“Improving access and responsiveness needs to be strongly founded on engagement with patients and should be a dynamic process. Providers should be required to demonstrate active engagement with people and local communities in developing services [...]. Providers should demonstrate how they respond to patient feedback and this is to be used to shape and improve services [...] Local Involvement Networks (LINks) [since replaced by Local Healthwatch], the voluntary sector and patient advocacy organisations are all further mechanisms to seek active involvement in service planning, delivery and monitoring.” [Primary care service framework: accessible and responsive general practice, para. 10 (NHS Primary Care Contracting 2008a)]
There are limitations to the conceptualisation of responsiveness as dependent on choice, voice and patient involvement. Changing providers is not always cost-neutral for users and exercising voice adds practical burdens with little reward. Hence users who exercise choice or voice may be few, self-selected and apparently unrepresentative (Pickard et al. 2006). Many people with common health conditions, such as mental health problems, are reluctant or unable to engage in the user movement, hence undermining the effectiveness of patient involvement (Campbell et al. 2007).

The key implications of definitions of responsiveness within the consumerism and patient engagement literature are, first, that responsiveness framed in this way is about patients as consumers taking responsibility for defining (Clarke et al. 2007) and asserting their needs. The implication of this is that less responsibility is placed upon providers to proactively plan for and support disadvantaged groups. This is in tension to some extent with the notion of responsiveness as a duty of providers and as a way of reducing inequalities (as discussed in Section 1.3.1.2). Reliance on patient choice and voice may result in responsiveness to those who are most articulate and demanding, at the expense of the vulnerable and needy. There has been much focus on the need for groups who are disadvantaged to have a voice, and on providers working to involve, and hear the voices of, seldom-heard groups. Second, a distinction can be made within this literature between the notion that responsiveness can be defined as the extent to which providers engage with patients and enable choice and voice, and the view that patient involvement and engagement is a key means of achieving or improving responsiveness by helping providers better understand patient characteristics and needs, particularly those of groups who are disadvantaged.

1.3.2 Responsiveness in policy

In English policy definitions of, and debates about, responsiveness reflect the different conceptualisations emerging from these three bodies of literature, as can be seen in the definition presented in the DH report Improving GP access and responsiveness (2009):
“Practice responsiveness is the way in which a practice communicates and engages with its patients and their carers and responds to their non-clinical needs and preferences, reflecting the different ways in which they might prefer to access the service and an appropriate clinician, book, or indeed cancel an appointment. It includes the practice’s attitude to customer service and friendliness of staff, the environment in which patients wait to be seen and the way in which they interact and support patients from particular groups, such as those with hearing or sight loss or people from a black or minority ethnic background.” [World class commissioning for GP services: improving GP access and responsiveness, p.15 (Department of Health 2009)]

This definition of responsiveness is closely linked with access, with the DH explicitly conceptualising practice responsiveness as a component of patient experience of access in primary care (Lyratzopoulos et al. 2012). Definitions of the concept incorporate communicating and engaging with patients and carers, making efforts to identify and meet their non-clinical needs (i.e. their needs in terms of accessing and using services, rather than health needs or needs relating to the consultation or the clinician-patient relationship) and engaging in efforts to support patients from specific groups who may be vulnerable or experience particular difficulties in using primary care (Tarrant et al. 2014). There is extensive literature on access to healthcare, including, for instance, a rapid review from The King’s Fund (Boyle et al. 2010), but for the purposes of this thesis, I define access as “the ease with which health services are reached. Access can be physical, financial or psychological, and requires that health services are a priori available” (Kelley & Hurst 2006). I have chosen this definition over others as it exemplifies the definitions used in the policies I consider in Chapter 2 (for example it is referred to ‘technical access’ ⁵ in World class commissioning for GP services (Department of Health 2009)), and is reflected in the literature on core values in general practice, with several papers and reports identifying ‘access’ as a core value

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⁵ “Technical access is the actual supply of appointments available, both in person or on the telephone, relative to patient demand. In relation to the 48 hours target, good technical access means there are appointments available at times that work for patients, which are readily offered to patients, and match patients’ preferences (e.g. are in person), within two days” [World class commissioning for GP services: improving GP access and responsiveness, p.15 (Department of Health 2009)].
(Section 1.2.6) and defining it in terms of availability of appointments at a provider close to patients’ homes. In contrast, responsiveness explicitly incorporates efforts to identify patients’ needs through communication and engagement (as established in the responsiveness literature (Section 1.3.1.3)), with particular attention paid to vulnerable groups (present in both the core values and responsiveness literatures (Sections 1.2.5 and 1.3.1.2)). Given the range of considerations present in the definitions of responsiveness reviewed (Section 1.3.1), and the fact that it appears to cover the work involved in achieving access (and other core values) rather than merely describing the desired objective, it seems analytically beneficial to distinguish between responsiveness and access.

Responsiveness has been prominent in UK policy since mid-2000s (e.g. World class commissioning for GP services (Department of Health 2009) cited above), and more recently, after my study data were collected, responsiveness emerged as one of the key lines of enquiry in the CQC’s inspection criteria (Care Quality Commission 2016b).

In the CQC publication How CQC regulates (p.5), CQC inspectors are said to “use professional judgement, supported by objective measures and evidence, to assess services against our five key questions: Are they safe? Are they effective? Are they caring? Are they responsive to people’s needs? Are they well-led?” (Care Quality Commission 2016c).

In the appendices to this guidance (p.35), the CQC has developed descriptors of practices that meet the criteria for a rating of outstanding, good, requires improvement and inadequate in relation to each of the five key questions. Here, responsive services are defined as those which “are organised so that they meet people’s needs” and an outstanding practice is one where “Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care” (Care Quality Commission 2016b). The full definitions are provided in Appendix 1 but an abridged version is provided here:

“Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care. [...] There is a proactive approach to understanding the needs of different groups of people
and to deliver care in a way that meets these needs and promotes equality. [...] People can access appointments and services in a way and at a time that suits them”. [How CQC regulates: NHS GP practices and GP out-of-hours services - provider handbook, p.35 (Care Quality Commission 2016b)]

1.3.3 Responsiveness as a tactic to achieve goals that are aligned with values

In the previous sections, I have presented the literature on organisational values and how responsiveness has been defined in the literature and in policy. Bringing these themes together, I suggest that responsiveness can be viewed as a concept conceptually overlapping with the values that have been highlighted by others (Pringle 1998, Starfield et al. 2005, Lakhani et al. 2007, Marshall 2009, Edwards et al. 2013, O’Malley et al. 2015) (Section 1.2). For instance, in the literature, responsiveness is linked with service quality (Parasuraman et al. 1988) (Section 1.3.1.1); quality features as a core value of general practice (Edwards et al. 2013, O’Malley et al. 2015) (Section 1.2). A key implication of the conceptualisation of responsiveness as service quality is a focus on universalism – all patients have the right to access a high quality service. This is also reflected in the policy definitions where customer service, the friendliness of staff (Department of Health 2009) and access to appointments in line with patient preferences (Care Quality Commission 2016b) are emphasised (Section 1.3.2).

A duty of providers when providing a responsive service, according to the literature, is a commitment to reduce inequalities and disadvantage (Darby et al. 2000) through proactive patient mapping and appropriate service design (Section 1.3.1.2). This draws parallels with the literature on core values, where a ‘population perspective’ emphasises fairness and a focus on identified disadvantaged groups (McWhinney 1998, Starfield et al. 2005, Lakhani et al. 2007, Marshall 2009, Edwards et al. 2013) (Section 1.2.5). A proactive approach to understanding and meeting the needs of different groups, including an understanding that needs will be different (Department of Health 2009), is present in policy, as is a commitment to meet these needs such that equality is promoted (Care Quality Commission 2016b) (Section 1.3.2). This also draws parallels with the value of patient-centred care, where patients can expect a personal

The third aspect of responsiveness, according to the literature, is consumerism and patient involvement. As argued in Section 1.3.1.3, this conceptualisation of responsiveness is not unproblematic (Pickard et al. 2006). Indeed responsiveness has experienced shifting contours (which are explored in more detail in Chapter 2), in line with the policy preferences of recent governments, for example the prominence of ‘choice’ and shared responsibility as a solution to the problems in the public sector, and within the most recent policy definition of responsiveness (Care Quality Commission 2016b). The notion of shared responsibility was also present in the literature on core values, although in just one recent report (Edwards et al. 2013), perhaps in response to the prevailing policy ‘wind’, which advocates giving patients responsibility for self-care, espousing a system where patients only seek care when it is really necessary (Section 1.2.7).

There are several omissions from the discussion above. The value of comprehensiveness, for instance, “the freedom to practice in accordance with the highest standards” using the fewest resources necessary (McWhinney 1998) does not feature explicitly in the responsiveness literature or policies. However, I suggest that this could be considered as part of a commitment to providing a high quality service to all patients (“highest standards”), whilst ensuring that the needs of disadvantaged groups are understood and met. In order to meet the needs of the general population and those considered vulnerable, practitioners need the flexibility to make difficult choices between competing priorities. Similarly, continuity of care is also absent. Marshall (2009) considers continuity to be a tactic to implement other values, whereas other authors see it as core (Section 1.2.2) and it forms an explicit part of the most recent policy definition of responsiveness (Care Quality Commission 2016b) (Section 1.3.2). In addition, although coordination is absent from both the literature and policy definitions of responsiveness, the importance of this value to responsiveness will become clear through the remainder of this thesis.
Given that multiple values are expressed by responsiveness, I further argue that responsiveness can be considered as a tactic (adopting the term used by Marshall (2009)) for achieving goals that are aligned with values rather than a value in itself. However, it remains potentially problematic that policy definitions of responsiveness in general practice draw on all three conceptualisations of responsiveness from the literature (service quality, inequalities, and consumerism and patient involvement). All have different implications about how responsiveness might be achieved, meaning that responsiveness in general practice remains a fuzzy and poorly delineated concept. In addition, although I am conceptualising responsiveness in policy as an attempt to realise values and achieve alignment of values among GP practices, efforts to achieve alignment between values and day-to-day practice are not unproblematic. A key issue is that shifts in value amplification and in the hierarchy of values (discussed in the following section) may be shaped by exogenous forces. It is for these reasons that I have chosen responsiveness as the subject of this thesis: it is an under-researched concept in the context of alignment with the values of primary care. I am seeking to explore how responsiveness appears in policy and how responsiveness as conceptualised in policy documents has been implemented into practice. I focus on discussing whether it is a useful concept in supporting quality management and improvement in primary care over and above existing conceptualisations, such as patient-centred care and accessibility. The study of the implementation of responsiveness presents an opportunity to gain a deeper insight into the challenges of achieving values-based change in primary care.

1.3.4 Prioritising values in the public sector
Where there is reasonable consensus about the core values of general practice (aspirational, and possibly espoused values, at least to some extent) (see Section 1.2), there can be challenges when attempting to realise these values in practice so that they are enacted and reflected in the organisation and delivery of care (Starfield et al. 2005, McWhinney 1998).

As discussed, challenges can arise if there is conflict between personal and organisational values (Section 1.1), and, as argued in Section 1.3.4.1, below, and through the remainder of this thesis, policies can reflect or make explicit core values
and hence can shape the landscape in terms of which values are prominent and given precedence at any given time. In turn, this influences how services are organised and delivered to reflect prominent values. Efforts to implement such policies into practice may vary in terms of success, depending on the alignment between policy (espoused) values and local (shared or aspirational) values (Bourne & Jenkins 2013), and on the approaches to implementation (Table 1, page 6).

In this section I consider how values are prioritised in policy, and the ways in which the implementation of policy goals that are aligned with values might face particular challenges. Given the framework of values in general practice I have chosen to focus on two concepts: values alignment and value amplification, as these are well-suited to the complexity of a concept such as responsiveness (see Chapter 2).

### 1.3.4.1 Values alignment

Value system alignment (or congruence) can be defined as the extent of agreement between an individual member’s value system and the organisation’s value system (Krishnan 1997, Limerick & Cunningham 1993). As discussed in Section 1.1.2, values can be categorised as espoused, attributed, shared, and aspirational (Bourne & Jenkins 2013). When a the status of a value is elevated (see Section 1.3.4.2, below, for a discussion of value amplification), the alignment (Section 1.1.2) of organisational values at the national level of the NHS (arguably ‘espoused values’ where value consensus is achieved among senior leaders) and local values (arguably ‘aspirational values’ where the members of an organisation, such as a general practice or CCG, share an understanding of what ‘ought’ to be prioritised) helps to make value-led initiatives legitimate, which bodes well for policy implementation (Exworthy et al. 2002). An example of such an alignment is responses at the NHS-wide level and local level of a general practice or CCG to a society that is becoming more consumer-led and where patients make choices and have high expectations.

The interdependency between the values held within an organisation and the achievement of change is key (Section 1.1.2). People within organisations can “live the values and show the behaviours”, for instance, through values-based recruitment and staff induction, training, ongoing one-to-one conversations, and team meetings.
(Workforce, Education and Development Services Undated, NHS Institute for Innovation and Improvement 2009) (Section 1.1.4). The literature suggests that the level of employee engagement with an organisation (i.e. the degree of discretionary effort employees are willing to apply to their work) is related to the alignment of values held by individuals and those espoused by the organisation (Alimo-Metcalfe & Alban-Metcalfe 2008), which has been described as “a positive attitude held by the employee towards the organisation and its values. An engaged employee is aware of business context, and works with colleagues to improve performance within the job for the benefit of the organisation” (Robinson et al. 2004). Past studies suggest that perceived value alignment is directly related to positive work attitudes and employee behaviour (Posner & Schmidt 1993, Scott 2002, Stevens 1999). Indeed, where an organisation’s mission and purpose overlap with the personal mission and vision of employees based on common values, motivation and satisfaction of employees is high and result in greater success of the organisation (Barrett 2006, Chippendale 1995, Williams 2002).

Alignment between an organisation’s values and those of its employees cannot be taken for granted. Even when organisational values are made explicit, which is not always the case (Section 1.1.2), the values held by management and employees may differ, as may the values held by different employees (Section 1.1.1). Thus ‘bringing organisational values to life’ within an organisation requires the investment of significant time and management attention (Sullivan et al. 2001). In the case study described by Sullivan et al. (2001), in parallel to a project management approach, managers at the company under study empowered employees to make changes on their own, without seeking prior management approval. Managers felt that the risk of such an approach was low because of a high level of understanding of, and commitment to, the company vision and values (having invested heavily in a process of identifying employees’ and organisational values), so any action initiated was likely to be directed toward achieving the company goals (Sullivan et al. 2001).

In contrast, values misalignment has been shown to result in employee dissatisfaction leading to workplace sabotage with negative implications for performance (Kraimer 1997, Pant & Lachman 1998, Enz 1988). To reduce the potential impact of conflict
between personal and organisational values, managers were careful to live the values and to work on dealing with the shortfalls in their own behaviour (Sullivan et al. 2001). Thus the espoused values held and lived by policy-makers and managers in DH, and the aspirational values of staff members in a local GP practice or CCG, should be aligned for successful policy-making and implementation of policies with goals that are aligned with values.

1.3.4.2 Value amplification

The starting point for a discussion of value amplification is the concept of ‘rhetorical frames’, which point to “the persuasive use of story and argument in policy debate” (p.32) (Schon & Rein 1994). The concept refers to a relatively coherent set of cultural symbols and political representations mobilised during social and political debates to frame the issues and shape the public’s perceptions (Marx Ferree 2003). Policy-makers need to justify their political choices; there is a need for concepts with which to frame solutions to policy problems in terms that are normatively acceptable to members of the public (Campbell 1998). Thus the construction of reform imperatives often takes the form of rhetorical frames appealing to shared cultural understandings (Béland 2009).

The literature on social movements provides an insight into the relationship between culture and framing processes (Béland 2009): scholars have studied framing processes in order to better understand the social and political construction of reality surrounding social mobilisation (Benford & Snow 2000, Oliver & Johnston 2000). For Benford and Snow, cultural factors impact the appeal and mobilising influence of framing processes. For example, “if the values or beliefs the movement seeks to promote or defend are of low hierarchical salience within the larger belief system, the mobilizing potential is weakened considerably and the task of political education of consciousness raising becomes more central but difficult” (Snow & Benford 1988). In addition, Snow et al. (1986) emphasise the importance of the “linkage of individual and [organisational] interpretative orientations, such that some set of individual interests, values and beliefs and [organisational] activities, goals and ideology are congruent and complementary”. As discussed previously, the values to which people subscribe do not occupy the same status but rather tend to be hierarchical, with some
being more prominent than others (Rokeach 1968, Williams 1970). Value amplification occurs when a basic value, which has previously not inspired collective action, is identified, idealised and elevated (Snow et al. 1986). In contrast, a value may be neglected if it falls into disuse (Tilly 1978), it may be taken for granted or become clichéd (Zijerveld 1979), or its relevance may be ambiguous (Goffman 1974). Anthony Downs describes the ‘issue attention cycle’ as where a problem comes onto the political agenda but once the real difficulties of successful change become apparent, interest in the issue tends to wane (Downs 1972). If any of these reasons for neglect are operative, the value will need to be focused, elevated and reinvigorated if an organisation is to mobilise its efforts to realise the value (Snow et al. 1986).

Importantly, political actors can rework the meaning of a well-known value in order to legitimise policy change (Béland 2009). In addition, ‘focusing events’ or crises can help to create fertile ground for policy-change (Birkland & DeYoung 2013), and ‘policy entrepreneurs’ and charismatic leaders can work to help shape decisions about policy (Helms 2012). As implied in the previous section, policy-makers can seek to shape policies such that they focus on values that are most dominant in achieving the desired changes in behaviour (Sections 1.3.2 and 1.3.3). Such policy-making can be viewed positively or negatively at the frontline of general practice, depending on whether the values espoused by the policy-makers align with those held by staff at the frontline. This will be explored further through this thesis.

1.3.5 Implementation of policy goals that are aligned with values in the public sector

As the sections above demonstrate, a critical element of implementation of policy goals that are aligned with values is the extent to which the values espoused by policy-makers are shared by, or aligned with the values held by, those responsible for delivering the service. A second consideration is the approach to implementation. Implementation of policy goals aligned with values in the public sector is not straightforward and can be affected by actors at the macro-, meso- and micro-levels. At the macro-level are government (or national organisations such as the NHS) and the laws (or policies) that flow from it. Laws, however, can be vague and complex (Peters
2015), and hence difficult to implement (a pertinent example being the 2012 Health and Social Care Act (Secretary of State for Health 2012)).

1.3.5.1 Tools to enforce policy implementation

Here I briefly consider some tools available to governments to enforce (hard tactics) or encourage (soft tactics) implementation of a policy as intended. However, as will become clear through this thesis, such tools are not always effective for policy goals that are aligned with values. Indeed, some of these tools can be counterproductive because they increase the distance between what organisations say and what they do (e.g. Chapter 5).

Bemelmans-Videc et al. (1998) suggested that policy instruments may be understood as Carrots, Sticks, and Sermons. A simpler version, Muscles and Prayers, implies that government can choose to exercise its power or can rely on moral persuasion to gain compliance (Gormley Jr 1989): government power can take the form of incentives or disincentives, but sometimes preaching is the only option, and is perhaps a more palatable approach for policy goals that are aligned with values, where government can appeal to aspirational values. Instruments may be based in old (command and control – or hard law) and new law (negotiation and collaboration – or soft law) (Salamon 2001, Mört 2004).

Whichever type of tool is chosen, the key goal of policy implementation is to ensure that acceptance and compliance with specific initiatives is achieved on the ground. Information and persuasion may be chosen as a policy instrument, and, depending on the legitimacy of the policy-making organisation or implementers, the policy might be accepted at the frontline. On the other hand, rigid enforcement and hierarchy may work, but this is an expensive choice and it can create mistrust and hence make it difficult for next time (Peters 2015). Psychological tools, such as ‘nudge’, use subtle incentives and disincentives to get people to behave in a desired manner (Thaler & Sustein 2008) and are based at the softer end of the implementation tool continuum. If such tools are used in the context of policies where there is alignment with accepted values (Section 1.1.2) then people are more likely to comply because they are reminded of the ‘right thing’ to do.
This notion of the ‘right thing to do’ is also relevant to policy-makers who are seeking to choose appropriate approaches for successful implementation (March & Olsen 1989). Unfortunately, it can be difficult for policy-makers to decide on criteria to evaluate different approaches, and the chosen criteria may even be contradictory, so judgement is required, based on the public interest (Ho 2012). There are many different criteria on which to base such a decision; two are considered here as they are strongly aligned with the aims of responsiveness, as explored in Section 1.3.3.

The first consideration is fairness. The public tend to want policies that are fair and that treat citizens in an equitable manner (Sen 2009). People may be willing to accept deprivations (and hence lead to successful implementation) if they are being treated equally and if they see that the programme is being implemented fairly (Slemrod 2007). However, this is immediately problematic as people think ‘fair’ is what benefits them, not others, especially those they do not particularly like (Faricy 2011). Thus removing personal conceptions of fairness is key to a just approach. Rawls considers a ‘difference principle’ (Rawls 2001) whereby policy choices are based on minimising differences in society, and thus can be considered as fair. Whether this fairness is grounded in equality of opportunity or equality of outcomes is debatable, and may vary depending on the policy and the politics of the government in power. Such equality, however, may be influenced by the use of discretion at the frontline of policy implementation, and can depend on the values held by those in public-facing roles.

The second consideration is stigma. Whilst equality is one of the underlying principles of fairness, some societies may struggle to maintain it. People may be stigmatised because of their race, religion or sexuality, or characteristics such as physical disability or mental illness. Targeting policies at these groups may be good design (see, for instance, Sections 2.3.3.2 and 6.4.2) – such a policy meets their needs and does not waste resources by providing for those who do not need it – but labelling may occur, resulting in stigma. Such labels may include deserving or undeserving (Handler & Hasenfeld 2006, Abbie Erler 2012) or being less capable, which may become a self-fulfilling prophecy (Bagenstos 2000). Weighing the targeted approach with the potential for stigma is an ongoing challenge for policy-makers and may depend on the
ideology, culture and politics of decision-makers (Peters 2015), and ultimately will lead to successful or unsuccessful policy implementation.

These considerations of fairness and stigma are highly relevant to responsiveness as a policy goal that is aligned with values. As demonstrated in Section 1.3.3, the values of fairness and equality feature strongly in definitions of responsiveness in both the literature and policy. The way in which a government chooses to enforce such policies such that values alignment is achieved may therefore be key to these policies’ success (Section 1.3.4.1).

1.3.5.2 Further challenges to policy implementation

As well as the balancing of fairness with stigma, there are many other challenges to successful policy implementation. For instance some policy goals that are aligned with values may be in conflict with each other, perhaps resulting in misalignment with efforts to shape service provision in ways that are seen to reflect core values, or where the enactment of one value undermines the enactment of another. Coordination across policies can be difficult, and can result in turf wars (Beale 1995, Blatter 2003). The most important policy goals (e.g. improving health) cannot be tackled by one department; health, nutrition, recreation, housing, all play a part. Enacting the value of coordination in general practice (Section 1.2.4), therefore, can be challenging.

Challenges with complex and ‘wicked’ issues such as these (Rittel & Webber 1973) can be addressed through governmental hierarchy, but networks and market devices can also be effective among organisations and individuals (Peters 2015). Further challenges can result from the political differences between parties in power and their use of vertical coordination, and the call on professionalism, which may contribute to the success of individual policies but may hamper cooperation with other programmes (Peters 2015).

In addition, measuring the impact of a policy is difficult (Peters 2015). The introduction of measurement as part of implementation may have unintended consequences, e.g. when performance standards result in ‘gaming’, whereby the effectiveness of a policy is reduced because people find a way to reach targets regardless of the intention of the policy (Radin 2006). Measuring impact is especially problematic when there is little
short-term benefit and measurement must be taken in the longer-term, or when the benefits of a short-term project decay quickly upon project completion (Salamon 1979). Such short-termism can also result in effort being applied to meet the needs of the (sometimes dysfunctional) measurement systems, such that the appearance of implementation (activities) masks the reality of the outcomes (achieving fundamental goals) (Bouckaert & Peters 2002). It can also be difficult to ensure that a policy targets the right people – that the service is delivered to those who are meant to receive it and not to those who are not (Ingram & Schneider 1990, Schneider 2013), whilst facing the challenges of fairness and the potential for stigma into account (Rawls 2001, Peters 2015). All of these considerations are relevant for the enacting of a tactic, such as responsiveness, to achieve goals that are aligned with values, as will be evidenced in my findings chapters where policy-makers, staff with strategic responsibilities at a locality level, and frontline staff in general practices recount their efforts to generate and implement policies that encompass issues of fairness and stigma, misalignment with other policies, and the detrimental effects of measurement (Chapters 4 – 6).

1.4 Research questions

I have used the core values of general practice (Section 1.2) to provide a theoretical framework in which to situate my research questions and analyse my findings. By studying the implementation of responsiveness into practice during a period when the concept was a prominent feature of primary care policy, lessons can be can learnt about the use of tactics to achieve goals that are aligned with values. My research questions are:

1. How is responsiveness defined in policy documents and in policy-makers’ discourse, what values does it reflect, and what problem(s) is it said to be able to solve? (Chapters 2 and 4)
2. What specific policies have been implemented in England since 1996 to address the issue of responsiveness? (Chapter 2)
3. How do meso-level actors in organisations with strategic responsibilities view and respond to the concept of responsiveness as espoused in policy? (Chapter 5)
4. How do frontline service providers view and respond to the concept of responsiveness as espoused in policy? (Chapter 6)

5. What are the key challenges to implementing responsiveness in primary care? Does the concept of responsiveness add value to efforts to implement goals aligned with core values in primary care? What are the lessons for using tactics to achieve goals aligned with values? (Chapter 7)

1.5 Format of this thesis

Having introduced the concepts of core values of general practice, public policy-making and implementation within public services such as general practice, and responsiveness within general practice, I turn next to the findings from my analysis of policies related to responsiveness in general practice. I describe my sampling and analysis methods, and consider how text in the documents framed the goals of responsiveness, what needed to be implemented and what was simply guidance, and where the responsibility for implementation lay. In Chapter 3, I describe my methodology and research design for the following empirical chapters. Chapters 4, 5 and 6 present the findings from my interviews with elite participants involved with developing and disseminating responsiveness policy, meso-level strategic staff charged with encouraging implementation of policies in general practice, and general practice staff at the frontline, respectively. I end with a discussion of the themes running through my thesis and the potential implications for general practice and future research.
2 Responsiveness policy initiation and evolution

The purpose of this chapter is to examine how, over the 19 years of my sampling frame, policy documents described and invoked responsiveness in primary care, specifically general practice. The findings I present attend to my first two research questions about how responsiveness is defined in policy documents and the problem(s) it is said to be able to solve, and the specific policies that have been implemented in England since 1996 to address the issue of responsiveness. First, I describe my methodology and methods of document selection and analysis. Second, I consider the overall purpose of the documents in my sample and the ways in which they cited responsiveness as an important goal, and whether and where specific policy initiatives were introduced to improve responsiveness. I also set the documents within the context of wider NHS policy and (re)organisation, which in turn is set within the context of the political party (or parties) in power. Third, I look in detail at text within the documents pertaining explicitly to responsiveness in the context of general practice. I discuss how the documents described the aims of responsiveness in general practice, whom responsiveness served, and for what reasons (i.e. the problem(s) it aimed to solve). I also consider whether and how these aims changed over time. Finally, I review the ways in which the documents advocated and supported implementation in general practice: which organisations and individuals were charged with the responsibility for implementing responsiveness, and how this changed over the timeframe.

2.1 Document analysis methodology and research design

2.1.1 Document analysis methodology

To explore the evolution and operationalisation of responsiveness in policy, I performed an analysis of policy documents relevant to responsiveness in general practice. An analysis of text within documents allowed me to ask questions about the practices, knowledges and understanding of the concept under study (Rapley 2007). In
the case of responsiveness policy documents, such an analysis enables the study of how responsiveness is produced and negotiated, how it was recommended to be operationalised into action, and the historical, social and cultural nature of these knowledges and actions (Rapley 2007). Similarly, in her study of personalisation in the English NHS, Needham studied discourse within policy documents and how it shaped the meaning of and reasons for promoting personalisation, allowing a conceptualisation of personalisation as ‘disruption’ (a radical shift in policy in response to failure) or ‘consolidation’ (an attempt to consolidate values and relationships, and balancing personal needs with fairness) (Needham 2011). Likewise, Borgstrom and Walter conducted a critical analysis of choice and compassion in end of life care (Borgstrom & Walter 2015). They looked for similarities in the discourses so that “patient choice and equitable provision of compassionate skilled care can be mutually reinforcing.” However, they also found discrepancies in the operationalisation of choice and compassion. In a similar manner, I have attempted to conceptualise responsiveness and the ways in which the documents articulate how it should be operationalised and implemented.

Exploring the text in documents involves focusing on what is said and what is not said. This enables a researcher to examine the ways in which an argument, idea or concept is developed, whilst also considering the silences, gaps or omissions (Rapley 2007). Also of interest is the rhetorical work of the text, i.e. how it attempts to convince the reader that the document author has authority and understanding of what is written (Rapley 2007). Issues include both the range of sources of knowledge and evidence that are used (i.e. the organisations involved either as interested or disinterested parties in the debate) and the forms and modes of knowledge and evidence (i.e. the nature of the (perhaps trusted and independent) experts within those organisations and the words they use to articulate the problem of interest) (Rapley 2007). The solutions to problems presented in documents, especially policy documents, depend on the perceived ‘owner’ of the problem and from whose perspective the solution is proposed. In the case of responsiveness, documents may present a patient perspective (i.e. the patient voice, in the case of a document authored by a patient organisation, rather than a policy-maker’s interpretation of what patients say, e.g. in a document
authored by the Department of Health (DH) based on findings from a patient consultation), and hence patients may (at least on the face of it) be ‘empowered’ to enact solutions (for instance, through the formation of a patient participation group). In other cases, where improving responsiveness is considered to be the responsibility of general practice, then GPs may be held accountable for enacting a solution.

Documents can also help researchers to understand the ‘histories of the present’, inviting research questions that focus on how ideas and practices emerge and evolve into what they are in the present (Rapley 2007). The longitudinal nature of my sample allows me to examine the strategies that have led to the present as well as those that were seen as failures and were therefore discarded.

A particular challenge of document analysis is the process of deciding which documents to include and exclude. Often there is a ‘seminal’ document that marks a watershed moment in policy-making. The suite of DH and DH-endorsed documents published in 2008/9 provided such a ‘moment’ in responsiveness policy (see Table 14 in Appendix 2). From here, I searched backward and forward in the DH archives (and more recently the live website), but knowing where to stop was challenging. As I was keen to look for changes over time and for potential links with the political party (or parties) in power, I ensured that transition points where governments changed were included. In the end practicalities prevented searching before 1996, as this was when the DH electronic archive began. Again, for practical reasons, I ended my search in 2014 when I started to write up my findings. Details of my search methods and inclusion criteria are provided in the following section.

2.1.2 Policy document sampling methods
Documents published between 1996 and 2014 were identified through archives of the DH website, hand-searching for references cited in these identified documents, and searching for documents mentioned by my elite interviewees (Chapter 4). Inclusion criteria are presented in Table 3 (overleaf). Documents were excluded if they were not: national; authored by, endorsed or recognised by DH; or relevant to responsiveness. Document types and titles were initially screened and then abstracts or introductions read to ensure that they were relevant to responsiveness. To ensure inclusivity the
entire document was searched for mentions of ‘responsive’ or ‘responsiveness’. Patient ‘experience’ (and related words, such as ‘journey’ and ‘satisfaction’, etc.) and ‘access’ were also searched for, and documents were included if they related to elements of responsiveness.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>For inclusion</th>
<th>Reasoning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates</td>
<td>1996 – 2014</td>
<td>Start of electronic archiving to start of write-up period</td>
</tr>
<tr>
<td>Sources</td>
<td>DH website (including archive)</td>
<td>To ensure inclusivity</td>
</tr>
<tr>
<td></td>
<td>Google search results</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reference chaining</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elite interviews</td>
<td></td>
</tr>
<tr>
<td>Document type</td>
<td>All White papers</td>
<td>Strategic direction of the NHS</td>
</tr>
<tr>
<td></td>
<td>DH-authored documents relevant to responsiveness (guidance, consultations,</td>
<td>Documents in between White papers that endorsed and/or promoted responsiveness</td>
</tr>
<tr>
<td></td>
<td>policies, reports)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NHS England-authored documents relevant to responsiveness (commissioning</td>
<td></td>
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<tr>
<td></td>
<td>development, policy)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DH-endorsed documents relevant to responsiveness (commissioned charity reports,</td>
<td>National documents that promoted responsiveness, endorsed by DH</td>
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<tr>
<td></td>
<td>incentive and targets frameworks)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NICE guidelines</td>
<td>Patient experience guidance, recognised by DH</td>
</tr>
</tbody>
</table>

Table 3: Inclusion criteria for the document sample

Thus, the sample included all White Papers and other policy documents, reports, guidelines and patient leaflets that were specific to responsiveness, access or patient experience, or that included reference to these either explicitly or implicitly (e.g. Green Papers, NICE guidelines, etc.). The aim was to be as inclusive as possible, so in the case of consultation documents, both the consultation and the post-consultation documents were considered for inclusion, but in some cases only the post-consultation document was included as the primary purpose of the associated consultation.
document was to describe how the consultation would work rather than to describe the content of the policy on which it was consulting.

2.1.3 Policy document analysis methods

I performed a thematic analysis of the policy and guidance documents to examine the ways in which responsiveness was evoked by policy-makers – the idealised view of what responsiveness meant and the ways in which it should be implemented (Braun & Clarke 2006, Rapley 2007). Analysis also drew on components of content analysis, where I quantified instances of particular words or policy intentions (Hsieh & Shannon 2005) with elements of conversational analysis, where I took account of what was not said as well as what was said (Rapley 2007) and grounded theory, where the coding related directly to the text rather than any pre-conceived ideas (Glaser & Strauss 1967).

Each document was read line-by-line and text that was specific to responsiveness, access or patient experience in primary care was coded in the qualitative analysis software, NVivo10. Coding was both inductive and deductive. Whilst I had themes in mind at the outset based on the characteristics of responsiveness identified within the NIHR study (Tarrant et al. 2014), I also developed themes bottom-up from the data (Charmaz 2006, Glaser & Strauss 1967). Open codes describing each unit of meaning were applied line-by-line to the documents. The aim was to be inclusive and thorough, coding where responsiveness or its components were either specifically mentioned or implied. Through comparison across documents the open codes were grouped into organising categories to reflect emerging themes. A sub-set of the categories and assignment of data were independently validated by my first supervisor (CT). The coding frame was further refined (Table 15 in Appendix 3).

Inspection of the large amount of coded text from this initial round of coding revealed the need to perform more focused coding to exclude less relevant data (e.g. data that also related to secondary care, or contained no substantive information about responsiveness), and to focus in on key emerging themes and sub-themes relevant to the research questions. To ensure only relevant data were included NVivo query text searches were conducted for text that included the terms responsive and
responsiveness in proximity to ‘general practice’ or ‘primary care’. Full details of the query are provided in Appendix 4.

The excerpts produced by this query, which I term ‘focused text’ in the rest of this chapter, were coded to explore higher order themes that had been identified – relating to justifications within the policy documents as to why responsiveness had been invoked as an aspiration for general practice and to accounts of where responsibility for responsiveness lay. My ‘invoked’ theme included codes: to be fair and equitable; to meet the needs of vulnerable and marginalised groups; to respond to consumer or customer demands and expectations; and to work with patients. ‘Responsibility’ included codes for organisations or individuals assigned responsibility in the text, such as commissioning organisations, performance-managing organisations, government, NHS staff and patients. Details of the coding frame for the focused text is provided in Table 16 in Appendix 5.

2.2 The policy documents sample

I identified 38 documents that met the sampling criteria. The documents and the major political and NHS events over the timeframe are depicted in Appendix 6. Most of the documents were authored by DH (Appendix 2). The most common type of document was policy (for information, action or consultation), followed by guidelines and White Papers. The sample also included incentive frameworks, reports and targets. The declared objectives of all documents were to improve the NHS, either by developing services based on patients’ needs, or reducing inequalities (often through reforms or structural change) (Appendix 2).

Some documents were focused solely on responsiveness, especially around 2008/9. The table in Appendix 2 highlights the specific policy initiatives that were introduced to explicitly improve responsiveness. Some documents were written for other reasons

6 Document types are self-described, either within the document (e.g. the DH information box) or on the website where the document was published.
but responsiveness formed a theme within them. Others advocated responsiveness in passing. Although a blunt tool, and one to be interpreted with caution, Figure 1 (page 51) displays the number of times the words ‘responsive’ or ‘responsiveness’ was used in each document. Also displayed is the frequency of the word ‘choice’ in these documents. As the figure shows, not all documents specifically mentioned responsiveness; these instead used other words or phrases to describe its meaning, e.g. improved access or patient experience (indeed such phrases were also present in documents where responsiveness was also mentioned). But given these limitations, according the figure, there were three peaks through the time period, the first of which was around 2003, with Building on the best (Department of Health 2003) and subsequent documents, during the mid-Labour years. Building on the best was the first document to unequivocally advocate choice; indeed choice was mentioned far more than responsiveness and this coincided with both responsiveness and equity (the full title of the document is Building on the best: choice, responsiveness and equity in the NHS). The second peak was at the beginning of 2006 with the White Paper Our health, our care, our say (Department of Health 2006). This paper advocated personalised and convenient care, and giving people a stronger voice in service improvement – all key elements of responsiveness. Again, choice was mentioned far more than responsiveness. The third and final peak was in 2008/9 towards the end of the Labour era, starting with the so-called Darzi report (Department of Health 2008a) where the focus shifted from quantity to quality of care. A suite of documents was published around this time which specifically targeted the need for responsiveness in general practice. Within these documents meanings and behaviours were attached to responsiveness and guidance was provided about ways in which to implement responsiveness in general practice (although still within the agenda of choice, which was mentioned as often as responsiveness). Shortly afterwards, the Nicholson Challenge took effect whereby 20% efficiency savings were sought throughout the NHS (National Health Service 2009). Responsiveness (and choice) continued to feature in

7 I have chosen ‘choice’ for reasons that will be become clear through this chapter, but in short, choice was seen, in many of the documents, as a solution for responsiveness (as opposed to equity and access which were goals of responsiveness), and yet simultaneously a concept that might be construed as in conflict with responsiveness.
documents after 2009, but less frequently. Indeed, choice still appears as a solution for responsiveness beyond the timeline (NHS England & NHS Improvement 2016).

Appendix 2 lists the documents in my sample, with a summary of each document’s purpose (based on the DH information box on the website or in the document if available, otherwise within the introductory chapter(s) of the document), and a summary of some of the examples of responsiveness within each (within introductory chapters in full-text documents, where available). Also provided is an indication of which documents included specific initiatives to address the issue of responsiveness (which are also listed in Box 2, below). As can be seen in Box 2 and Table 14 (in Appendix 2), just seven of the 38 documents met this criterion. Six of these were published in 2008/9 at the ‘seminal moment’ in responsiveness policy-making (Section 2.1.1). The seventh document was in 2014, and, although mentioned rarely in the document text (Figure 1 overleaf, document 2014-03), responsiveness formed one of the ‘ambitions’ of general practice outlined in the document.

<table>
<thead>
<tr>
<th>Box 2: Documents with specific initiatives to address responsiveness in general practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report of the National Improvement Team for primary care for access and responsiveness (Department of Health 2008c)</td>
</tr>
<tr>
<td>No patient left behind: how can we ensure world class primary care for black and minority ethnic people? (Lakhani 2008)</td>
</tr>
<tr>
<td>Access and responsiveness: what matters to patients? (Box 2008)</td>
</tr>
<tr>
<td>Primary care service framework: accessible and responsive general practice (NHS Primary Care Contracting 2008a)</td>
</tr>
<tr>
<td>World class commissioning for GP services: improving GP access and responsiveness (Department of Health 2009)</td>
</tr>
<tr>
<td>Improving access, responding to patients: a ‘how-to’ guide for GP practices (NHS Practice Management Network 2009)</td>
</tr>
<tr>
<td>Improving general practice: a call to action, phase 1 report (Dyson 2014)</td>
</tr>
</tbody>
</table>

Although the political party (or parties) in power changed twice during the timeframe, the meaning and aims of responsiveness remained fairly constant. As will be seen in the following sections documents in the late 1990s often expressed similar or identical goals for responsiveness to those expressed in the 2000s and 2010s. The ways in which
these goals were to be achieved, however, evolved through the timeframe and will be considered in detail in the following sections.

![Figure 1: Frequency of 'responsive' and 'choice' in the documents](image)

**2.3 Policy definitions of and goals for responsiveness in general practice**

As described in the previous section and Appendix 2 the aims of the policy documents in my sample varied, although all were intent on improving the NHS albeit by different means. All advocated the need to be responsive in all sectors of the NHS. In this section I focus on the reasons to be responsive in the context of general practice or primary care, and what needed to happen to make these aspirations a reality, according to the policy documents. Analysis was based on the ‘focused text’ within the documents: text that relates to explicit reference to responsiveness in the context of general practice or primary care. The findings in the following sections were developed from the coding to the ‘invoked’ and ‘responsibility’ themes. The number of text

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8 Although I am primarily interested in general practice, my analysis took account of other organisations that might impact on general practice, such as primary care trusts (PCTs), strategic health authorities (SHAs), clinical commissioning groups (CCGs), government, etc.
Through my analysis I found that the documents defined responsiveness as understanding and meeting the needs and expectations of patients through providing a high quality and equitable service to patients who are consumers of the service.

**2.3.1 Meeting patients’ non-clinical needs**

The policy documents prescribed many practical issues relating to meeting patients’ needs. Here, needs are those Bradshaw (2013) labels as *normative*, that is, those that “the expert or professional, administrator or social scientist defines as need in any given situation” (Section 1.3.1.2). The characteristics of responsiveness as relating to meeting patients’ needs were most fully explained in responsiveness-specific policies and guidance in 2008 and 2009 (Department of Health 2008c, Box 2008, NHS Primary Care Contracting 2008b, Department of Health 2009). Responsiveness was described in terms of: providing access (e.g. the ease of making an appointment to see a GP and the convenience of that appointment); providing good customer service (e.g. the friendliness of receptionists); coordination of care (e.g. text reminders for...
appointments and smooth transitions to and from secondary care); and ensuring a suitable physical environment (e.g. comfortable chairs in the waiting room and a suitable system to call patients into their appointment) (Tarrant et al. 2014). Although only explicitly defined in these few documents, there was evidence of these responsiveness characteristics throughout all the policies I reviewed.

“...practices need to get the physical environment right (e.g. use of automatic/sliding doors in reception), they need to get the attitudes right (helpful, sensitive and facilitative rather than obstructive, abrupt and intrusive) and they need to make it as easy as possible for services to be accessed.”

[Access and responsiveness: what matters to patients? p.4 (Box 2008)]

Though not specifically defined as part of responsiveness, other ways of meeting patients’ needs were considered important in the documents. Primary care organisations (PCOs) were expected to provide information to patients about available services, and to have effective telephone systems, electronic systems and information systems for sharing data.

“The provision of more and better information to patients is central to making primary care services more responsive to people’s needs and to share decision-making about their care and treatment. All PCTs now publish, and distribute to every household, a short annual leaflet – Your Guide to Local Health Services – which gives information about the range and performance of all local services.”

[A responsive and high-quality local NHS: the primary care progress report 2004, p.22 (Department of Health 2004c)]

2.3.2 Meeting expectations for quality

Throughout the documents there were references not only to patients’ needs but also to expectations. Drawing on Bradshaw’s taxonomy expectations are analogous to a combination of ‘felt need’, which “is equated with want. When assessing need for a service, the population is asked whether they feel they need it” and ‘expressed need’

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9 It is worth noting that this progress report is reporting the implementation of a policy set out in an earlier document and is not in itself making new policy.
which “is felt need turned into action.” (Bradshaw et al. 2013). Policies throughout the timeline stated that patients had the right to expect high-quality primary care services and that these expectations were legitimate and should be met. These expectations spanned some or all of the characteristics of responsiveness, such as ease of access, as well as the provision of a universal quality service.

“People want the security of knowing that their health and well being is catered for. This means they want a NHS that provides fast and responsive services within a national framework that ensures national standards are consistently at a high level of quality. They want a NHS that is responsive to their needs and listens to their views.” [Shifting the balance of power within the NHS: securing delivery, p.11 (Department of Health 2001)]

This quote, above, is from the era following the NHS Plan (Department of Health 2000) in 2000, where talk of national standards, quality and patients’ expectations were commonplace. As such this document was very much of its time; for instance standards were later superseded by frameworks, and targets by incentives. However, the continuity of the importance of responsiveness as part of a quality service (Section 1.3.1.1) was maintained throughout the timeframe.

In some instances a high-quality service was described as one that was responsive, and it was made clear that this was something to which PCOs should aspire. Responsiveness, here, included the provision of patient-centred care – care that was designed and delivered in ways that put patients’ needs before the logistics of the service. Responsiveness was also seen as a way to personalise care for individual patients, ‘treating the patient in front of you’, and delivering continuity.

“The NHS also scores relatively poorly on being responsive to the patients it serves. It lacks a genuinely patient-centred approach in which services are designed around individual needs, lifestyles and aspirations. Too often, patients are expected to fit around services, rather than services around patients. The NHS is admired for the equity in access to healthcare it achieves; but not for the consistency of excellence to which we aspire. Our intention is to secure
excellence as well as equity.” [Equity and excellence: liberating the NHS, p.8 (Department of Health 2010a)]

The above quote, from Equity and excellence (Department of Health 2010a) in 2010, was, like the earlier excerpt from the Shifting the balance of power (Department of Health 2001), of its time. But whereas Shifting the balance of power focused on national standards and targets, Equity and excellence was published in the era following the so-called Darzi report (Department of Health 2008a) when personalised care rather than national standards was advocated. However, the importance of the aims of responsiveness continued through the timeframe, even as wider framings shifted.

Alongside patient-centredness and personalisation, the role of consumerism was also a common theme. With a shift in culture within and beyond the NHS, patients were seen as consumers of NHS services – customers who chose where and when to receive care at their own convenience (Section 1.3.1.3). Documents described patients who expected a health service that met the levels of access and responsiveness seen in the corporate world, such as banking or online shopping. Patients were no longer passive recipients of remedies prescribed by powerful doctors, but rather expected to be treated with respect as consumers of customer-centred services.

“Society is changing and we now live in a consumer-led world with an emphasis on a more responsive culture from those providing primary care services, which necessitates the need for a cultural change.” [Improving access, responding to patients: a ‘how-to’ guide for GP practices, p.i (NHS Practice Management Network 2009)]

There was acknowledgement, in some documents, that there was much work to be done to achieve this. In some cases patient expectations were invoked as a rhetorical device to drive improvement.

“This is a tough and challenging programme. On some fronts there will be early progress. Others may be for the long haul. Some may take time to show visible improvement. But the end result will be an NHS that responds to a changed and
changing world.” [The new NHS: modern, dependable, para. 10.8 (Department of Health 1997)]

This quote, above, demonstrates early New Labour (in 1997) approaches to improving the NHS, with its programmatic whole-NHS approach to change. More recent documents, as we will see later in this chapter (Section 2.4.2.3), focused more on local change to achieve the aims of responsiveness.

2.3.3 Providing an equitable service

A common reason to be responsive, as cited in the focused text of the policy documents, was to ensure fairness and equity (Section 1.3.1.2). Providing for needs in an equitable way is similar to Bradshaw’s definition of ‘comparative need’. Here, “a measure of need is obtained by studying the characteristics of the population in receipt of a service. If there are people with similar characteristics not in receipt of a service, then they are in need” (Bradshaw et al. 2013). There were two main reasons for advocating equity in the documents. First, it was seen as a way to provide a fair and consistent service to all patients, regardless of their background or demographics. Second, in order to be fair to everyone and to achieve equity, it was seen as important to focus on the needs of vulnerable and marginalised groups, to reduce inequalities and disadvantage.

2.3.3.1 Fairness for all

The theme of equity and fairness for all was consistent through the documents over the timeframe and through successive governments with different political ideologies, as the quotes below demonstrate (taken from documents published in 1997, 2003, 2008 and 2014 respectively). A key aim of primary care was seen as providing a consistently high-quality service (although the definition of high-quality was inconsistent) to every patient, regardless of their background or situation.

“The Government wishes to build on these approaches, ensuring that all patients, rather than just some, are able to benefit.” [The new NHS: modern, dependable, para. 2.7 (Department of Health 1997)]
“For too long equity has been an excuse for mediocre service on the grounds that it was fair. The NHS now aims for equity of excellence: to make the best available to all.” [Building on the best: choice, equity and responsiveness in the NHS, p.13 (Department of Health 2003)]

“All NHS patients regardless of where they live now, where they were born or their ethnic origin, have the right to expect fair and equal access to primary care services that are responsive to their needs.” [No patient left behind: how can we ensure world class primary care for black and minority ethnic people? p.8 (Lakhani 2008)]

“These ambitions are designed to meet the varied needs of all our communities across the country. We want to ensure that everyone gets access to the same excellent high quality services.” [Improving general practice: a call to action, phase 1 report, p.6 (Dyson 2014)]

Equity was given prominence throughout the timeline. Indeed the founding values of the NHS were often cited in the Foreword or Introduction chapters of documents, re-emphasising the importance of a service that is free at the point of delivery and available to everyone. There appeared to be a continuous implicit acceptance that equity and fairness had not yet been achieved and that their attainment formed a long-term goal. According to the documents the persistence of health inequalities to the present day intensifies the need for equity and responsiveness for all.

“Creating an NHS which delivers that kind of service every day, for everyone, requires a real culture change. People understand that it will take time, and that it must be done in a way which is fair and equitable for the whole population. But we are determined to set the direction.” [Building on the best: choice, equity and responsiveness in the NHS, p.7 (Department of Health 2003)]

2.3.3.2 Fairness for vulnerable and marginalised groups

Meeting the needs of patients who are seen as vulnerable was a key priority in many of the documents. Patients’ vulnerability was described in terms of any combination of, for instance, being: of a black or minority ethnic (BME) background; old or young;
of Romani descent or a traveller; homeless; a patient living in an area of high deprivation; part of a hard-to-reach or seldom-heard group; or a patient with multimorbidities, physical disabilities or learning difficulties. Building capacity in poorly served areas was also seen as a way to make equal access a reality.

“Practices particularly need to ensure they assess needs and provide services in ways that promote more equitable access to services for different groups, including patients from BME communities, patients with disabilities and patients with mental health problems.” [Report of the National Improvement Team for primary care for access and responsiveness, p.17 (Department of Health 2008c)]

Sometimes these vulnerable groups were described as a specific example of how to meet the needs of everyone, as demonstrated above. In these cases responsive care was needed to meet everyone’s needs, including those who are seen as vulnerable. In other documents vulnerable patients were singled out as groups requiring special attention and care. In parts of the documents relating to issues other than responsiveness in primary care (for instance text encouraging people to eat more healthily or engage in exercise), this could perhaps be interpreted as somewhat paternalistic – people are unable to take responsibility for themselves and to make decisions, so the documents’ authors felt they should ‘nudge’ them towards being a ‘good patient’ who makes the ‘right’ choices, (The Behavioural Insights Team 2016) as the following quote demonstrates. It is note-worthy that the ‘nudge’ methodology, although formalised by the Coalition government through its Behavioural Insights Team (also known as the Nudge Unit) in 2010 (The Behavioural Insights Team 2016), was in use in policy-making during the later Labour years (as evidenced by the elite interviewees in Section 4.5.1 and a government report based on work undertaken on behalf of the Labour government in 2008/9 and published in early 2010 prior to the

10 Most of the policy documents refer to ‘Gypsies’, which I have avoided here due to (conflicting) opinions about whether Gypsy is a racial slur (e.g. https://www.theodysseyonline.com/word-racial-slur). Direct quotations are cited verbatim.

11 A stated aim of the nudge technique is “enabling people to make ‘better choices for themselves’“ (http://www.behaviouralinsights.co.uk/about-us/)
general election (Institute for Government 2010) and still available on the Behavioural Insights Team website), perhaps suggesting that liberal paternalism was (and continues to be) part of official policy and implementation.

“Patients will work increasingly in partnership with professionals with the support of decision aids and information to help them make the right choices” [The NHS improvement plan: putting people at the heart of public services, p.68 (Department of Health 2004b)]

However, within text about responsiveness for marginalised groups the policies seemed to be less about influencing the behaviour or beliefs of such groups and more about affirming the need to provide appropriate support in order to even the playing field.

“We will work with patient organisations and primary care trusts at local level [...] to support...] patient choice in every primary care trust, focusing support on patients who are most disadvantaged.” [Building on the best: choice, equity and responsiveness in the NHS, p.41 (Department of Health 2003)]

In this way the responsiveness agenda could be seen to link to concerns with equity and fairness – though as the excerpt above illustrates, the link between responsiveness and choice remained present, with vulnerable groups to be enabled to exercise the same choices as enjoyed by others.

2.3.3.3 Tensions and paradoxes

The interaction between providing an equitable service and one that is personalised to individuals was acknowledged as a potential tension in the documents, which advocated that a balance should be achieved (Needham 2011). The apparent paradox between providing a nationally consistent service and one that is locally responsive is reminiscent of debates between those who claim that a one-size-fits-all NHS is no longer fit for purpose and those who maintain that the alternative is tantamount to a postcode lottery (British Broadcasting Corporation 2008, Exworthy et al. 2002, Hirschman 1980).
“The White Paper aims to renew the NHS as a one-nation health service offering fairness and consistency to the population as a whole. At the same time, the proposals in the White Paper ensure that the NHS delivers a personal service which is sensitive and responsive to the needs of individual patients. The Department of Health [has a key role] in helping to achieve an appropriate balance between national consistency and local responsiveness. [...] There will be a new focus on quality in NHS Trusts, so that patients get the twin guarantee of consistency and responsiveness from their local health services.” [The new NHS: modern, dependable, para. 6.8 (Department of Health 1997)]

Another potential paradox was that of a consumerist and choice-based culture, and its apparent conflict with meeting the needs of vulnerable people – people who may find it difficult to access services or make choices based on information. However, some documents during the Labour (see the first quote, below) and Coalition (see the second quote, below) periods appeared to advocate both approaches – meeting the needs of the vulnerable and the consumer (see also Section 2.3.2). PCOs were expected to tailor their services to individuals, measure their satisfaction, and make appropriate changes, to the benefit of all patients.

“More responsive and personalised care will mean benefit for all members of the community – black and white – through the lessons learnt in service development. [...] More responsive and personalised services tailored to the identified needs of patients will benefit all members of the community.” [No patient left behind: how can we ensure world class primary care for black and minority ethnic people? p.3 (Lakhani 2008)]

“[Choice of GP practice] is likely to be particularly valuable for people living in more deprived communities that have traditionally had fewer GP practices and less responsive primary care services. There should also be benefits for people from socially excluded and vulnerable groups, such as the homeless or travellers, who have the poorest access to primary care and often find it difficult to see a GP.” [Inclusion health: improving the way we meet the primary health care needs of the socially excluded, p.6 (Department of Health 2010c)]
Thus, improving responsiveness bottom-up through patient choice, including choice for vulnerable groups, was a response to the consumerist culture, whilst tailoring services was a way for frontline providers to respond to a top-down steer.

2.4 Strategies for making responsiveness happen in general practice

So far in this chapter I have described how the policy documents endorsed the need to be responsive in primary care – what it entailed and what its benefits were, and for whom. In this section I examine the strategies and approaches that were evoked in the documents and consider how responsiveness was expected to be achieved in practice.

2.4.1 Targets, incentives and accountability

One approach to implementation was through the introduction of targets and incentives, and by assigning accountability. Running a primary care service that, whilst being responsive, was also cost-effective and efficient, was seen to be of paramount importance throughout the timeline. The policies made the reader aware that, whilst monetary investment would be or had been made, value for money and good stewardship were essential.

“And it is also about making sure the NHS achieves value for the tax payer, building on an already efficient system, to: improve productivity; introduce independent scrutiny and inspection; strengthen accountability to the public it serves and who pay for it.” [Delivering the NHS plan: next steps on investment, next steps on reform, p.12 (Department of Health 2002b)]

Both in times of plenty (until 2009) and in times of austerity (2010 onwards) responsiveness appeared to be closely associated with efficiency and value for money. Macro-level organisations (e.g. the government, DH) expected meso-level organisations (e.g. SHAs, PCTs, CCGs) to develop incentives for GP practices (such as leverage through the QOF and offering a Local Enhanced Service (LES)) and to commission services that were resilient to future funding pressures. This was perhaps most apparent during the period of sustained efforts to reduce the national deficit by limiting public spending: of the eight documents from 2010 onwards, five included a
call to provide an efficient service, with two of these documents making explicit calls to save money as demonstrated in the excerpt below from 2014. This contrasts sharply with documents in the early 2000s where funding was plentiful and monetary investment in the NHS was extensive.

“It would require investment in new care models and would be achieved by […]
“catch up” (as less efficient providers matched the performance of the best) […]
It would improve the quality and responsiveness of care, meaning patients getting the ‘right care, at the right time, in the right setting, from the right caregiver’. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years.” [The NHS five year forward view, p.36 (Care Quality Commission et al. 2014)]

Accountability for expenditure was a dominant theme throughout the timeline: any changes that were made to become more responsive should be accountable to patients, the public and tax-payers. Policies stated that PCOs should be transparent and clear about what had been done and why, how much it cost, and whether or not it was effective. It was seen as important that data were published to hold PCOs to account and to enable patients to engage with choice.

“Comparative quality information of this kind will help primary care clinicians understand and compare different areas of performance and identify areas for improvement. Publication of data will also provide much greater transparency about the quality of local services and support the public in making more informed choices about which services to use.” [NHS next stage review: our vision for primary and community care, p.46 (Department of Health 2008b)]

During this time meso-level organisations, such as PCTs, were also held accountable. PCTs were expected to work with practices to commission appropriate systems and to performance manage these. The following quote demonstrates the complexity of the theory of change to influence responsiveness: a practice uses patient choice to work with the PCT to facilitate improvements in responsiveness for patients, thus benefiting these patients.
“Effective commissioning will depend greatly on the quality of the relationship between PCTs and their general practices. Where they work well together, practices will drive improvements in quality, efficiency and responsiveness within the financial and strategic framework set by PCTs, marrying closeness to patients with a population perspective. Together they can have a high impact on local services by using the influence that practices will have on patient choice to lever change at the PCT level in order to benefit patients’ experience.”

[Health reform in England: update and next steps, p.28 (Department of Health 2005b)]

To enable accountability documents endorsed the need for measurements and audits. Measures were developed and targets were set. These included specific individual targets (e.g. getting a GP appointment within 48 hours) or milestones (this must be achieved by a set date), as well as the development of a framework for responsiveness: a document comprising a plethora of targets but also incentives to meet them, and, in some cases, practical suggestions for ways to achieve these targets (NHS Primary Care Contracting 2008a).

“The PCSF [primary care service framework] sets out a number of possible approaches PCTs might want to take to utilise the additional resources allocated to them [...]. The purpose of the framework is to incentivise practices and provide them with resources to tackle the specific access issues relating to their own practice and their patients. [...] It can be used in a number of ways to develop new approaches or change existing working practices through the implementation of: incentive schemes; capital grants; local enhanced services.”

[World class commissioning for GP services: improving GP access and responsiveness, p.21 (Department of Health 2009)]

Both incentives and sanctions were sometimes included – both carrots and sticks (Bemelmans-Videc et al. 1998) (Section 1.3.5.1). Incentives were usually monetary and/or contractual. If PCOs acted in a particular way, they were rewarded with funding. If they did not meet targets, funding was withheld. Performance management discourse was dominant: in order to achieve responsiveness, individuals, staff groups
and organisations needed to be monitored and cajoled into acting appropriately, using performance management techniques and financial incentives, including incentives based on patients’ views.

“And we are aligning incentives to support choice and responsiveness. [...] For the first time, the patient experience will directly impact upon GP reward.”

[Building on the best: choice, equity and responsiveness in the NHS, p.33 (Department of Health 2003)]

However, some policies made it clear that targets were not always the answer; in Labour’s second term, there appeared to be a backlash against targets, and nudge began to take hold (see also Section 2.4.4).

“[This document] does not set out a raft of new targets for the NHS.” [Delivering the NHS plan: next steps on investment, next steps on reform, p.12 (Department of Health 2002b)]

2.4.2 Delegation of responsibility and promoting innovation and intrinsic motivation

As demonstrated in the previous section accountability for responsiveness was distributed throughout the NHS hierarchy, from government and DH, through meso-level organisations such as SHAs, PCTs and CCGs, down to the micro-level of staff within GP practices. To enable this accountability responsibilities for improvement were delegated; this delegation of responsibility comprises the second approach that I consider in detail.

2.4.2.1 Legislation

One such delegation tactic invoked in the documents was legislation. Legislation was only rarely mentioned in the context of responsiveness in primary care, but there were two policies (both setting out the ways in which primary care should be provided to vulnerable groups) that did. The first, No patient left behind (Lakhani 2008), cited the Race Relations (Amendment) Act 2000 and how PCTs should ensure that they were compliant when providing services for BME patients. The second, Inclusion health, a DH policy for information, was to provide “...a framework for driving improvements in
health outcomes for socially excluded groups” (p.6) (Cabinet Office 2010). The dominant reference to legislation therein was to the NHS Constitution. Although the Constitution is not a law in and of itself, the Constitution webpage says “No government can change the Constitution without the full involvement of staff, patients and the public. The Constitution is a promise that the NHS will always be there for you” (Department of Health 2015). Also in Inclusion health policy-makers championed distributed responsibility as a moral imperative as well as for legal reasons; it was made clear that the whole NHS should be responsible for improving healthcare for excluded populations. These documents are examples where the background legislation was highly congruent with norms and values and so was deliberately brought into the foreground to lend further weight to the call for responsiveness throughout the NHS.

“To bring about changes, we need action in all parts of the system, not just within health and social care, and over different time scales. Taking this forward will require a focused and coordinated effort, both nationally and locally.” [Inclusion health: improving the way we meet the primary health care needs of the socially excluded, p.43 (Cabinet Office 2010)]

2.4.2.2 Sharing good practice

A second tactic for delegating responsibility was sharing good practice. The DH document, No patient left behind, was structured around a series of case studies of good practice, detailing how primary care should be providing excellent services to BME patients (Lakhani 2008). The report called on organisations and individuals to continue this culture of sharing good practice, thus moving away from top-down diktats and instead leaving GP practices room for discretion and creativity (although it should be noted that a potential unintended consequence of competition between providers is that GP practices may be less willing to share; more on this in Section 2.4.4).

“Practices should use the examples of good practice found in this report to deliver high quality care for BME patients and strive to provide a personalised, accessible and responsive service to all their patients.” [No patient left behind:
how can we ensure world class primary care for black and minority ethnic people? p.23 (Lakhani 2008)]

Sharing good practice was also cited as a way of making the best use of staff; staff could showcase their ways of working to help other PCOs to be more responsive. Indeed, one key document, a ‘how-to’ guide, was authored by a group of active practice managers, thus allowing the usual policy-makers in DH to share responsibility for policy with implementers at the frontline.

“Over the next 12 months, we will be creating a new national NHS Practice Management Network, to connect all practice managers across the country. [...] We look forward to working with you so that we can help each other overcome the future challenges facing us as practice managers.” [Improving access, responding to patients: a ‘how-to’ guide for GP practices, p.i (NHS Practice Management Network 2009)]

2.4.2.3 Localism, innovation and intrinsic motivation

The third tactic of delegated responsibility that I consider is based in the text relating to the move away from control-from-the-centre towards a more local approach. During the Labour years the government held itself accountable for improvements by setting the strategic direction and performance managing PCOs (first quote, below, from 2008). However, during the Coalition era accountability was delegated to localities, away from central control (second quote, below, from 2010).

“...it should be the Government that sets the framework for the NHS and is held accountable in Parliament for the way that it operates. There must be a continuous thread of accountability through the system to the Government of the day...” [High quality care for all: NHS next stage review final report, p.79 (Department of Health 2008a)]

“The Department will revise and extend quality accounts to reinforce local accountability for performance, encourage peer competition, and provide a clear spur for Boards of provider organisations to focus on improving
outcomes.” [Equity and excellence: liberating the NHS, p.14 (Department of Health 2010a)]

An example of innovation at the local level included encouragement for providers to understand the needs of people within their local area, e.g. by PCTs undertaking population mapping and needs assessments, and the subsequent segmenting of populations 12(Tarrant et al. 2014) for service delivery within GP practices. Calls for these innovations were evident throughout the timeframe and through three successive governments, despite the shifts in accountability (the quotes below are taken from documents published in 1996, 1997, 2008 and 2011 respectively).

“...sensitivity to patients’ needs and wishes requires flexibility in the way services are provided: the needs of individuals vary; the needs of communities vary: some population groups experience more illness and premature death than others; some face particular difficulty in accessing services; and services in rural areas will be different from those in urban or suburban areas...” [The National Health Service: a service with ambitions, p.24 (Department of Health 1996b)]

“Health Authorities will have a number of key tasks: assessing the health needs of the local population, drawing on the knowledge of other organisations, drawing up a strategy for meeting those needs...” [The new NHS: modern, dependable, para. 4.3 (Department of Health 1997)]

“What shone through clearly from the review was the need for PCTs to actively consider the profile of its local population in order to provide services appropriate to local needs.” [No patient left behind: how can we ensure world class primary care for black and minority ethnic people? p.11 (Lakhani 2008)]

12 Segmenting populations appeared to be a half-way house between a one-size-fits-all service (felt to be ineffective) and a service that tailors care to individuals’ needs (felt to be unachievable within financial constraints). Policies appeared to advocate population mapping as a way to be responsive to patient groups but there is no mention of potential challenges with this approach, such as the heterogeneity of patients within a given segment of a population and the resources required to collect useful data and to then make use of the information collected. See the NIHR report for an analysis of interviews with general practice staff about the difficulties with patient mapping.
“It will be equally important that, as more decision making is taken locally to reflect the needs of patients...” [The operating framework for the NHS in England 2012/13, p.8 (Department of Health 2011b)]

Documents early in the Coalition government were particularly critical of the Labour government’s perceived top-down target-driven policies (although there was no mention of the consequences on public health funding due to local government spending cuts).

“Centralisation has failed. There have been far too many central initiatives, with power hoarded in Whitehall. Multiple top-down targets about improving health and reducing inequalities have been imposed on local communities. We will end this top-down government. It is time to free up local government and local communities to decide how best to improve the health and wellbeing of their citizens, deciding what actions to take locally with the NHS and other key partners, without undue interference from the centre.” [Healthy lives, healthy people: our strategy for public health in England, p.11 (Department of Health 2010b)]

Whilst organisations were encouraged to be innovative, this was always framed (throughout the timeline including during the Coalition government) within tight boundaries and alongside coercive techniques (including, at various points in the timeline, targets, incentives and sanctions, monitoring, reporting, transparency, competition, or a combination of some or all of these), and it might be argued that this has the potential to stifle some kinds of innovation.

“Around the country, the NHS is increasingly developing more innovative, patient-centred services. It is often in primary care that some of the most dynamic and creative reforms are taking place, helping to move services out of more traditional hospital settings into more convenient community settings to improve both quality and efficiency. Giving people greater choice of GP practice will provide more momentum to these exciting changes in primary care.” [Your choice of GP practice: a consultation on how to enable people to register with the GP practice of their choice, p.3 (Department of Health 2010c)]
Thus the authors of the document cited above were, again, holding up examples of good practice (Section 2.4.2.2) that incentivised others to follow. Broadly such incentives were not money-related; they were aspirational, tapping into professionals’ intrinsic desires to provide an idealised service – one that partnered with patients, improved public health, and where professional boundaries were overcome. These documents were urging practitioners to change rather than telling them, empowering them to improve the service they provided, akin to the earned autonomy of clinician managers in NHS Trusts during the mid-2000s (Hoque et al. 2004).

“This White Paper sets out a radical new approach that will empower local communities, enable professional freedoms and unleash new ideas based on the evidence of what works [...]. This approach will reach across and reach out – addressing the root causes of poor health and wellbeing, reaching out to the individuals and families who need the most support.” [Healthy lives, healthy people: our strategy for public health in England, p.23 (Department of Health 2010b)]

In order to engage in innovation and provide a locally responsive service, staff in primary care were expected to develop appropriate skills and experience, e.g. through training, being proactive and taking on leadership roles. They were called to respond to incentives to behave in a certain way and to take on leadership roles that involved being innovative and changing the culture within the primary care workforce. This was evident throughout the timeline.

“This challenge cannot be met from Whitehall. The improvements to services can only be delivered by frontline staff working with patients and the public – reform must come from within the NHS. [...] And changes to the culture and working practices within organisations to devolve decisions to frontline staff and encourage the development of clinical networks across organisations.” [Shifting the balance of power within the NHS: securing delivery, p.12 (Department of Health 2001)]

Innovative systems were advocated as a way to improve responsiveness but also as a way to help staff feel valued, by, for instance, juxtaposing innovation and talent.
“Successful GP practices do not allow bureaucracy to stifle innovation but instead embrace new technologies and models of care where they can deliver benefits for patients. [...] Successful practices also recognise that primary care provision is about much more than access to GPs and that they need to make the most effective use of the skills mix within their practice if they are to provide the most effective and responsive care for their patients.” [Report of the National Improvement Team for primary care for access and responsiveness, p.18 (Department of Health 2008c)]

These changes to the way staff worked required a change in workforce culture. Staff were expected to evaluate their current working practices and to change them in significant ways. This responsibilisation of staff appears to build on their intrinsic motivation, supplementing it with extrinsic rewards and penalties to which staff were expected to respond as rational actors (Cheraghi-Sohi & Calnan 2013).

“There is a good deal to build on – committed staff, the many examples of good practice, new structures now in place to ensure a stronger patient voice at every level in the NHS. Nonetheless, NHS staff, hospital trusts and primary care trusts all told us that there is a lot further to go.” [Building on the best: choice, equity and responsiveness in the NHS, p.55 (Department of Health 2003)]

Sometimes it was made clear that staff were responsible for enacting innovative change (first quote, below). In other documents there were appeals to patients to use choice as a driver for change (and the flow of money), but patients and staff often appeared conflated within the text, despite the different mechanisms invoked (second quote, below).

“Most of the contact that patients have with the NHS is through a primary care professional such as a community nurse or a family doctor. They are best placed to understand their patients’ needs as a whole and to identify ways of making local services more responsive.” [The new NHS: modern, dependable, para. 2.7 (Department of Health 1997)]
“The balance of power must be shifted towards frontline staff who understand patients’ needs and concerns. A shift in the balance towards local communities so that they reconnect with their services and have real influence over their development.” [Shifting the balance of power within the NHS: securing delivery, p.5 (Department of Health 2001)]

Alongside the themes of localism and innovation was the practical application in terms of finances. Practice-based commissioning (PBC) during the mid-Labour years, \(^{13}\) (Department of Health 2005a) for example, was hailed as a way to ensure that localities were enabled to spend money according to the needs of their patients, rather than being dictated to by central command (although it was found to be ineffective in practice (Curry et al. 2008)). This ownership of budgets was seen as providing a way for localities to be innovative, ensuring that money followed innovation that improved responsiveness and providing incentives that supplemented intrinsic professional motivation. It was also seen as a way to encourage cross-boundary working and value for money.

“We also expect that PBC will lead to the development of more responsive and innovative models of joined-up support within communities. Some practices, such as Bromley-by-Bow practice in Tower Hamlets, are already successfully developing such services. We will ensure that practice-based commissioners are free to pursue similar innovations, for example through locally enhanced well-being services. […] Practice Based Commissioning will give GP [practices] more responsibility for local health budgets, while individual budget pilots will test how users can take control of their social care. These will act as a driver for more responsive and innovative models of joined-up support within communities […] which will provide better value for money.” [Our health, our \(^{13}\) See Creating a patient-led NHS: delivering the NHS improvement plan for a full definition, but in brief: “Primary care clinicians and trusts need to be able to focus on their top priorities: maximising health; improving primary care and management of long term conditions; [and] local service planning, managing the care pathway, enabling choice, and getting value for money. The new system offers an opportunity for primary care practitioners to achieve more in all of these priority areas. Practice based commissioning will resource and incentivise practices to invest in maintaining the health of their patients. It will also allow practices to offer more care in the practice, through new services in the community and pharmacies, and through joint arrangements with hospitals and other providers.”
2.4.3 Support across NHS hierarchies and cross-boundary working

Building on the notion of cross-boundary working, in this section I consider how the strategies to promote and encourage cooperation between staff and organisations were used to improve responsiveness. An example of this was the ongoing call to form multi-disciplinary teams, crossing professional boundaries (such as those between GPs, allied health professionals and nurses) and traditional structural demarcations within the NHS (such as those between primary and secondary care).

“Modern health care relies increasingly on team work: the development of multi-professional teams, working not only in hospitals and primary care settings, but across the traditional boundaries of health and social care, is a key priority.” [The National Health Service: a service with ambitions, p.34 (Department of Health 1996b)]

As evidenced during both the Labour and Coalition eras providers and commissioners were urged to work with other organisations in partnership. This included organisations that were part of the NHS performance management hierarchy (e.g. trusts, PCTs, SHAs) and commissioners (e.g. NHS England local offices, CCGs). Being receptive to cultural change, building on good practice, being committed to the NHS Constitution, and working alongside DH, were seen as key.

“Our area teams are working with CCGs to develop primary care strategies that draw on the insights and experience of people across all these different groups and support a more integrated approach to providing care and support across primary care, community health services, social care, the voluntary/charitable sector and specialised services.” [Improving general practice: a call to action, phase 1 report, p.9 (Dyson 2014)]

There was also evidence of calls for the formation of partnerships with agencies outside of healthcare. Providers, commissioners and organisations with the remit to manage performance (e.g. PCTs, SHAs) were encouraged to think and act holistically –
to consider areas such as housing and employment, and in later years, public health (now under Local Authority jurisdiction).

“Ambition two: holistic, person-centred care: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.” [Improving general practice: a call to action, phase 1 report, p.6 (Dyson 2014)]

2.4.4 Competition and choice

The question of how far integration and partnership (Sections 2.4.2.2, 2.4.2.3 and 2.4.3) are compatible with the call for greater competition is explored in this section. Part of the culture change advocated throughout the timeline was adapting to patients as consumers (Sections 1.3.1.3 and 2.3.2). Practice managers were given specific responsibility for providing for consumers’ (as opposed to patients’) needs. This was outlined in a guide aimed at and written by practice managers (NHS Practice Management Network 2009). Its premise was based on the GP practice as a business that should embrace the consumer-led culture.

“As we move into this changing culture, it is our job to ensure that we are able to utilise a full range of systems, tools and resources at the front line, which in turn will benefit our businesses.” [Improving access, responding to patients: a ‘how-to’ guide for GP practices, p.i (NHS Practice Management Network 2009)]

To enable money to follow the patient-consumer, competition and choice were enshrined throughout primary care structures, e.g. by introducing payment by results.

“If the public could genuinely choose their practice, their needs and preferences would have more impact on shaping services. We need, therefore, to make real the choices that people should have and reward existing practices and other new providers who respond to those choices.” [Our health, our care, our say: a new direction for community services, p.58 (Department of Health 2006)]

Many documents, throughout the timeline, claimed that choice was the definitive solution to meeting patients’ expectations. Primary care appeared to be held accountable to patients through allowing them to, for example, choose their GP
practice, but was also being driven by the need to be accountable upwards – responding to a top-down call to be flexible and innovative when implementing policy.

“Patient choice will be a key driver of the system and resources will flow to those hospitals and healthcare providers that are able to provide patients with the high-quality and responsive services they expect.” [The NHS improvement plan: putting people at the heart of public services, p.12 (Department of Health 2004b)]

According to the documents, whatever the reason for being responsive it was usually the GP practice that was expected to take the lead, given that GP practices were (and continue to be) the principal providers of primary care.

“Capacity planning is important in ensuring GP practices provide the right mix of services at times that meet the needs of their patients. The best GP practices all have good capacity management processes that reflect, for instance, the optimal balance (on any given day) between on-the-day appointments, advance appointments, telephone consultations and open access slots.” [Report of the National Improvement Team for primary care for access and responsiveness, p.17 (Department of Health 2008c)]

However, elsewhere in the documents the usual providers (GP practices) were not necessarily seen to be the only or best providers of responsive care. Indeed, new ways of working were encouraged: either integration of existing providers or the commissioning of new providers (e.g. commercial providers with an alternative provider of medical services (APMS) contract) or models of care. Providers were also encouraged to be innovative, although what this meant in practice was often unclear.

Building on the nudge technique documents used words such as empower (so

14 ‘Best’ practices were those that scored highly for patient satisfaction in the first national GP Patient Survey in January 2007. The authors of this document visited best and worst performing practices across the country and as an expert team who “work[ed] in and are [were] hugely knowledgeable about general practice” determined “10 common factors and behaviours displayed by the best GP practices and their PCTs”.
providers could take control) or expect (so providers felt compelled), thus appealing to individuals’ intrinsic motivation [bolding added]:

“We will **empower** clinicians further to provide more integrated services for patients by piloting new integrated care organisations (ICOs) bringing together health and social care professionals from a range of organisations.” [High quality care for all: NHS next stage review final report, p.65 (Department of Health 2008a)]

“We also expect that some existing practices will wish to combine extended boundaries and extended opening hours for maximum coverage for people. We will expect new providers in particular to offer this option to patients.” [Our health, our care, our say: a new direction for community services, p.74 (Department of Health 2006)]

As demonstrated by these quotes there were two main reasons for encouraging integration and new models of care. First, integration was seen as a way of achieving responsive care. Organisations that work together and across boundaries were felt to be more responsive to patients through providing holistic care rather than being constrained by institutional boundaries (see also Section 2.4.3). Second, whilst opening up primary care to new providers was seen as a way to improve responsiveness, the means by which this was achieved, according to the documents, was through giving patients choice, thus creating a competitive market. This was particularly noticeable during the middle of Labour’s time in office (Figure 1 on page 51). There was no mention in the documents of the tensions that may arise in a system that advocates both cooperation and competition between providers.

**2.4.5 Mobilising and educating patients**

The fifth strategy for implementing responsiveness in general practice that I consider is the mobilisation and education of patients through communication and responsibilisation.
2.4.5.1 Communication with patients

Communicating and building trusting relationships with patients was seen as important for the implementation of responsiveness. It was felt that patients expected effective two-way communication grounded in a culture of listening to patients, taking action as appropriate, and telling patients what had been done.

“Patients have told us time and time again that it is relationships and communication at every level which make the difference. The success of these changes is in the hands of every receptionist, every clinician, every medical secretary and hospital manager. The job of the NHS and the Department of Health is to support these staff at every level.” [Building on the best: choice, equity and responsiveness in the NHS, p.68 (Department of Health 2003)]

As well as a strategy for implementation, listening to patients and stakeholders was an explicit goal of responsiveness. Documents prescribed that, in order to provide for people’s needs, there must be conversations with patients to find out what those needs were. Some documents advocated a consultative approach working alongside those who would be affected by the changes that would be made.

“Be more open and listen to what people are saying, respond with simple language; start from the assumption that you do not have the answers” [Improving general practice: a call to action, phase 1 report, p.6 (Dyson 2014)]

“How can primary care be sure it is providing and commissioning the right services for its local population, if it doesn’t regularly ask them?” [Report of the National Improvement Team for primary care for access and responsiveness, p.11 (Department of Health 2008c)]

Staff were expected to have cultural awareness and sensitivity when communicating with patients, especially when working with vulnerable groups for whom “just a single episode of poor treatment or care can result in a lifetime of mistrust of public services” [Inclusion health, p.26 (Cabinet Office 2010)]. Staff were also encouraged to be advocates for patients – not simply providing for their needs in a passive way but working alongside them to get them what they needed and wanted. Documents stated
that staff should aspire to more than a minimum standard: excellence was the goal for each member of staff, which was seen to require significant behaviour change. Responding to both staff’s intrinsic and extrinsic motivations, support and training should be provided, ensuring that staff felt valued and that they received appropriate standards of pay and conditions.

“Howver, developing this improved range of services in primary care depends on having increasing numbers of staff with the right skills, training and motivation working in teams to offer tailored and responsive services…” [A responsive and high-quality local NHS: the primary care progress report 2004, p.23 (Department of Health 2004c)]

The way in which patients (and other stakeholders) were positioned and constructed varied between and within documents. In some cases being responsive meant speaking with individual patients at a GP practice to find out what they believed was needed. In other cases documents referred to groups of patients: either a formally-convened group such as a PPG or groups of patients based on particular demographics such as black and minority ethnic patients or patients with disabilities. Groups could also include wider stakeholder groups that represented patients such as charities or special interest groups. PCOs (GP practices and PCTs/CCGs) were encouraged to develop ongoing relationships with these groups by seeking their views on a regular basis to find out what they needed and expected. This included ongoing engagement with marginalised and vulnerable groups, and was evident throughout the timeline.

“Local Gypsy and Traveller Communities should be involved in developing new services or adapting/front-ending existing services; this engagement should be properly resourced and care should be taken to avoid tokenism. A key part of this involvement should involve listening and responding to the stories and views of their own local communities…” [Primary care service framework: Gypsy and Traveller communities, p.7 (NHS Primary Care Contracting 2009)]

Some documents were primarily concerned with the patient and public involvement agenda, and used the broader concept of responsiveness as a means to promote PPGs
in practices. These documents affirmed that patients should make efforts to be heard and should voice their concerns so as to effect change.

“PPGs should be able to discuss access and responsiveness with their practices and to identify solutions together. Different triage models and skill mix should be discussed with PPGs before, during and after implementation. PPGs can work with practices to ensure smooth implementation of innovations such as internet booking or touch screen check-in and to address problems such as high numbers of patients who do not attend their appointment.” [Access and responsiveness: what matters to patients? p.4 (Box 2008)]

This same document advocated the responsibility of general practice to nurture PPGs such that patients felt able to contribute effectively.

“The workshop discussed how Patient Participation Groups can work with their practices to promote better access and responsiveness. [...] Further education and support is needed to allow Patient Participation Groups to deliver on their full potential and to help practices to become more responsive. Practices need to be willing to engage and to listen, to commit and to respond. PPGs need to be able to challenge and to play the role of critical friend, without fear of being alienated as a result.” Access and responsiveness: what matters to patients? p.5 (Box 2008)]

2.4.5.2 Responsibilisation of patients

As described above documents detailed listening to (via surveys, feedback, complaints) and working with patients (PPGs, vulnerable groups). An additional dimension was that patients should play an active role and take responsibility, e.g. by managing their own health and making choices. To improve responsiveness people were expected to take responsibility for managing their own information, undertaking research or contributing to decision-making.

“Everyone will have their own HealthSpace allowing people to make their preferences known, which will in time link to the new electronic health records,
which are being introduced from next year...” [Building on the best: choice, equity and responsiveness in the NHS, p.19-20 (Department of Health 2003)]

Patients were encouraged to take responsibility for keeping themselves healthy and managing their health condition(s). Patients were (and continue to be) assigned the responsibility to seek out information (rather than passively receiving it) and to make informed choices based on their reasoned understanding of that information.

“Most healthcare starts with people looking after themselves and their families at home. [...] Each week will see millions of hits on the NHS Direct [now NHS Choices] internet site. As well as providing fast and reliable information on a wide range of conditions, it will also be valued as an easy way to contact patient and self-help groups.” [The NHS plan: a plan for investment, a plan for reform, p.18 (Department of Health 2000)]

Helping patients to manage themselves was the counter-balance to providing for people’s needs and wants (some documents implied that patients could be over-demanding or have unreasonable requests) whereby patients were encouraged or given responsibility for looking out for themselves to make the right decisions and choices. This was evident throughout the timeline, as the quotes below demonstrate (from the Coalition era (2010) and the mid-Labour years (2004) respectively).

“People do not want Government, or anyone else, to make these decisions for them. [...] They wanted clear and credible information, and where they wanted to make a change and found it hard to make a healthy choice they expected to be provided with support in doing so – whether directly or through changes in the environment around them – so that it is easier to ‘do the right thing’.” [Choosing health: making healthy choices easier, p.5 (Department of Health 2004a)]

“[Our approach will] reflect the Government’s core values of freedom, fairness and responsibility by strengthening self-esteem, confidence and personal responsibility; positively promoting healthy behaviours and lifestyles; and adapting the environment to make healthy choices easier...” [Healthy lives,
Patients were also expected to make their preferences known, to exercise choice, and to take responsibility for themselves in return for primary care providing a consumer-centred service. Healthcare is perhaps unique in this respect, as traditional customers in the corporate sector are not usually expected to shoulder such responsibility.

“In future, patients and carers will have far more clout and choice in the system; and as a result, the NHS will become more responsive to their needs and wishes. [...] We are also clear that increasing patient choice is not a one-way street. In return for greater choice and control, patients should accept responsibility for the choices they make, concordance with treatment programmes and the implications for their lifestyle.” [Equity and excellence: liberating the NHS, p.16 (Department of Health 2010a)]

Giving power to patients seemed to be presented as an effective way of reconciling the consumerist culture with the vulnerability of some patient groups. Where patient power was advocated, there was also a responsibility of staff and organisations to seek out and listen to patients’ views, so it should be possible to both hear from vulnerable groups, and to provide for their needs in the guise of consumer as well as needy, hard-to-reach patient, according to the documents. As described above even vulnerable groups, who may not traditionally have been expected to take responsibility for their care, were expected to make reasonable choices – about their care, their personal budgets or service design (Section 2.3.3.3). They were expected to participate in the Expert Patient Programme (now Self Management UK (Self Management UK 2016)) or PPGs, and to access information about services to inform their choices.

“Responsive and flexible Inclusion Health services [for homeless patients] will make a difference by: [...] Enabling clients to have a say in the design and delivery of their services” [Inclusion health: improving the way we meet the primary health care needs of the socially excluded, p.31 (Cabinet Office 2010)]
2.5 Summary

The documents in my sample described the characteristics of responsiveness in a discrete and normative way: this is what general practice and primary care needs to do to be responsive to patients. They largely referred to ‘doing things’ to or for patients because patients deserve to have their needs met. Responsiveness was seen as a worthy aspect of quality primary care, perhaps partly because it is difficult to argue against its merits.

The descriptions of what needed to change in order to become responsive or more responsive varied across the documents though not necessarily in tandem with the political party or parties in power. Contrary to my expectations the meaning of responsiveness remained fairly constant albeit with different emphases: the concept of responsiveness was recruited as a means by which the goals of core values could be achieved. However, the reasons to be responsive and the purpose this served varied through the documents and timeframe. Responsiveness was linked to various core values which shifted over time, including access, patient involvement and choice, and reducing inequalities. Being responsive was seen to be a solution to helping primary care deliver on a variety of core values.

Providing special care for vulnerable groups was a common concern in the policy documents through both the Labour and Coalition years (Figure 2, page 52). Sometimes vulnerable people were described in the context of fairness and equity, in that vulnerable people should be given access to the same responsive service as other, less vulnerable patients. In other documents (and sometimes within the same documents), vulnerable people were singled out as requiring special attention. This singling out was not represented in explicitly paternalistic terms but rather in a way that appeared to respect the vulnerable and their need for extra attention in order to bring their care up to the same standard as that of other patients. In addition the choices patients made, according to documents, contributed to the responsiveness of GP practices by aligning them with financial incentives. However, inequalities persisted throughout the timeline and beyond, despite receiving great attention within the
documents examined here and elsewhere in public policy and healthcare research, as Exworthy concluded:

“...that the issue of health inequalities is on the agenda nationally and locally but implementation is hampered by deficiencies in performance management, insufficient integration between policy sectors, and contradictions between health inequalities and other policy imperatives. Thus, the government’s expectations are not only dashed locally, but also local expectations are being dashed at the centre.” (Exworthy et al. 2002)

In terms of implementation of responsiveness in general practice documents advocated a locally-led approach and were concerned with providing a service that met local needs: the nature and needs of local populations should be mapped so that a service responsive to them could be provided. However, there remained a tension between the performance management of localities and meeting central targets similar to that described by Greener et al.:

“The extensive use of performance targets and inspection regimes means that decision space is lost as national targets have to meet, and [frameworks] put a definite limit on the possibilities for innovation in the local provision of healthcare. These are both centralising forces.” (Greener et al. 2009)

This apparent creative tension may even have been a deliberate ploy, enabling positive outcomes from contradiction such that successful practices were deemed successful by measures such as the GP Patient Survey, and by non-tick-box exercises such as developing innovative services. Thus GP practices with a strong consumer orientation and satisfied customers potentially led to increased business profits, whilst enhanced resources could also be achieved through incentivising patient satisfaction.

Across the policies being responsive was seen as good practice. The documents sometimes acknowledged that staff and organisations were already being responsive and needed to build on this. Other documents were concerned with facilitating and/or incentivising change, sometimes advocating dramatic culture shifts, to become more responsive. The documents laid claim to setting this need within a national context,
providing a steer and equipping staff with tools to meet the need. In short, policies
drew on professionals’ intrinsic motivations to provide a good service, and backed this
up with carrots and sticks.

The analysis presented in this chapter has answered the research question about how
responsiveness is defined in policy documents, the values it reflects, and what
problems is it said to be able to solve. Definitions included making efforts to
understand and work to address patients’ needs and expectations (for technical
access, good customer service, coordination of care, and a suitable physical
environment (Section 2.3.1)). It was adopted to solve problems of improving quality
(by being patient-centred and providing a personalised service), addressing
inequalities (by ensuring fairness to all, including marginalised and vulnerable groups
(Section 2.3.3)), and delivering to a consumer agenda (by treating the patient as a
consumer (Section 2.3.2)). The documents also speak to how responsiveness can be
implemented – the structures that need to change, and the activities that are seen (by
policy-makers) to be necessary to drive practices to become more responsive.

The goals of responsiveness (to solve the problems outlined above) align with the
values of general practice outlined in Section 1.2 (Table 4), overleaf. Although I have
considered the goals of responsiveness separately, there is some overlap, particularly
between quality and consumerism as consumers expect a high-quality service.
This chapter has also attended to the research question about which specific policies have been implemented in England since 1996 to address the issue of responsiveness. Six such policies were published in 2008/9 at a ‘seminal moment’ for responsiveness policy-making, and a seventh document was published in 2014 (Section 2.2 and Appendix 2). It has explored the definitions of responsiveness in policy and identified the values that these reflect.

In the next chapter I present my methods for collecting and analysing interview data to accompany the documentary analysis presented in this chapter. The findings chapters thereafter present views about policy-making by elite participants (Chapter 4), the drivers for and tensions with implementing responsiveness from the perspective of meso-level staff (Chapter 5), and what it means to actually ‘do’ responsiveness in day-to-day practice from the perspective of frontline staff (Chapter 6).

Table 4: Alignment between core values and policy goals of responsiveness (brackets indicate tactic as opposed to definition)
3 Methodology and research design

In this chapter I describe the methods I used to access, collect and analyse data from interviews with elite participants in the Department of Health (DH), the Cabinet Office and other strategic organisations, and members of staff in GP practices and Clinical Commissioning Groups (CCGs). I defend my choice of qualitative methodology and describe the empirical field and the difficulties I encountered.

First, I provide an outline of my research design. Second, I defend my choice of qualitative methodology to address my research aims, and I pay particular attention to the challenges that can arise when interviewing elite participants (a key component of my empirical fieldwork). Third, I explain my methods of empirical data collection and analysis. Fourth, I consider the ethical implications of my work, and finally I provide an account of my reflexivity throughout the study.

3.1 Research design

My research design is outlined in Figure 3 (page 87). I performed an analysis of policy documents about responsiveness in primary care in order to describe the evolution and operationalisation of responsiveness in policy (Chapter 2). This was followed by interviews at three levels corresponding to what the literature terms the macro-, meso- and micro-levels (Section 1.3.4.2). The macro-level included high-level organisations such as the government, the Cabinet Office, DH or NHS leadership. Steering (Osborne & Gaebler 1992) was seen to be the responsibility of macro-level organisations. The macro-level was concerned only with developing and disseminating the policies on which the previous chapter is based. It did not take responsibility for rowing (Osborne & Gaebler 1992) and implementation on the ground. As was seen in Chapter 2 macro-level responsibilities included developing and applying accountability and performance management frameworks, distributing responsibilities for implementation throughout the NHS hierarchy, setting the precedent for a culture of sharing good practice, and enshrining competition and choice within primary care.
structures. To learn more about the context of the policies described in Chapter 2 and the ways in which they were constructed and disseminated, I conducted and analysed interviews with policy-makers in DH, the Cabinet Office and other strategic organisations.

Meso-level organisations included PCOs at the interface with patients, e.g. GP practices, but also those intermediate organisations working with and/or performance managing GP practices or commissioning frontline services, such as PCTs, CCGs and SHAs. Whereas the macro-level was responsible for setting the agenda and issuing edicts, the meso-level comprised organisations charged with *implementing* responsiveness in primary care. GP practices were invariably providers of care (organisations that met face-to-face with patients and provided for their needs). Intermediate organisations were commissioners (organisations that commissioned or contracted services) and/or performance managers (organisations with a carrot/stick relationship with providers). Meso-level organisations were expected to take responsibility for areas such as organising the way in which to provide services, encouraging partnerships and inter-agency working, developing locally-led services, and taking on budgetary responsibilities. Responsibility was thus devolved from the macro- to the meso-level organisations. I undertook and analysed interviews with strategic staff in GP practices, public health and CCGs to understand attitudes towards responsiveness and the role of mid-level organisations in implementing policies relating to responsiveness.

For the meso-level responsibilities to be enacted individuals were required to make changes to the way they worked at the micro-level. This included both staff and patients, and a change in the relationship between the two. I analysed interviews with a diverse sample of frontline GP practice staff (GPs, practice managers, receptionists and nurses, undertaken by a colleague and myself as part of the NIHR study) about how they interpreted the meaning of responsiveness and the realities of implementing responsiveness at the frontline of general practice.
3.2 Methodology

3.2.1 Qualitative methods

Qualitative research methodology is diverse and complex, encompassing a variety of perspectives and methods, and hence can be difficult to define. Early work by Glaser and Strauss emphasised the value of qualitative research for theory generation (Glaser & Strauss 1967), a perspective that has been strongly influential, although it has since been argued that the constant comparative method used in grounded theory involves both induction (theory generation) and deduction (theory testing) (Strauss & Corbin 1990). There is a vast literature on the origins of qualitative research methodology and
its subsequent evolution and expansion, including numerous ‘how to’ guides (Glaser & Strauss 1967, Strauss & Corbin 1990, Miles & Huberman 1994, Richards & Morse 2013). This literature is not considered here as I have approached this study from a health services research (HSR) perspective. Historically, definitions of qualitative research in HSR often focused on differences between quantitative and qualitative methods where qualitative methods can involve “the collection, analysis and interpretation of data that are not easily reduced to numbers” (Murphy et al. 1998). However, qualitative research has since developed its own identity or multiple identities (Rapley 2007). Qualitative methods have common features including ways to explore the meanings of people’s (either individuals’ or groups’) experiences, explore interactions and communications, and analyse documents (Rapley 2007). Unlike quantitative methods, which aim for representativeness, qualitative research enables depth and gives insight into attitudes and experiences. As well as looking for what has happened in people’s experiences, it also enables exploration of how and why providing rich and detailed data. Such methods recognise that the researcher is not independent of the data; indeed the interactions between the researcher and the participant, and the researcher’s interpretation, form part of the data (Murphy et al. 1998). My choice of data collection methods is explored in the following sections.

3.2.2 Interviews

Interviews are a practical and effective way of gaining insight into the thoughts and views of individuals without imposing a predetermined set of indicators such as one would find within a quantitative design (Britten 1995). Whilst interviews might be seen by some as presenting an artificial environment and thus introducing artefacts into the data (Silverman 2001), they can allow insight into participants’ views. For elusive concepts (such as responsiveness) semi-structured interviews can provide a way of getting at these views where other methods, such as observation, would not be possible. Interviews can also give access to people’s accounts of what has happened in the past, which is ideal for retrospective events such as policy-making. However, there are some disadvantages (Murphy 2003). Interviewees may reconstruct their experiences for the purposes of the interview (e.g. by presenting public accounts) and there may be recall problems. These problems can be minimised by developing
rapport and trust with participants, probing for context to reveal inconsistencies, and treating interview transcripts as accounts rather than facts (Murphy 2003).

There is extensive guidance on good practice in conducting interviews (Kvale 2008, Bryman 2016, Green & Thorogood 2013) but interviewing people in positions of power and influence has been identified in the literature as presenting particular challenges. My research involved interviews with an MP, senior NHS leaders and policy-makers in the Department of Health; as such I discuss the literature on interviews with ‘elites’ below.

3.2.3 Interviews with elite participants
The definition of elites is open to debate, and can vary according to the research being undertaken. Ultra elites, a term used by Zuckerman, describes individuals who hold significant power within a group that is already considered to be elite (Zuckerman 1972). McDowell describes professional elites to be individuals who are “highly skilled, professionally competent, and class-specific” (McDowell 1998). Hybrid elites, a term used by Parry, describes elite individuals with critical knowledge that does not necessarily exist within traditional institutions (Parry 1998). Others have referred to the elite in a relational sense as compared to the researcher or an average person in society (Stephens 2007). However, this power does not always translate into the interview setting. One scholar found that the participants mostly likely to make attempts to exert their authority over her were the less senior workers (Smith 2006). In many cases it is not necessarily the leaders of organisations that can claim elite status but rather those with social capital and in positions to exert influence (Burt 1992, Parry 1998, Smith 2006, Woods 1998). Indeed, elite status can change over time and between locations.

I will use the definition adopted by Harvey: “[elites are] those who occupy senior management and Board level positions within organisations [who] have significant decision-making influence” (Harvey 2009) as this best describes the people I interviewed.

Interviews with any respondent can produce difficulties but the literature suggests that there are unique challenges associated with interviewing elite participants. Some
of these challenges are outlined below. I then detail how the literature suggests that these might be overcome.

### 3.2.3.1 Challenges in elite interviewing

The first step in any interview study is to access the interviewees. Elite interviewees are, by definition, senior and, therefore, busy individuals. Taking an hour out of their diaries to be interviewed by a junior researcher to no benefit to themselves may not be top of a busy elite individual’s priority list. Access is a pathway from initial contact through to the interview, and at any point there is the potential for other priorities to take precedence (Harvey 2009). Even during an interview there is a high probability of distractions and interruptions.

Building trust is important. Interviews with elite participants may include potentially sensitive questions, for instance about salary or power relations within a group. Research questions may include investigation of barriers or problems that were encountered by the elite participants. To ensure that these questions fall on fertile ground interviewees must feel that they can trust the interviewer – that their answers are confidential and that the data will be used sensitively. Researchers should be armed with the tools to handle evasive answers.

Power relations are likely to affect interviews. A junior researcher may not necessarily feel empowered to ask sensitive questions of an elite participant or to invite the interviewee to speak beyond the party line. Again, trust will play an important part in these dynamics. It is important to make use of devices to reduce this power gap.

### 3.2.3.2 Effective practices in elite interviewing

Successful access to elite participants is largely due to researchers’ persistence and willingness to take opportunities as they present themselves (Yeung 1995). There are many contributing factors such as the effectiveness of a particular social network and the circumstances at the time (McDowell 1998), both internal to the organisation and relating to wider political issues. Pursuing multiple avenues of contact has the dual advantages of an increased likelihood of a good response rate and a reduction in the potential bias of speaking to people within a given social network (Harvey 2009).
Timing is of utmost importance to busy elite interviewees, and a balance must be struck between suggesting an interview that is too long (leading to a high number of refusals) and too short (leading to limitations in quantity and quality of data) (Harvey 2009). Harvey suggests that 45 minutes is a realistic target, and that most elite interviewees book out one hour in their diaries (Harvey 2009).

Some of the potential challenges faced when gaining access to elite participants, and suggestions for overcoming these, are summarised in Table 5.

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Plan of action</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I’m too busy right now”</td>
<td>Don’t interpret as a definitive no (Aberbach &amp; Rockman 2002). If another interviewee suggests them, then try again. Persevere.</td>
</tr>
<tr>
<td>Little known researcher identity</td>
<td>When contacting by email ensure that the organisation’s affiliations are clear and explicit, adding legitimacy. Also mention the funder.</td>
</tr>
<tr>
<td>Unknown contact details</td>
<td>Mimic email addresses of other contacts at that organisation, e.g. <a href="mailto:firstname.surname@company.com">firstname.surname@company.com</a> (James 2006).</td>
</tr>
<tr>
<td>Gatekeepers</td>
<td>Be prepared to summarise the research succinctly in lay language. View gatekeepers as potential opportunities not barriers.</td>
</tr>
<tr>
<td>Availability</td>
<td>Be prepared to conduct interviews in the evenings and at weekends, over the phone or in person as the interviewee prefers (Harvey 2009). Suggest dates if the interviewee does not, and be flexible. Predict the length of the interview to be a little less than it is likely to be (Dexter 2006). Once trust is established the interviewee may be willing to talk for longer.</td>
</tr>
<tr>
<td>Positionality</td>
<td>Consider the relationship with an elite participant as one involving a sliding scale of intimacy rather than being one of dualism (Herod 1999). Be aware of the effect of an organisation’s reputation (Herod 1999) and the discipline of the research group (Harvey 2009).</td>
</tr>
</tbody>
</table>

Table 5: Challenges and actions to overcome them in elite interviews

An effective method of gaining trust with any interviewee is prolonged contact over a period of time (Harvey 2009). One possible solution is to take time to build rapport with interviewees prior to the interview, through all the contacts the researcher has
with them, e.g. the first contact, the contact to arrange a time for the interview, etc. (Ostrander 1993). Being transparent can also help (Harvey 2009) by providing information about who the researcher is, the nature of the research, the funder, the expected length of the interview, how the data will be used, anonymisation and dissemination.

Elite participants are likely to expect interviewers to have researched them in the context of the interview topic (Harvey 2009). A shortcut to trust being built up is a shared knowledge of issues of interest to the interviewee. Interviewees have been known to test their interviewers (Zuckerman 1972) by challenging them on their research and its relevance.

Every interviewee is different but in general elite participants prefer to be asked open questions, “[preferring] to articulate their views, explaining why they think what they think” (Aberbach & Rockman 2002). Interviews with elite interviewees can often include questions that are difficult for the interviewer to pose, such as annual salary, educational background, etc. It is likely that a respondent may choose not to answer a question. Berry advises to politely ask the question again and, if this proves unsuccessful, to ask another question and then circle back to the original question (Berry 2002).

A device to enable successful interviews with elite participants is that of presentation of the interviewer. The skill of the interviewer to act the part that is expected of them is paramount. The most effective interviewers are those who can adjust their style to suit their respondent and make them feel as comfortable as possible. This may include, for instance, playing dumb or being sisterly for older patriarchal figures or women of the same age holding similar positions, respectively (McDowell 1998). Judgements need to be made quickly by observing the body language and verbal clues presented by the participants. Reducing the power gap between elite interviewees and junior interviewers can be facilitated by exchanging business cards (Yeung 1995), handshakes, eye contact and body language (Holt 2010). This is, of course, more difficult over the telephone.
There are mixed views about the relative merits of interviews held in person in comparison with over the telephone. Telephone interviews have obvious logistical advantages such as not being limited by geography and the ability for respondents to cancel at short notice without too much guilt. These advantages can lead to higher response rates and higher efficiency (Stephens 2007). Some commentators feel that telephone interviews should not be viewed as second-rate and in fact should sometimes be viewed as the method of choice for the reasons given above (Holt 2010). However, cultural differences can be difficult to identify over the phone (Harvey 2009) so face-to-face interviews are of paramount importance in some cases.

The literature presents disagreements on whether interviews with elite participants should be recorded. Recording has the clear advantage of allowing interviewers to focus on the questions and answers rather than note-taking, and analysis is made easier by having verbatim transcripts. Some researchers have found that better data are produced without recording devices as participants are more likely to talk ‘off the record’ (Peabody et al. 1990) and are more relaxed (Byron 1993). Others have found that few interviewees refuse recording and that the majority quickly lose any inhibitions initially caused by the presence of a recorder (Aberbach & Rockman 2002). Silences can also be a useful tool for encouraging more detailed answers (Berry 2002) although care should be taken not to create an overly-awkward silence (Harvey 2009).

There are also conflicting views within the literature on how to deal with distractions during interviews with elite participants. Phone interruptions are common and it may be advisable to encourage the interviewee to answer the call (Dexter 2006) as it provides time for the interviewer to catch up with note-taking and provides a more detailed picture of the respondent (Harvey 2009). However, this must be balanced against the possibility of a disjointed and unfocused interview should the disturbances be numerous.

Harvey advises researchers to adopt a reflexive attitude towards difficult interviews (Harvey 2009). He argues that difficult interviews can be avoided by thorough homework on the background of the elite participant’s organisation and by having good reasons for the relevance of all the questions in the interview schedule.
Later in the chapter I describe the reality of implementing these strategies (Section 3.3.1.1.2).

3.2.4 Secondary analysis

To understand how frontline staff viewed responsiveness, I conducted a secondary analysis of data collected as part of the NIHR study (Tarrant et al. 2014). The purpose of these interviews for the NIHR study was to develop a framework of how responsiveness was defined by staff in order to ensure that the patient-report measure we were developing would be useable for and acceptable to those for whom it was designed. The purpose of the re-analysis for this thesis was to gain an insight into how staff understood and operationalised responsiveness, as defined in the policies, and the challenges they faced when trying to implement it; thus the purposes were closely related but subtly different. As the data were available to me, reusing the data was time and resource efficient, and was aligned with the recommendations of the recent debate about reducing waste in health research (Ioannidis et al. 2014, Chalmers et al. 2014).

Secondary analysis of qualitative data was the subject of extensive debate in the 1990s. Qualidata was established by the ESRC (Corti & Thompson 1998), with the aim of compiling an archive of social science qualitative data for secondary analysis, and various reviews and discussion papers were published examining the approach (Hinds et al. 1997, Mauthner et al. 1998, Thome 1998) along with a book on the subject (Heaton 2004). A special issue of the online journal *Forum: qualitative social research* was dedicated to the methodology (Corti et al. 2005), and more recently a review of secondary analysis using open data claimed that the method had become sufficiently accepted that it must now be regarded as mainstream (Bishop & Kuula-Luumi 2017).

In Heaton’s overview of the methodology, she suggests that there are three main modes of secondary analysis (Heaton 2008). The first is through formal data sharing, for instance via an organisational or open archive. The second is through informal data sharing, where primary researchers make their data available to others for secondary analysis or where primary researchers pool their data. The third mode is where researchers reuse their own self-collected data to investigate new or additional
questions. Again, a group of researchers can pool their data, or a sole researcher or research team can reuse their own data without involving independent parties (Heaton 2008). This final mode is that which I have chosen for the purposes of this thesis. Specifically, I was aiming to conduct a “more in-depth analysis of an emergent issue or aspect of the data, that was not addressed or was only partially addressed in the primary study”, which Heaton terms supplementary analysis (Heaton 2008). When combined with analysis of primary data from elite interviewees and strategic-level staff, this formed assorted analysis (Heaton 2008).

Although arguably considered as mainstream (Bishop & Kuula-Luumi 2017), there are ongoing challenges in secondary analysis. One of the main issues is that analysis is often carried out on data collected by others, causing problems related to a lack of contextual knowledge about the research process in terms of data collection and emerging concepts. Even when researchers are reusing data from a study with which they were involved, interpreting data collected from other team members can be problematic, as can the time elapsed between data collection and reanalysis (Heaton 2008). In the NIHR study, data were collected by a colleague (Janet Willars) and myself. It is a strength of this secondary analysis that we met for regular discussions about our reflections and ideas for analysis, both in person and in the form of reflexive diaries, records of which I had access to for the purposes of this thesis.

Another strength of this secondary analysis is the compatibility and fit of the data to my research questions (Heaton 2008). The interview guide for the NIHR study (Tarrant et al. 2014) was not modified to reflect emerging themes (due to its purpose of ensuring acceptability of the patient-report measure rather than being purely explorative), which ensured that similar issues were explored, and hence produced reasonable data coverage (Heaton 2008). In addition, there was significant convergence between the original research questions and those being addressed in my PhD study, and it was specified on the participant information leaflet that data would be used as part of my PhD study. Staff’s definitions of responsiveness and the way in which they evidenced their responsive behaviour were systematically explored in each of the interviews, thus combining the secondary analysis with analysis of primary data collected for the purpose of this thesis was relatively unproblematic.
As with all qualitative research, there are ethical issues to consider. For ethical secondary analysis a researcher must be satisfied that participants have provided adequate informed consent for retaining the data, for sharing the data with others, and for reusing the data for purposes other than those for which it was originally collected (Heaton 2008). The first of these issues was covered by the ethics approval for the NIHR study (Tarrant et al. 2014) which stipulated that data would be stored for seven years following publication of the final report. The second issue was resolved by ensuring that the raw data were only shared with two members of the supervisory team, both of whom were involved in the NIHR study (Tarrant et al. 2014), resolving any issue with confidentiality. The third supervisor (Graham Martin) did not view the raw data, but rather only accessed the written work provided for his comment, where data were fully anonymised. As discussed above, the third issue was addressed by ensuring that the research questions for this thesis were closely related to those of the NIHR study (Tarrant et al. 2014). In light of this, no further ethical approval was sought for the secondary analysis.

3.3 Methods

In this section I describe the methods I used to collect, analyse and member check data. I conducted three sets of interviews. The first set was with 17 elite policy-makers at DH, the Cabinet Office and other strategic organisations. The second set was with 12 individuals including strategic-level members of staff at some of the GP practices involved in the NIHR study, and staff at local CCGs and in public health. The third set comprised interviews with 21 members of staff (of which I conducted 11) at nine GP practices, completed as part of the NIHR study.

3.3.1 Data collection

3.3.1.1 Elite interviews

I conducted interviews with elite participants to track the rise of responsiveness as an aspiration for primary care, its meaning and value, and its place in primary care policy at the time of the interviews. I aimed to interview elite participants at DH, the Cabinet Office and other strategic organisations.
3.3.1.1 Recruitment and consent

For each policy document that I had identified to be of interest at the onset of the interviews a contact person was identified. These were identified in various ways including the named contact person at the start of the report, the author, or someone identified by web searches for their involvement with the document. Further contacts were identified during the interviews when elite participants suggested someone with whom I may wish to speak. Others were identified when I contacted someone and they refused but referred me on to someone else. This snowballing method (Beamer 2002) is a useful way to contact hard-to-reach individuals, be they elite interviewees or disenfranchised groups, but given the dangers of relying on snowballing for the heterogeneity of the sample, this was only one of several strategies. I also worked with my supervisors and a colleague who had been seconded to the Cabinet Office drawing on their insider knowledge of people and management structures to identify relevant contacts who were not necessarily linked to a specific document but who had an interest in the field.

The plan was to conduct up to 15 interviews face-to-face or over the phone with people instrumental in policy initiation, development or writing. All potential participants were contacted initially by email. Email addresses were identified by web searches or intelligent guesswork (i.e. firstname.surname@organisation.suffix.uk). One email was forwarded by a mutual colleague. For interviews in the past I have usually predicted an hour or so for patients and half an hour for professionals with the flexibility for longer or shorter depending on how much the interviewee had to say. For elite interviewees I suggested no longer than an hour and that the interview may be shorter than this. If potential participants declined, a shorter time was offered in response. The email template is shown in Appendix 7 which was amended to suit each potential participant.

As the research was not of a sensitive nature I felt that telephone interviews were an entirely appropriate method for these interviews. I felt that it was likely that the elite participants would value the convenience of a telephone interview; I gave potential interviewees the choice but I fully expected the majority to choose the phone method
(only two opted for the face-to-face option). This was also more convenient for me as I had limited resources in terms of time and budget.

Upon agreement in principle elite participants who opted for telephone interviews were asked to formally consent by email by confirming their agreement with a set of statements (Appendix 8). For face-to-face interviews participants either emailed their consent in advance or signed a paper copy of the emailed form. Interviews were arranged at a time to suit the elite participant. Interviewees were assured of confidentiality which was especially important for this group as they may have known each other. To support the intention of protecting anonymity the policy documents from which the elite interviewees were drawn are not identified here although the larger sample of documents is discussed in Chapter 2.

3.3.1.1.2 Interview content and conduct

Interviews were semi-structured according to an interview schedule (Appendix 9). The interview guide was constructed entirely of open questions and particular attention was paid to the order in which they were asked. As well as making logical sense they were ordered as such to provide the interviewee with the opportunity to give long answers and short answers, thus providing variety. I augmented this by the usual interjections of ‘Ahhh’ and ‘Yes’, or more specifically encouraging phrases such as ‘Really?’ or ‘Interesting!’ (Marshall 1984). Interviews were conducted using the schedule as a guide but elite interviewees were encouraged to speak about the issues they considered important, and I asked probing questions to ensure I fully understood what they were telling me. The number and nature of these additional probes were adjusted depending on the expected length of the interview. Particular care was taken to judge the difference between a pause for thought and the end of an answer. 15

My plan was to provide as much flexibility as possible for the respondents if they experienced interruptions, and I reassessed the success of this policy after each

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15 In one interview the elite participant paused for longer than I expected and I interrupted his train of thought by moving on to the next question. I became acutely aware of silences in later interviews and I became extremely sensitive to allowing participants to move at their own pace.
interview. In fact only two interviewees were interrupted and both interruptions were brief and did not, in my opinion, affect data quality.

The interview guide includes a description of the preamble used at the start of each interview (Appendix 9). This information was also provided prior to the interview, either at first contact or when a potential interviewee expressed an interest. In some cases it was appropriate to share the interview guide with the interviewee prior to the interview; indeed one elite participant asked to see it in advance (I provided a shortened version, Appendix 10).

Some schedules were amended to reflect the elite participant’s role and the nature of the work they had done or were doing at the time of the interview. The length of the interview was agreed beforehand and was confirmed at the start of each interview. Participants were reminded about the purpose of the interview and were asked to reconfirm their consent to the interview being digitally recorded; face-to-face interviewees were asked to sign a consent form if they had not consented by email. I also provided details about the methods I intended to use to keep their interview data confidential and their identities anonymous. After consent was confirmed the digital recorder was switched on.

Prior to each interview I ensured that I had an in depth knowledge of policy and guidance documents in the area of responsiveness, especially those with which the interviewee was involved. This allowed the first few minutes of the interview to go as well as they could, giving me the opportunity to prove my legitimacy and thus encourage the participant to invest time into the interview.

All bar two interviews were by telephone so I needed to make decisions about the way in which I should present myself following email and/or phone contact alone. This was sometimes difficult as physical cues were harder to read and thus harder to respond to. I planned to play the role of PhD student – a novice to their expert – making it explicit that I would like to learn from them, expressing gratitude, using phrases like “I didn’t know that, tell me more” as appropriate to elicit further information, and thanking interviewees when they signposted me to relevant references. On some occasions this tactic felt inappropriate and I adopted a peer-to-peer approach. It was
not possible to use body language and eye contact as a means to reduce the power gap over the telephone so I relied on my email and phone manner.

I preferred to record my interviews and I encouraged potential interviewees to consent to this with reassurances of confidentiality and anonymity. It may also have been helpful that the recording device was not visible during telephone interviews. However, I provided interviewees with the option to refuse as an unrecorded interview is better than no interview. I did not explicitly plan to offer to send participants a copy of the transcript but on occasions it felt appropriate as a way to provide assurances of anonymity. If someone had wished to withdraw, I planned to suggest that they either withdraw completely or indicate any parts of their interview they did not wish for me to quote. In the event this was not required. In one case I offered an interviewee the option to edit or delete excerpts of his transcript but after reading it he did not feel the need.

If continued efforts were made to avoid a question, I moved on to the next question with little fuss (Harvey 2009). However, the way in which an elite interviewee avoided a question or provided an answer to a different question was of interest in itself and formed a fascinating aspect of my analysis. For example one elite interviewee was surprised at my line of questioning and refused to answer a question about a government inquiry. Even after justifying my reasons for asking the question he continued to refuse. I circled back to the question later in the interview when trust had been further established but he did not change his mind for fear of being identifiable. This incident is described in full in Chapter 4.

I was not asking for any personal information about the interviewees apart from their involvement with responsiveness policy and guidance. However, I did acknowledge that I should remain prepared for some interviewees to consider a question to be awkward unexpectedly and was appropriately sensitive as in the situations such as the example described above.

I made attempts to do my homework about participants before each interview and ensured that I understood the relevance of each of the questions in the interview guide. I learned from any bad experiences when they occurred. For example, in one
interview, after a long pause I began to ask a follow-up question at which point the interviewee carried on talking about the previous point. In later interviews, if I was unsure whether the pause was because the point had been made or if it was still thinking time, I left it a little longer before moving on.

3.3.1.1.3 Elite interview analysis

When analysing qualitative data there are many methods available which broadly fall into two groups. The first group comprises methods that are tied to a particular theoretical or epistemological position, for instance, interpretive phenomenological analysis or conversation analysis. The other group of methods comprise those that are essentially independent of theory and epistemology and can be applied across different approaches. Thematic analysis is one of these latter methods; it “provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data [and] is not wedded to any pre-existing theoretical framework...” (Braun & Clarke 2006). For the purposes of this thesis I have used thematic analysis to focus on the meanings participants assign to their experiences of responsiveness in primary care.

Elite interviewees’ transcripts were edited by replacing names of other elite individuals I had interviewed that were mentioned in the course of the interviews with codes. Names of other well-known or influential actors within politics and DH were left as identifiable. Transcripts were imported into NVivo8 (or later NVivo9, NVivo10 or NVivo11) software. Elite interviewees’ transcripts within NVivo were labelled with the policy document with which they were involved for my own purposes. These are not reported here to ensure anonymity.

My methodological approach was based on thematic analysis (Braun & Clarke 2006) drawing on the constant comparison method (Glaser & Strauss 1967, Pope & Mays 1995) for coding data, using both a deductive and inductive approach. When I analysed the interview transcripts I took into consideration that the accounts offered by elite participants might have been constructed as public accounts rather than their true views. I used my research questions to both generate the interview guide and to frame (but not constrain) my analysis. I open-coded the transcripts, organised open codes
around my research themes to generate a coding framework, ensuring that the framework I developed fitted those data and took into account new, emergent and interesting themes. The final coding frame is shown in the Table 17 in Appendix 11.

3.3.1.2 GP practice and CCG staff interviews

As part of the NIHR study a diverse sample of 13 PCOs were recruited with the support of the Primary Care Research Network – East Midlands and South Yorkshire (PCRN-EMSY), which included practices in a deprived inner-city area, an affluent rural area, and an area with a high BME population. For the purposes of this thesis I included only the nine mainstream GP practices in my sample as my research questions focus on general practice rather than primary care in the wider sense (i.e. walk-in centres, pharmacies and specialist GP practices for particular patient groups, which were also included as part of the NIHR study). The characteristics of the recruited GP practices are described in Chapter 6 and full details of GP practice and staff recruitment are provided in the NIHR study report (Tarrant et al. 2014).

Purposive sampling ensured that a range of staff with a variety of frontline roles were included: practice managers, clinicians (GPs, nurses) and secretarial and reception staff. Staff were approached by me or the other interviewer on the NIHR study with permission from a senior member of staff at the practice, or they were approached by the main contact at the practice at my request. Staff were often difficult to contact and so multiple attempts were required by phone and/or email. Staff were assured of confidentiality and any questions about the NIHR study were answered. Formal written informed consent was taken prior to each interview. The interview guide was developed based on a review of the literature and discussion within the NIHR study team. Interview guides were modified as the interviews progressed to ensure their relevance to specific primary care settings (the guide for GP practices is shown in Appendix 12).

Interviews were held during 2011 at the GP practices where the members of staff were based (one was by telephone) and were arranged for a date and time to suit the participants. A total of 21 interviews with GP practice staff at the nine mainstream
practices were conducted (I conducted 11 interviews and my colleague conducted ten). Interviews were digitally recorded, transcribed verbatim and anonymised.

A second set of interviews with staff was conducted during 2013/14 for the purposes of this thesis. These were interviews with strategic-level individuals such as practice managers or GP partners rather than junior staff within GP practices, and also CCG and public health staff as it was important to seek views from individuals who had an insight into the impact of policy on GP practices’ priorities and service design.

Some of these participants were recruited from practices that were participating in the final stage of the NIHR study. Practices were contacted and asked who would be the most appropriate person from that organisation to approach. With this gatekeeper’s permission the suggested individual was contacted (in some cases the gatekeeper chose to self-select) and invited to participate (see invitation email in Appendix 13). Interviews were arranged to take place either face-to-face at a location of their choice (mostly likely their place of work) or over the telephone (see interview guide in Appendix 14). One interview took the form of a self-completed questionnaire as the participant did not have time for an interview (Appendix 15).

In addition to staff based at those GP practices that took part in the first round of interviews, I recruited staff from a wider sample of practices from outside the East Midlands region; these were practices that came on board as part of the large-scale testing of the patient-report measure in the NIHR study. A purposive sample of staff was selected with diversity of experience and perspective in mind such as variation in individuals’ job roles (likely to be GPs or those in senior management roles) and practice demographics (rural, urban, deprivation levels, size of organisation).

Given my focus in this PhD on the role of mid-level organisations in implementing responsiveness, senior staff (whose roles included improving responsiveness within the locality) at two local CCGs were also approached. These were essentially recruited via ‘cold calls’ as CCGs were not previously involved in the NIHR study and the interviews were solely for the purposes of this thesis. Snowball sampling was used to enlarge the sample. The interview guide for strategic staff in GP practices was revised to include questions about responsibility for responsiveness (Appendix 16).
The aim was to interview up to 15 people (a pragmatic sample size), to explore participants’ views of how implementation of responsiveness was placed within in a wider policy and organisational context, with a particular focus on the role of mid-level organisations such as CCGs and other local stakeholder organisations.

Each interviewee was assigned a sequential number and the digital recordings were named likewise. Recordings were sent to transcribers who had signed a confidentiality agreement with the SAPPHERE research group, of which I was part, and were trusted to keep all information completely confidential. Interviews were transcribed verbatim, excluding confirmatory noises such as “hmm”, “uh-huh”, etc., as these were not of interest to my analysis and added confusion to the flow of text.

3.3.1.2.1 GP practice and CCG staff interview analysis

I analysed staff interviews using a thematic approach (as described in Section 3.3.1.1.3). Frontline staff interviews were carefully read to look at how staff described the delivery of a responsive service at local practice level. Of particular interest was how staff defined responsiveness, why they felt it was important (or not), how they were implementing it, barriers and facilitators to implementation, and the proactive and reactive elements of responsiveness. Coding was both inductive and deductive as described in Section 3.3.1.1.3. I had themes in mind at the start of the process, based on the interview guide, but I also developed themes bottom-up from the data (Glaser & Strauss 1967, Charmaz 2006, Pope & Mays 1995). Open codes were generated and applied line-by-line and then grouped into organising categories, and were checked by my first supervisor (CT). The coding frame was further refined (see Table 18 in Appendix 17) during analysis. A similar approach was taken with the strategic staff interviews: using the themes in the interview guide as a starting point, creating detailed codes to best describe the interviewees’ responses, and reorganising the codes and themes as the coding progressed (see Table 19 in Appendix 18).

Attention was paid to the impression management work that interviewees exhibited in their interviews, such as presenting themselves as competent, reasonable and moral (Goffman 1969) rather than treating interviews as providing direct access to reality. For example only one of the frontline staff interviewees felt that responsiveness was a
‘bad thing’, and all subscribed to the view that responsiveness was important to them and their organisation. However, in the analysis, particular attention was paid to examples staff provided of where they might not have been as responsive as they had initially indicated and the reasons for this.

In addition to drawing on the analysis of interviews, reflexive diaries were used to record my observations during visits to GP practices, for instance noting aspects of the environment and my observations of the way in which the staff interacted with patients. These notes were used to inform further interviews (by highlighting issues of interest into which to probe in later interviews) and, later, the analysis (by helping to formulate ideas for the coding frame).

### 3.3.2 Ethical considerations

#### 3.3.2.1 Ethical approval

As part of the NIHR study NHS ethical approval was granted for the first round of interviews with GP practice staff (Nottingham Research Ethics Committee 2, reference 10/H0408/49, 10 May 2010) and no further ethical approval was sought for the secondary analysis (Section 3.2.4).

A protocol amendment was submitted to (and approved by) the same committee (substantial amendment 7) because the NIHR study protocol described the second round of interviews with practice staff as informal chats about the usefulness of the measure rather than formal recorded interviews with PhD-specific questions.

University of Leicester ethical approval was granted for the interviews with elite participants and CCG and public health staff (reference elj1-e0ea7, 18 November 2011).

#### 3.3.2.2 Ethical issues

I considered my study to be low risk. Emotional harm and confidentiality are considered in detail below. Other issues that were considered included informed consent, the well-being of the interviewer and the burden to participants, all of which were deemed to be extremely low risk.
3.3.2.3 Emotional harm to participants

Any interview, however apparently benign, has the potential to upset people. This is particularly true for interviews involving sensitive subjects and/or vulnerable participants. This study, however, centred on a subject that, whilst occasionally controversial, was not likely to elicit extreme emotional reactions from staff and elite participants. GP practices that agreed to participate in the NIHR study were aware of responsiveness as a concept and had an idea of what the interviews would entail before they agreed to take part. GP practice staff, on the whole, are required to be of strong disposition given the stresses of their job, and are not people whom I would consider vulnerable. Having said that, interviews were conducted with sensitivit, and care was taken to seek honest opinions from staff and elite participants. Confidence and humour helped to build trust; indeed several interviewees began some of their answers with “I shouldn’t really say this but...” However, many interviews (especially with elite participants) were littered with sloganeering and clearly well-rehearsed answers. In these instances it helped to use simple prompts such as “Tell me more about that” or “What do you mean by that?” which appeared to help to steer the interviewees off-script.

Sometimes I used repetitive probing to ensure that I had understood participants’ views. Probing was conducted thoughtfully and care was taken not to cause offence. In practice this went well but two elite interviewees and one member of GP practice staff asked me to stop the digital recorder during their interviews. Elite interviewees were concerned about the potential for them to be identified through my line of questioning. The member of practice staff was concerned about giving ‘wrong’ answers. All agreed to continue after they were reassured.

Written or emailed informed consent was provided by participants prior to their interviews and participants were reassured that they could pause the recorder to ask questions during the interview or stop the recorder at any time to terminate the interview.
3.3.2.4 Confidentiality and anonymity

Staff participants in the frontline interviews were assured of confidentiality within the NIHR study team. Elite and strategic staff interviewees were assured of confidentiality within my PhD supervisory team. GP practice staff interviews were anonymised during transcription to remove any identifying information such as places, names and organisations. I anonymised the elite transcripts post-transcription so I could cross-reference other elite interviewees who were taking (or who were going to take) part. When using quotations I ensured that participants could not be identified especially as staff within GP practices knew each other and elite participants were likely to operate closely with others. Transcripts were labelled with a code rather than an interviewee name. For all elite quotations I have omitted these labels to further protect the interviewees’ anonymity. On some occasions I removed text referring to specific potentially identifiable opinions or policy elements. Recordings, anonymisation keys and transcripts were stored separately. Any paperwork (such as consent forms and ‘About You’ forms) was kept securely in a locked filing cupboard in a locked office.

3.3.3 Reflexivity

As discussed in Section 3.2.1, qualitative methods recognise that a researcher is not independent of the data they collect, and that data are jointly created by the researcher and participants. A researcher must then interpret the data to produce an account of the participants’ experiences. Thus reflexivity is an important element of the qualitative approach because a researchers’ own experiences shape the data, which is co-constructed with the research participants (Kvale & Brinkman 2009).

3.3.3.1 My stance towards responsiveness

This co-production and interpretation of data may have impacted on the conclusions I reach in this thesis. I approached the study with the view that responsiveness is a ‘good thing’, with phrases like “motherhood and apple pie” ever-present in draft reports of the NIHR study. In addition, I was immersed in policy documents that advocated responsiveness which, as intimated in Section 2.5, took an entirely positive

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16 This phrase did not appear in the final report.
and uncritical view of responsiveness. Whilst I made efforts to put distance between my own viewpoint and the views expressed in the policy documents and by the interviewees during the analysis phase, I may, at least in part, have been unsuccessful. The frontline interview topic guides were written for the purposes of helping the NIHR study team to develop a measure of responsiveness, and were, therefore, based on the assumption that responsiveness was something that was worthy of attention. This may have impacted less on the elite and strategic-level interviews, as the topic guides were written for the purpose of this thesis. However, they will not have been immune, as (i) the elite interviewees will have also held this viewpoint, having been involved in policy-making in this area, and (ii) the strategic interviews began with an explanation of the policy definition of responsiveness, hence shaping the interviewees’ expectations for the interview.

During the interviews, I made efforts to question this assumption through in-depth probing about the consequences of being responsive to patients, and some participants were keen to share views that attempts to be responsive were not necessarily cost-free and could create tensions for both staff and patients. Indeed, one interviewee expressed views that indicated that he did not agree with the concept (Section 6.4.2.1). However, I cannot claim that the line of questioning did not affect other interviewees, despite my efforts to mitigate the effects of my consonance with the aims of responsiveness.

3.3.3.2 My involvement with a patient participation group

Within the first six months of the NIHR study when I was forming the project advisory group, I visited the PPG at the GP practice where I am registered to ask if I could present the emerging findings of the project over the next two years, and to seek their opinions on the development of the patient-report measure, its acceptability and its usefulness. Members of the PPG were keen to pursue this relationship. Soon after I saw an advert for new PPG members, so I applied. I was an active member of the PPG for nearly three years, attending meetings and providing advice and practical help when developing annual questionnaires for patients, to ascertain patients’ views of the changes the PPG was instigating and for the purposes of the DES payment. The main raison d’être for the group was to improve the appointment system and this remained
the case throughout my tenure. It did not feel right to continue to use the group as a sounding board for the NIHR study findings; indeed I presented the final findings as a *fait accompli* at the end of the project and after I had resigned from the group.

My experience as a member of this group gave me insight (albeit contextual within my own GP practice; every practice and PPG are different) into the ways in which a PPG is run, the challenges it faces, and the hard slog active and responsibilised patients endure to agree and enact change. Despite a rhetoric of supportiveness from the practice management, this support comprised attendance of the practice manager at quarterly meetings and very little else. Between meetings the practice manager was invariably difficult to get a hold of and appeared to have little time to dedicate to the needs of the group and to perform the work 17 that was agreed during the meetings.

Whilst my experience as a PPG member was helpful for the NIHR study, it also affected my stance towards my PhD research questions and my interviewees’ responses. It provided insight into the types of people who volunteer for PPGs, i.e. not hard-to-reach or vulnerable groups but more the ‘usual suspects’. Despite best intentions from the practice, the PPG’s lack of power, resources and active support became apparent during my three years’ membership. As such I find myself agreeing with some of my interviewees’ views about paying “lip-service” to patient involvement (Section 5.2) and involvement being “weak” (Section 4.5.5).

3.3.3.3 *My interview technique*

In terms of reflexivity and interviews, it was important to reflect on my performance after each interview, and particular attention was paid to the way in which I presented myself in order to improve for future interviews. Informal debriefs with colleagues and supervisors were also helpful in some cases, mostly to help with my confidence to continue as I was doing, as well as keeping a reflexive diary which allowed me to look back at my experiences and key findings and start to form relationships between developing ideas.

17 Examples of work included visiting other local practices to investigate their appointment systems, responding to findings from the PPG patient survey and providing data for the quarterly PPG newsletter.
4  Responsiveness as an aspiration: elite perspectives

In this chapter I turn to the views of policy-makers. I use the term *elite participants* to describe those I interviewed, as explained in Chapter 0 (page 89). Elite participants were those who were involved in leading on, developing, writing, publishing or disseminating policies that included responsiveness. First, I describe the interviewees in detail. I go on to consider what responsiveness meant to them, how and why responsiveness emerged as a policy issue, and the ways in which they (and others) attempted to influence implementation into practice.

4.1  Elite interviewees

I interviewed 17 elite participants between May and November 2012 identified from a sub-set of the policies described in Chapter 2. Of the 16 named potential participants whom I contacted initially I secured interviews with twelve. One interview was with two people – the second interviewee was invited by his colleague. Four named potential participants explicitly refused to take part for a variety of reasons (they were no longer involved in that line of work, they were too busy, they did not feel they could contribute). Of these four, two recommended that I contacted someone else. All named potential participants responded to my invitation or follow-up reminder. One email was sent to a generic email address, i.e. generic_contact@organisation.suffix.uk, and I did not receive a reply, even after a reminder. Two non-participants recommended I contact a further three people, of whom two were already participating and the other agreed to take part. I contacted a further five people by snowball sampling (either explicit recommendations during the

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18 The sub-set included policies that I had identified at the time: mainly but not exclusively those published between 2003 and 2012 with responsiveness in the title or as a main aim of the policy.
19 One of the initial 16 contacts was the wrong person as they shared a name with the person I meant to contact. When I contacted the right person, he recommended that I speak with someone else.
interviews or when an interviewee mentioned someone with whom I felt it would be good to talk), of whom three agreed to take part (Figure 4).

Figure 4: Sampling of elite interviewees

4.2 Confidentiality and anonymity

Elite participants varied in their feelings about confidentiality and anonymity. Eleven interviewees were not at all concerned, four were somewhat concerned but were easily reassured, and two were more concerned but still consented to recording. Concerns related to worries about being identified with views that might not be considered to be ‘on message’ with colleagues or organisations with whom or which the interviewees had ongoing relationships or had worked in the past. I provided reassurance by offering to send interviewees draft copies of my work (thesis chapter
or paper) so they could review it and check that they were happy that they could not be identified. The two people who were most concerned were offered their transcript, so they could remove text that they felt might be identifiable. One felt that this was not necessary. The other took up the offer but, in the end, he chose not to edit it. However, he did express ongoing concern about his anonymity.

“Please be careful how you write that. I’m just telling you honestly, it will be political, but that’s the reality.”

“And sometimes, and this is not for quoting I suppose, because they might realise who said it, but sometimes [interviewee goes on to describe sensitive issue]. I think if you could quote that quite carefully because that could be from the, you know that could be picked up as obviously coming from somebody like me.

YES, SURE. YOU’RE NOT THE ONLY ONE TO SAY IT THOUGH. BE ASSURED.”

Given these concerns elite interviewees’ characteristics and roles are presented in very general terms to protect anonymity (Table 6, page 113). Their roles were diverse and included directors, civil servants, management professionals, advisors, MPs, and NHS leaders. Interviewees’ involvement in responsiveness policy included: chairing review groups; advising on, developing, writing or publishing policies; operationalising or disseminating policies; or being responsible for policies. The documents with which each individual was involved are not reported. All documents are hereafter referred to as ‘policies’ (including past and current guidance documents, policies, reports, government departments, White Papers and political areas of interest). Although five interviewees were female all are reported in the male form. All involvement is reported in the past tense. As there is a possibility of identification (e.g. through particular views or timings) I have not labelled any quotations.

20 Although this interviewee expressed concern about being identified for what he said, many other interviewees made the same point. I have also redacted the point he made so I feel that I can quote him to demonstrate such a concern about identifiability.
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*Table 6: Elite interviewees’ roles in responsiveness policy*
4.3 Elite participants’ definitions of responsiveness in general practice

The focus of policies on responsiveness was to draw attention to non-clinical aspects of care (Section 2.3). But the term ‘responsiveness’ is ambiguous and there has been a strong tendency to focus on the clinical consultation when considering quality in primary care (Tarrant et al. 2014). However, in contrast to frontline staff who often confused clinical and non-clinical needs (see Chapter 6), elite interviewees rarely defined responsiveness in terms of clinical experiences. Those who spoke of meeting clinical needs did so in broad terms, such as the patient journey or keeping patients healthy.

Elite interviewees assigned various non-clinical meanings to responsiveness, many of which were not mutually exclusive. Meanings included finding flexible ways to consult with and listen to patients (drawing parallels with the theme of meeting patients’ needs in the policy documents (Sections 2.3.1) and service quality in the literature (Section 1.3.1.1)), making special efforts to listen to those who might be considered socially disadvantaged (akin to the theme of providing an equitable service in the policies (Section 2.3.3) and inequalities in the academic literature (Section 1.3.1.2)), and acting on the feedback they received. Improving capacity to allow patients access to the care they needed was seen as key, especially where there was a high health need or poor primary care access. Reducing health inequalities was also an aim for some policies, according to participants. They felt it was important that patients experienced the same high quality care whatever their background or location.

Participants viewed responsiveness as a ‘good thing’ and most described responsiveness as an aspect of quality, akin to the themes of meeting patients’ needs and meeting expectations for quality in the policy documents (Sections 2.3.1 and 2.3.2) and service quality in the literature (Section 1.3.1.1). In the wake of the Mid-Staffs enquiry, quality was the word of the moment. My interviews took place after the scandal broke but prior to the publication of the so-called Francis report (Francis 2013). As one participant described, “whether it be booking the appointment, seeing the GP,
the kind of quality of care that they get from the GP and the follow up afterwards” [bolding added]. Listening and communicating were also seen as important:

“Having got access, the next set of things that I would say were important in responsiveness is GPs listening to what patients had to say. And communicating back to them. So I think responsiveness, if it meant anything it would be listening and communication.”

Listening as a way to understand patients’ needs and provide for needs was a majority view, with interviewees describing responsiveness as providing a personalised, flexible service – understanding patients’ needs and preferences and delivering them, rather than offering a one-size-fits-all service. One interviewee put it this way: “I think of it as being the ability of the health service to get into the mind of the person on the other side of the table, who’s receiving a service and understand what’s important to them and deliver it.” Another interviewee spoke of how reasonable most patients were, and that, in most cases, they had legitimate expectations (expressed needs which aligned with normative needs, according to Bradshaw (Bradshaw et al. 2013) (Section 1.3.1.2)).

As well as providing for people’s needs within a GP practice, a number of participants felt that responsiveness should include the bigger picture, i.e. helping people to stay healthy, providing joined up care and a smooth experience, and looking at outcomes: “You know the soft stuff. Now real responsiveness is really getting beyond that and talking about the outcome”. They were also concerned with the wider environment such as social and housing needs.

“...and I think the standard general practice model was a very kind of linear one, very narrow roots into the practice and a very reactive approach [...]. And I don’t think that met the needs of an awful lot of people [...]. So I see general practice as one element of promoting good health.”

Other meanings interviewees associated with responsiveness included continuity of care and the location of service provision. One interviewee referred to “customer service and customer care” as a way to describe responsiveness as its meaning can be elusive: “I think because, you know, patient responsiveness, would you know what that
was if it sat on your head?” Another interviewee took customer service a step further and felt that responsiveness was the softer side of choice and that responsiveness was perhaps a historical necessity: with the move towards choice and consumerism in healthcare (see meeting expectations for quality in the policies (Section 2.3.2) and consumerism and patient involvement in the literature (Section 1.3.1.3)), it was necessary to create a discourse that encouraged providers to create something that is worth choosing between:

“And I suppose really during that period the concept of responsiveness started to emerge. I’ve never felt, to be frank myself, it’s a particularly easy word [...] but it was difficult to find another word that expressed if you like, the opposite of choice, i.e. you couldn’t have choice unless the people who are providing the service were responsive to people’s preferences and needs. So that’s how the sort of concept came in a way to sort of balance the harder edged concept of choice.”

Pulling together all these definitions I might describe responsiveness, from the elite interviewees’ perspectives, as ‘flexible ways to consult with and listen to patients who use primary care, and act upon the feedback in such a way as to improve services for everyone using those services, including those who might be considered socially disadvantaged’. However, the interviews indicated that responsiveness is not a distinct concept around which people can mobilise efforts; it can get lost in efforts to improve access.

4.4 The emergence of responsiveness in policy

In this section I consider what elite participants said about how responsiveness entered the policy arena and why and how it became embedded in policy. I found two central themes: changes in society and changes in political priorities.

4.4.1 Changes in society

Whilst 2008 and 2009 were the years when responsiveness came to the fore in terms of specific policies (evidence of successful value amplification by policy-makers (Section 1.3.4.2), see also Section 4.4.2), my analysis of policies in Chapter 2 showed
responsiveness had been on the agenda for many years prior. Elite interviewees concurred with this and cited business needs, changes in society and consumer demands as a reason for its rise (as I also found in the policies (Section 2.3.2) and the literature (Section 1.3.1.3)). As one interviewee put it, the public “is more sophisticated and actually ‘I can do all my banking online, why can’t I deal with [my] doctor online?’ \textit{Well there’s all sorts of issues with confidentiality and... ‘Well, that’s the same for my bank. It’s even worse for my porn site, you know.’}” Interviewees felt that patients were more demanding than in the past, and, despite the high access scores reported in the GP Patient Survey, one purported, “\textit{And they are still not happy. But you know, to be honest, good is not good enough. Because patients want more than this.}” Interviewees saw responsiveness as a way to meet these (usually reasonable) expectations; as one said, “\textit{Service is more demanding, expectations are higher.}” This view aligns with the text in one of the policy documents examined in Section 2.3.2, which stated that, “\textit{Real change will happen at the front line, with support from the centre, fuelled by encouragement and expectation from patients...” [Building on the best: choice, equity and responsiveness in the NHS, p.55 (Department of Health 2003)]. However, increasing expectations could cause problems, as a participant reported, “\textit{I think the more we offer, the more appointments we offer, the more demand it will generate. So it’s a conundrum to be solved.”}

The way elite interviewees and those they were quoting referred to patients reflected the changing times. Patients were variably described as customers and consumers as well as patients. Interviewees felt that the focus on customers and the consumption of healthcare was due to shifts in society, such as the private sector being “\textit{quicker and slicker}” and public services not listening to their customers in the same way. However, interviewees were also aware that a change in language was not enough and that a “\textit{sea change}” in mind-set was also needed.

A senior NHS leader believed that the origins of responsiveness were two-fold: a natural extension of previous work on the patient experience and patient-centredness, and “\textit{I suppose just by [...] good common sense, that it’s all very well having extended opening hours, but getting through the door is one thing, and then feeling that you’ve been treated with dignity and respect and so forth is another}”. Others spoke of the
relationship between responsiveness and access as a sub-set of quality, and also as using responsiveness as a way of looking at things differently, as an interviewee reported, “rather than just taking out the word access and we were tired of the plan-do-study-act [...] And it was almost something waiting to stop and start in a different way.”

Nine participants felt that responsiveness in general practice was a natural continuation of the well-evidenced work undertaken by the WHO on the responsiveness of whole health systems (World Health Organization 2000) (Section 1.3.1.2) or following on from previous work undertaken by DH or other bodies, such as the Darzi report (Department of Health 2008a) and the NHS Plan (Department of Health 2000), to name just two, both of which are examined in detail in Chapter 2.

Eight participants cited more nebulous beginnings. Some felt that their policies were a reaction to the findings from the first GP Patient Survey (a ‘focusing event’ creating fertile ground for policy-change (Birkland & DeYoung 2013)) which included reducing inequalities, whilst others felt that their policies were a re-hashing of old Acts and slogans. Indeed, some interviewees described their policies as providing evidence for an abstract concept, as one suggested:

“But I think the difficulty is [the findings weren’t] necessarily put together in a form which allows you to actually see how vigorously grounded on evidence. [...] I mean what will have happened, a numbers of these parameters where they’ve been plucked out of thin air, as some sort of concept, would they have been verified through embodiment in these official documents and saying this is an important measure.”

Similarly, another participant found that, when developing his policy, the origins of responsiveness were difficult to pin down, unlike policies arising from clinical research, where the evidence base is more clearly identifiable.

“...which isn’t unusual when you go hunting back to find out why does everybody think that it’s important, where does it come from. [...] clinical research is more likely to think that something is manifestly good in itself [...]”
and so we went back and back and you thought ‘actually this is all one reference’.”

Some interviewees suggested that responsiveness was a way in which policies could begin to shift the focus of attention away from secondary care to primary care, in line with what society needed.

“I keep using this phrase one million consultations every 36 hours, 800,000 of those are in primary care. So that’s where the action is and we’d been concentrating, because I think it was essential in terms of the NHS’s relationship with the public, on secondary care. And I think [the policy] was an attempt to try and shift that and recognise the importance of GP care.”

These long-term ambitions were realised by some policies, according to interviewees who cited the longevity of the policies with which they were involved. Some participants cited indirect impacts based on changing the ‘rules of the game’ with a view to a long-term shift in the way policy-makers, NHS staff, patients and the public think about general practice:

“...it set a tone and the ideas that are in it have been really very influential over the last decade I would say, and it’s interesting that you’re talking about responsiveness even now, with changes of Government and so on. [...] So I think it did set some very high level concepts within thinking about the NHS which have not gone away.”

Some interviewees felt that the way in which responsiveness manifested at the time of the interviews was a product of iterative changes in societal norms and expectations. The need for responsiveness was still great according to four interviewees, and although two felt that that the word responsiveness had gone out of fashion, they felt that “the whole issue of [patients at whom the particular policy was targeted] I think is still very real”. For instance, the epidemic in long-term conditions and their effects on health services was an important factor according to one interviewee who felt that if responsiveness were to “take a back seat” then “the National Health Service would go bust.”
Thus responsiveness was becoming embedded over recent decades, primarily because of broader societal shifts towards consumerism, patient centeredness and involvement, and an increased focus on equality – and this has been both reflected in and strengthened by policy.

4.4.2 Political priorities

As well as societal changes, most elite interviewees also cited political influences on responsiveness. Political support for a given policy was deemed important by the interviewees especially if financial and human resources support followed the rhetoric, for instance through backfill for a practice manager’s day job (which in turn motivated him to give more, for instance through working weekends) or hands-on support with an elite interviewee’s project work. Some interviewees were of the opinion that the priorities of governments in recent decades, whatever their politics, did not affect agenda-setting for responsiveness (see also Section 3.1 for my description of the macro-level agenda-setting responsibilities).

“...although there’s a huge amount of party political controversy around health, actually in terms of health policy there’s been virtually no disagreement between health policy over the last 25 years. And both [New Labour] and [the Coalition] would argue that, in order for primary care to work, it has to be accessible, people have to be able to know where it is to know what they can expect from it and be able to secure it easily. And by those tests I think the truth is that over a very long period, responsiveness, access to primary care has become a progressively bigger issue.”

But the priorities of the incumbent government were seen by other interviewees to drive the responsiveness agenda, meaning that values were being neglected (Tilly 1978), and interest in the issue was waning (Downs 1972): when the “government changes it [responsiveness] falls off the radar”.

“...one would hope that this may evolve in some ways, if there isn’t another government change and we don’t have an entirely new system... I think that’s the difficulty isn’t it, where we’re living in quite strange times in terms of how
these things will be used and what’s going to be given priority in the NHS over the next few years.”

One elite interviewee spoke of how centrally-driven initiatives ran the risk of being “reductive”, in that some policies needed simplifying to such a level to make them relevant to all organisations and individuals that they lost their meaning and therefore their power and potential impact. But in contrast to the apparent desire from the centre to simplify policy, another interviewee spoke of the complexity of recent central reforms.

“I’ve just been at a seminar and there used to be a Financial Times health journalist called Nick Timmins. On Thursday on the King’s Fund website he’s published a pamphlet called Never Again. And it’s his analysis of what the Healthcare Reform Bill has been about. And the answer is it is impenetrable [...] I think the Government has failed to explain to anybody, including themselves, what all that was about.”

As well as the effects due to government changes, participants also spoke of how individual politicians and civil servants could change political priorities very quickly (Downs 1972).

“The other thing is, to be honest, that politicians love initiatives. And they love initiatives a great deal more than they love implementation. So politicians are always moving on to the next big thing. [...] there’s no doubt at that level, things are driven by individuals, they’re driven by powerful political imperatives. Sadly I think policy cycles are very short.”

“And [the Board created after the NHS Plan] had about 20 people on it, a third patient representatives, a third clinicians and a third managers. [...] I thought it worked really, really well. And John Reid got rid of it when he came in as Secretary of State. I won’t say that was the beginning of the rot, it wasn’t quite because we then had Patricia Hewitt as Secretary of State and then Andy Burnham. In fact I was only in the Department for [a number of] years and I had five Secretaries of State.”
Individual politicians were powerful actors and, according to the interviewees, could influence the content of a given policy referring to, for instance, the personalities of those in Number 10 and the subsequent need for prime-ministerial sign-off, which an interviewee described as “very controlling”. Another participant told the story of how a minister shaped the title of a policy.

“...we wanted to say the future is happening, it’s just not evenly distributed. [...] [The minister] came in and said I want to [policy document title.] [...] It was [the minister’s] title. [...] I remember him in the room saying ‘this is what this is about, isn’t it? So that’s what we’re going to call it.’ It was entirely his title.”

Similarly, one interviewee spoke of the changes happening at the time of our interview, and how he felt about the ways in which the Secretary of State for Health was shaping the policy at that time.

“...many of us in the patient movement were a bit horrified at the idea that GPs were the people that would most know what patients wanted after 30 years of campaigning for the idea that patients are the ones who know what patients want. [...] I mean [the Secretary] is a technocrat really, isn’t he? So [...] he seized the machine as a way of delivering healthcare rather than health outcomes as the way of shaping the machine.”

The influence of individual politicians in the idiosyncrasies of the policy-making process were alluded to by some interviewees. One participant, who directed a review group and led on the development of a policy, gave two examples of how he circumvented the rational-bureaucratic system of policy-making. This participant embodies that of a policy entrepreneur (Peters 2015) described in Section 1.1.

“...there was one particular bit of [the policy] that I was desperate to get in, which kept being dropped by the civil servants or by No. 10 or by someone, you know it kept disappearing from the drafts. And I finally shoved it back in at the very last minute, I just rewrote the paragraph and put it back in and it was so last minute that nobody ever took it out again ((laughs)).”
“…there was another occasion where there was something that was quite debated which I was very keen on, and I was trying to persuade people to include this particular idea and they didn’t want to. And I bumped into [another elite interviewee] in the corridor, he was [...] in charge of it [...] from a political point of view and I said, ‘Oh [name] I need to talk to you about X’, and he said, ‘That’s fine [name] I’m really busy, I’m off to [place] for a meeting, you just do what you think is best.’ And if I hadn’t bumped into him I probably wouldn’t have done that.”

This circumventing of rational evidence-based policy-making processes was also evident in other contexts. Two interviewees provided insight into how policies were made to appear that they were based on consultations with patients and the public, but ultimately the priorities within those policies were politically engineered. For instance, one participant described how a consultation was conducted and how politicians and advisors then prioritised an element of policy that was not as important to patients as many of the other elements. Another described how a politician made a policy announcement and conducted a post-hoc consultation in order to demonstrate that it was a legitimate priority to patients.

“I came out with a list of about 15 [policy elements] of types of [policy] that people wanted. Of which I would have to say, [policy element 1] was pretty low on the list in terms of public response. But through the sort of process of policy development and the engagement of political advisers, in particular [another elite interviewee] in the DH [...] those 15 [policy elements] I think finally came down to five, of which [policy element 1] became the sort of key headline for Government policy even though that wasn’t what patients had most told us that they wanted.”

There were several instances in the interviews where participants felt that a political aim differed to their own, although it remained complementary. In this example, a specific policy objective (access) happened to align with broader policy themes (quality) in a fortuitous way (an incidental finding from a consultation), uniting several change agents behind them:
“The main intention from a political point of view was to improve access. [...] For me it was to just improve the general quality of general practice, which was the responsiveness bit. And the two come together.”

4.5 Implementation of responsiveness into practice

In the elite interviewees’ accounts I identified four mechanisms by which responsiveness could be implemented into primary care: targets, incentives and accountability; delegation of responsibility and promoting innovation and intrinsic motivation; cooperation; and patient engagement. I consider each in turn.

4.5.1 Targets, incentives and accountability

Broadly, according to interviewees, targets could take two forms: incentives (carrots) or penalties (sticks) (Bemelmans-Videc et al. 1998) (Section 1.3.5.1). In some cases there appeared to be confusion between the two, as one participant said, “If a trust is scoring poorly, it thinks it’s going to have a financial penalty, or more a financial incentive to perform better.”

Many targets and performance management measures were mentioned by interviewees, including: QOF, DES, LES, CQUIN (Commissioning for Quality and Innovation), PCT initiative funding, the Friends and Family Test, and the GP Patient Survey. These were used in various ways: to provide data nationally; to review practices’ performance; to identify under-performers and highlight problems; to raise standards; to perform audits; and to inform other targets. Participants described how these targets were developed and the ways in which they were implemented. In particular interviewees described how data (for instance admissions and readmissions, outcome measures, survey results) could be used to feed back to GP practices (or other organisations) to promote the desire for improvement. In the spirit of the performance management ethos, one interviewee felt that primary care was likely to move towards sanctions (sticks) rather than incentives (carrots) in the future. In contrast, another interviewee felt the opposite, and that a shift in political ideology was demonstrated by the move away from sanctions (hard law (Salamon 2001, Mörth 2004)) towards an incentivised approach (Bemelmans-Videc et al. 1998) (see also Section 1.3.5.1):
“So there was a political context there. [...] I think what happened under the then Labour Government, which was a big improvement on what we had before, was a focus on targets and initiatives which contribute. But I suspect now [during the Coalition] they’d be looking much more as they have done about how can you make the whole system improve. And within that to look for more incentives.”

When discussing how targets were designed there was a strong feeling that they should be developed locally and that this would instigate the greatest positive change, as one interviewee said, “What we would hope with local relationships, local incentives, is to aspire to be even better. You know, national ventures tend to have a limitation.” Despite the suggestion that more coercive national measures would be needed in the future, there was a recognition that these had limitations and that local ownership for such extrinsic incentives was also needed for the system to be effective.

This sentiment was echoed in various forms. One participant was of the view that change management in such a large organisation as the NHS should be “handled at a local personalised level.” Similarly, another interviewee spoke of priority-setting at a national level with accountability for improvement at a local level (see also Section 2.4.2.3 for corresponding findings in the policy documents):

“...effectively [the policy is] the marching orders for the service. [...] it’s the place at which the Government priorities for health and healthcare are set out. And alongside those we set out what the tools, the mechanisms, the rules of the game, the available money and all of that, that local organisations to get on and respond to the priorities as articulated.”

“What they [at the local level] can’t dodge is prioritising it, but what they can work out is what their most appropriate response is. So that’s quite a big shift and we’ve tried to build much more discretion locally into the system.”

This aligns with wider government discourse (especially from the Coalition onwards) of focusing on outcomes and allowing discretion with processes. The view from the top was consistent, with one very high-level interviewee concurring that “the talk was very
much about trying to move away from top-down targets and try to place much more freedom, but also much more responsibility upon clinicians themselves to improve services."

Participants spoke at length about using targets, measures and incentives to facilitate change. Specific examples included the DES for patient participation, offering out-of-hours in 80% of practices, and opening a GP-led health centre in every PCT area. At a wider level participants felt that a combination of nudging (Section 2.4.4) and mandating was effective.

1st interviewee: “Unless you legislate you can’t really use the word ‘should’ ([laughs]).”

2nd interviewee: “Yeah, that’s right. Or ‘must’. Yeah I think part of it, part of what we do is push through guidance, through...”

1st interviewee: “We nudge, don’t we?”

2nd interviewee: “Yes. Nudge.”

[...]

1st interviewee: “And the Department will be holding them to account.”

2nd interviewee: “Yes, they will. They’ll be mandating them, yeah.”

A number of participants were involved with policies that were developed some years ago. Whilst they acknowledged the recent shift from national to local targets, they were also keen to accentuate the positive long-term effects of national initiatives, like the QOF, in terms of reducing variation (“because GPs are small businesses, they vary massively”) and changing GPs’ behaviour for the better.

“I know a lot of people don’t like QOF but I, honestly it’s made a huge difference, not least forget, when we talk about responsiveness and care, [...] but [...] since we’ve had QOF and similarly when we had incentives in general practice in the 1990 contract, the gap between the performance of practices in posh areas and more underprivileged areas narrowed after the incentives were introduced...”
Participants described the mechanisms by which incentives and sanctions were effective, although in some cases interviewees appeared confused about how things worked, as one interviewee said, “I’m not sure that what they’re doing is pushing people in that direction or leading people in that direction.” Another interviewee felt that pushing and pulling were effective mechanisms:

“Anything that is this size [...] all the analysis you use to super-tankers or whatever [...] if you’ve got a million interactions every 36 hours, you can’t say they’ll all change. What you can do is provide a leadership which says, and try and incentivise the best, and then try and keep the change going, sort of like a sheepdog. You know, you need people yapping at their heels all the time.”

Elite interviewees felt that the only way to successfully and consistently implement targets was by contractual means, as described by one participant, “I’ve talked to a number of GPs about this, is that I think the way general practice is currently configured, general practitioners are basically bunches of small...are basically collections of businesses. [...] So if you pay them to do something they’ll do it. If you don’t pay them to do something, they either may not do it, or they may not do it as well.” The notion of GPs as instrumentally rational utility-maximisers is perhaps more salient than with other public servants working in bureaucracies: the need to think of the financial bottom line is only going to exacerbate GPs’ inclination to respond to incentives and ignore the rest (Cheraghi-Sohi & Calnan 2013). One interviewee said he felt “gloomy” and that it was “depressing I suppose that a lot of practices will only change when they’re paid to do it.” Other interviewees also expressed their disappointment.

“And so the crux of it, without contractual changes in the GP contract, we can’t force them to do anything, they have to be encouraged. [...] And [this change to the contract] was very successful in its uptake. [...] But to be fair it wasn’t really winning the hearts and minds, a lot of them were doing it in a tick-box way to get the money.”

It seems that the reluctance to use contractual mechanisms is related to the amount of effort that would be needed to change the contract appropriately, rather than
necessarily with the likely efficacy of a contractual change, i.e. it is not necessarily that sermons and incentives are seen as more effective than contractual changes, but more feasible. Thus, despite their frustration about targets, elite participants accepted that they were sometimes the best (and easiest) way to change behaviour. However, they expressed concerns about the reality on the ground. I identified five specific problems from the elite interviewees’ accounts.

First, there were problems with targets that assumed that one-size-fits-all, such as the QOF, as one interviewee claimed, “the [QOF] that’s been a terrible thing for patient choice. [...] Yeah, so the payment system. Because that standardises GP behaviour. [...] Rather than giving them flexibility. It rewards them for standard behaviour. And it also doesn’t reward them for patient experience at all.” Thus, if incentives result, to some extent, in standardisation or isomorphism, the interviewees appeared to be questioning whether it is possible to incentivise responsiveness when responsiveness is about a very localised response to very particular needs. In addition, interviewees felt that the DH treated all PCTs the same and that PCTs treated all the practices the same.

“So what happened was it was very heavily performance managed at PCT level. And where a group of GPs said, ‘we’re not doing this’, the PCT chief executive being hauled up to London and told you know, ‘what are you playing at? Why isn’t your practice doing it?’ And the poor chief executive was saying, ‘they don’t want to.’ And [chief executive was] expected to go back and twist [the GPs’] arm, which was you know, a bit daft really...”

Second, there was a lack of measures for responsiveness, as described by eight interviewees. Responsiveness is an elusive concept, according to interviewees (Section 4.3), and as such, is difficult to measure and therefore to incentivise. One interviewee was measured against the delivery of certain outputs – these were achieved, which, in turn gave his team “the space to do something a bit softer.” Another interviewee was of the same opinion:

“[Responsiveness] wasn’t something that had a big big sort of political backing behind it, and that may have been a good thing actually, because, I mean there
was such controversy surrounding those other targets for primary care, which were perceived as being very politically inspired, I think it helped that we were able to do this in a somewhat different way.”

The change in government in 2010 appeared to have upset the responsiveness programme according to some interviewees. With the subsequent reorganisation of the NHS, demise of PCTs and launch of CCGs, interviewees felt that incentives to be responsive were lacking as so much effort had been put into reconfiguration.

“And whilst we had an infrastructure before that held GPs to account, the PCT that worked in some places and not others, so it’s variable in how well it worked, now we’ve got a completely untried system of GPs holding each other to account with no obvious infrastructure, no obvious leaders. And so whilst it may be much more effective in giving GPs ownership and responsibility and they’ll respond to it, there’s no evidence and proof that that is going to happen.”

Thus in an environment populated with so many incentives, anything else (like responsiveness) gets crowded out (Frey 1994, Frey & Jegen 2001). This lends further support to the focus on slower, less tangible, but perhaps more sustainable change in culture, as direct levers (carrots and sticks) would be susceptible to crowding out which can happen at any time given a change of government or minister. Working to change ‘hearts and minds’ in a more indirect way – changing the nature of the understanding of the field – may not get instant results but may be more durable.

“...we didn’t want to spend [time] on devising measures, we just wanted to get on and do something. And I, even objectively, I think what we did was well-received and provided some additional value.”

Third, where measures did exist for aspects of responsiveness, there were problems. Problems took two forms: perverse effects on other parts of the primary care system; and inadvertently encouraging a tick-box mentality. One perverse effect was that of losing LES money to run extended hours because a practice wanted to close their patient list to help manage workload. Closing the list would have helped the practice
to be more responsive to their registered patients, but the PCT would not allow it. Another example was having to offer extended hours in rural communities where it was felt that it was not needed; but practices were still going ahead with it to avoid losing the money allocated to the service. Still another example was the 48-hour access target where practices were only allowing patients to book a day ahead, causing huge problems for people with long-term conditions who were then unable to book appointments for their health checks.

“So if you remember when there was the 48 hour access, one of problems we faced was that a lot of GPs said patients all had to come within 48 hours, you couldn’t book ahead. [...] The strength of targets is you make big improvements, the weakness is it often can be interpreted in a rather narrow way.”

This desire to make, or perhaps to not lose, money tended to encourage practices towards a tick-box mentality, according to participants. Examples included signing up for the PPG DES because “they just see the money” and using guidance where “you forget the person sitting in front of you and you turn it into a tick-box”.

“So for me they got the target right but missed the point, so their mind-set hadn’t changed. And it’s the mind-set of responsiveness as how can we have better service to our patients in all its facets that I think was what we were looking for.”

The importance of getting the balance between incentives and sanctions right was emphasised, and participants spoke of how this balance may change in the future – that carrots had not worked (or perhaps can only go so far) so performance management and greater use of coercive or punitive measures were needed.

“So it’s not about minimum standards, but it’s when they can go even better and innovate and create and [...] we can incentivise them to do even better. But when they come up short of the standards that everybody has a reasonable right to expect, they get a penalty. So it’s this interplay between incentives and sanctions that’s really important. And again I think we’ve tried to work hard at getting the balance between those two things right. Do you incentivise
someone to do more or do you fine them for not doing it? [...] [There has been] more in secondary [care], but the GP contract and all of that have been much more at the incentives end, less at the sanction end. [...] I think some of the balance might shift.”

Fourth was the issue of motivation. As previously demonstrated (page 127), elite interviewees suspected that many GPs were motivated by meeting business needs rather than patient needs:

“And since GPs seem to be primarily motivated by money, that seems to me to be an extremely good mechanism. But I mean I’m blunt, I think GPs operate like a cartel. They divvy up the market between them and then they refuse to let the market move.”

Others felt that the main motivation was pressure from those granted the power to monitor performance and who held the purse strings: “[Some practice managers] will only do whatever their doctors or PCT demand of them and only react if they actually have a problem raised and chucked at them.”

Finally, the combined effect of these issues could sometimes result in questionable behaviour from both practices and PCTs, according to interviewees. They felt that practices could become susceptible to gaming such as choosing which patients to hand surveys to, or taking DES money but not fulfilling the funding criteria. Likewise, they described how PCTs might “over egg” the QOF or use questionably underhand or “cheeky” tactics such as becoming a member of a peer support email circulation list in order to monitor what was going on at ground level:

“In my neck of the woods we had made up a list of practice managers, but embedded in that list was the PCT staff that were involved in the different patches within it. Which was a bit cheeky, because all you could see from your list was ‘[Name of the network]’, or whatever they called it here. But it took some digging to find out how they were always finding out about when you were having goes at them, because actually you were copying it straight to
them. [...] When they were able to catch you and almost deal with the problem before you actually had identified the problem, it's damn aggravating.”

4.5.2 Delegation of responsibility, awareness and engagement, and promoting innovation and intrinsic motivation

In line with the policy documents, elite participants highlighted the importance of delegated responsibility for responsiveness (Section 2.4.2). Effective engagement at both the system and the personal level were seen as key.

“Sometimes people always blame the system because that’s easier than to take any personal responsibility. But individuals are part of the system. I accept systems’ review and system processes, but individuals make a huge difference too.”

I found the same themes in the elite interviews as I found in the policy documents. Legislation was mentioned rarely. Interviewees accentuated how some policies also intended to set priorities and provide practical tools to help make change a reality on the ground, as well as to set targets and incentives (as described in Section 4.5.1). They felt that the aims of these policies were to share good practice and to provide toolkits such that staff could tailor their approach to their local context and act on their intrinsic motivations to improve the delivery of care. Cooperation was seen as key, as was the context of competition and choice. Finally, engagement with patients was felt to be important. I consider each in turn.

4.5.2.1 Engagement, awareness, and promoting key principles

Some interviewees felt that their policies had affected what people thought and did. The policies (or the process of developing the policies) were seen to have: helped the elite participants and other policy-makers to engage with GP practices that had previously been difficult to engage with; helped responsiveness become an accepted concept; enabled the sharing of good practice; and encouraged people in primary care to view the patient as a customer. In turn, elite participants felt that this had helped to change GPs’ behaviour, enabled GP practices to make quicker decisions and to change their ways of working, and encouraged GPs to actively look for the early stages of ill-health. Successful dissemination and local helpdesks were seen as important.
“It brought together, in fairness, some of the work that we’d probably had all heard of, a bit like that practice that you said, ‘Oh yes that practice does everything.’ But it widened it to others. It engaged with managers and practices that we’d never engaged with really, to be honest.”

Interviewees spoke at length about how policies in and of themselves were not always successful at changing culture and behaviour. Getting people on board through other communication strategies was seen as an important tool. One participant spoke of his successes and failures in this area. He described how his team used professional bodies, networks, conferences and exhibitions to promote responsiveness. A survey he undertook at the end of his programme “showed that the concept of responsiveness in primary care had been accepted.” He seemed to reject quite explicitly an approach premised on contractual means, preferring sermons and approaches that attempted to change hearts and minds (Bemelmans-Videc et al. 1998):

“So we weren’t really aiming at getting everybody to be responsive. Because we felt you can only do that probably through contractual means. So what we were aiming for was to support those that wanted to become more responsive be more responsive, and to get a greater ownership of the concept generally. [...] we were trying to shift opinion I guess.”

Another interviewee concurred with this, suggesting that looking beyond measurement and trying to promote the essence of their policy was more important than demanding that GP practices complete complex measures.

“I know that most people don’t read reports, so I suspect that what was more important was the work that [another elite interviewee] did just in terms of getting around the country and debating with GPs, with members of primary care trusts, what mattered to them, and it’s those sorts of conversations I suspect that start to create something a bit more akin to a social movement, they’re the things that will lead to people thinking ‘ah, maybe we should pay a bit more attention to this or maybe we could do that differently.’”
However, the interviewee who ran the end-of-programme survey (page 133), had realistic expectations, and of one particular initiative he said (as previously cited in Section 4.5.1), “But to be fair it wasn’t really winning the hearts and minds, it was, a lot of them were doing it in a tick-box way to get the money.” Another interviewee, speaking about the product of this same piece of work, was also circumspect about its success:

> “On the initial push every practice got a copy of [the policy] and some use it to prop up their tables, I’m sure, and it hasn’t been opened. Others, it’s a well-thumbed thing because, and almost they’re going through it like a checklist, ‘well I could do that, that might be a good idea, how do I get that in here and trying to move the practice forward’…”

### 4.5.2.2 Localism, innovation and intrinsic motivation

The theme of localism was evident in interviewees’ accounts. This could take the form of the management of centralised targets to be delegated to meso-level organisations (Section 3.1).

> “The issue is how can we get them to be systematically implemented? And the report of course was nothing to do with the DH. The DH can’t manage all of this [...] it was aimed heavily at PCTs as well as practices, with some push to SHAs…”

Five participants spoke of how their policies intended to instigate high-level change, from centralisation towards becoming locally- or patient-led. This was not always in terms of using targets and incentives (as others did, Section 4.5.1), but instead focused on principles and outcomes rather than processes:

> “These sort of titles have been around for, you know patient-led NHS and all that stuff [...] and of course it’s easy to be cynical about the titles, but the principle behind it is absolutely right.”

At a political level, the aims were broader, as one participant spoke of instigating locally-led system-wide change.
“[The NHS is] the largest public service by a country mile. [...] it’s not pipelines, it’s personalised service one-to-one, between a clinician and a patient in a one-to-one relationship. You have to respect that, and that’s why change management of the scale that I’m convinced is required has to be handled at a local personalised level.”

These interview excerpts demonstrate that, in part, the political desire for responsiveness was as a result of the shift towards locally-led change (because locally-led change is ‘right’, therefore responsiveness is ‘right’), but also that responsiveness is a way of making locally-led change happen (to shift the policy landscape towards localism). This process was similarly demonstrated in Martin and Learmonth’s study of leadership as a way of instilling localism at the frontline in which they found that policy was, in part, a rational, linear process whereby an aim is decided and then implemented, and partly a much more jumbled up process wherein value judgements, decisions about what to do, and the act of trying to do it are very difficult to disentangle from one another (Martin & Learmonth 2012).

“You know it’s fashionable to say the NHS is a complex adaptive system, but you can’t run complexity by linear rules from a central body. You can certainly set standards, you can certainly do some of the thinking and the principles, but in the complex adaptive system you’ve got two factors. It can only be delivered locally and, second, it’s got to bring complexity together. [...] ...patient measurement, what patients think, has got to be a fundamental part of that assessment process.”

4.5.3 Cooperation and cross-boundary working

Encouraging partnerships was also seen to be an important aspect of successful implementation. According to interviewees, this might include developing a shared vision and enabling practices and their management organisations (formerly PCTs and SHAs) to work together. 21 Other types of partnership included those between

21 However, my interviews with staff on the ground suggested that the extent to which a shared vision was developed around responsiveness was questionable (see Chapter 6).
practices and patients. Good leadership and improving clinician-patient relationships were seen as key.

Developing a shared vision through cooperation with other organisations and through the use of change management initiatives was seen as important. Strategies were both formal, such as use of the *NHS Change Model* (NHS Improving Quality 2016), and informal, such as working alongside the implementation of other policies, e.g. stratifying patient needs according to chronic disease status or socio-economic status. At a wider NHS-level, effective commissioning was encouraged, as was implementing specific policy initiatives such as choice.

“I think this has been through a number of different iterations, but the so-called *NHS Change Model* which the NHS Commissioning Board [now NHS England] is now using as its [...] ways of working, starts from the principle that the most important thing you have to do is to develop shared vision, in other words you can have what objectively looks like a sort of really strong policy, but unless locally you’ve got clinical leaders and other influential people within the local community who want to, you know, who believe in it and want to do it, then it has somewhat limited effect.”

Positive peer pressure and support was mentioned by only two interviewees. In the new world of CCGs at the time of my interviews, one participant emphasised the value of peers questioning each other’s practice and learning from each other. Another interviewee hoped that CCGs would not take on the performance management role in the same way as the outgoing PCTs, but that peer pressure would be effective:

“Look, we’re not saying you’re bad GPs, this isn’t the Department of Health saying, this is not some faceless bureaucrat from the NHS Commissioning Board, we are your peers saying we think that there’s more you could do, and we can help you in providing even better services that patients like.”

Thus, this interviewee understood the difficulties that the CCGs faced – they were expected to achieve a hard-nosed transformation in GPs’ attitudes, but to do so through peer pressure and soft influence without any sticks or sanctions, even though
they were to be held accountable. Some elite interviewees felt that this local pressure would be more effective than distant, centralised sermons (Bemelmans-Videc et al. 1998).

4.5.4 Competition and choice

The choice agenda was one example of how elite participants felt that an incentive had the potential to change primary care. Interviewees described the pilot programme of allowing patients to choose their GP practice – the DH’s “flagship policy for general practice at the moment” – a policy mainly aimed at commuting workers. One participant cited the RCGP’s Commission on Generalism in Medicine (Royal College of General Practitioners 2013), and how “choice around primary care would have been a fantastically powerful and would be a fantastically powerful tool. Especially if, as it is, patients are linked to pay. So if you’re a GP and you’re doing a good job, you’ll earn more money. Because patients will come to you, or to your practice. If you’re not doing a good job they’ll go somewhere else and you’ll lose money.” Similarly, one interviewee drew parallels with the improvements seen within the wider care system, such as direct payments in social care “enabling people to determine their own home care arrangements and support of disabled people, that sort of area has worked.”

Three interviewees spoke about clinically-led commissioning and how responsiveness played a part, through the use of incentives and peer pressure to reduce inequities. Some participants showed enthusiasm for the future and felt that access and responsiveness “will be on the agenda of clinical commissioning groups” because the purpose of GP-led commissioning was to reduce variation. The interviewees did not note, although others have (Section 1.3.1.3), that there can be downsides to competition in that it can encourage practices to be responsive to certain groups (who are desirable for whatever reason, e.g. they are greater in number and easier to deal with) over others (who are less desirable, e.g. those who are hard-to-reach).

4.5.5 Patient engagement

Engagement between primary care staff and patients was viewed as a facilitator to responsiveness, such as through educating patients. Some participants cited patients’ increasing dependence on doctors as a catalyst for more responsiveness in policy, and
educating patients in self-care as a potential solution. Thus elite interviewees saw responding to higher consumer expectations as important (Section 4.4.1), but were also keen to raise those expectations themselves by encouraging patients to become more active in their healthcare.

“…patients are becoming much more educated and [...] knowledgeable, and in a civilised society we should respect that. [...] And I think patients are a step ahead of us and the service. [...] in all aspects of their life, banking, shopping, booking things, they have such a lot of choice. They’re empowered, they are king, you know. But when it comes to health they are very passive. They’ve been made to be passive.”

PPGs were also seen as a potentially effective way to engage with patients, although there was an understanding that attitudes needed to change in order for such a partnership to work:

“[Members of PPGs] are all patients of those general practitioners and the general practitioner is the doctor to the patient, and so that both parties have got to overcome, they’ve got to cross a river and realise that [...] the whole team have got to treat everybody as equals”.

Another interviewee concurred that PPGs were important for responsiveness: “the patient participation DES, and that is still current and it encourages practices to ask their patients what they want and respond to it. And again it was written to win hearts and minds.”

Policies that were developed in partnership with patients – the consumers of a responsive health service – were felt to be the most successful. One participant said, “I talk about push me, pull you model and it isn’t all about professionals being pushed, it’s also patients pulling.” Likewise, another interviewee felt that “… it’s a culture, it’s a way of thinking, it’s a way of being partners with patients.” Yet another felt that the involvement of patients in the running of general practice was paramount: “…what I think is needed is a kind of ongoing structure where the patient voice is central to the way the practices develop.”
Despite interviewees’ acknowledging the importance of patient and public involvement, they also referenced how changes in primary care at the time of the interviews had not helped the cause. According to participants, responsiveness could easily become crowded out (Frey 1994, Frey & Jegen 2001) by the distractions created by restructuring, as well as by incentivised targets (Section 4.5.1).

“And I worry that one of the main potential benefits of patient and public involvement will be lost [...] It becomes very much about the structure, the decision-making structures.”

The processes within the new structures at the time of the interviews were, according to an interviewee, comparable to performance managing GP practices, which was “antithetical to responsiveness”. He felt that “if responsiveness had really changed the game [...] the practices would recognise the importance of taking patients with them through this period of change, which I don’t see much evidence of.” There were similar views from other interviewees, one of whom described lay involvement with the newly-formed CCGs as “still quite weak”. Some interviewees felt that services had been fragmented with “turf wars going on [...] which probably won’t be helpful in promoting responsiveness”, that responsiveness had “been diluted”, and that the focus had returned to clinicians rather than patients: “the ministry of the supplier” (Clarke et al. 2007). In contradiction to the positive change of improved access cited by one interviewee, another participant suggested that access had “gone down [...] in terms of being able to get an appointment when you want to.”

4.6 Summary of elite interviewees’ perspectives

The elite policy-makers I interviewed described what responsiveness meant to them in terms of changes in society and a combination of changes to, and longevity in, political priorities. They outlined the ways in which implementation could be facilitated or hampered by centrally-driven top-down levers such as targets and performance management, and less coercive long-term measures such as incentives and peer support. The complex relationship between responsiveness and choice was discussed, along with the contractual status of GP practices and the consequences for responsiveness.
This chapter has provided evidence of the wicked problem (Rittel & Webber 1973) that responsiveness seeks to solve. Meeting the needs of different patient groups is a problem that is difficult to define (Section 4.3), multi-causal and unstable (Section 4.4), that has no clear solution and for which interventions can have unintended consequences (Section 4.5.1), and involves multiple actors (Section 4.4.2) and social complexity (Peters 2015) (Sections 4.4 and 4.5). To conclude, elite policy-makers appeared to be struggling to try to find the right combination of approaches that compelled action without dictating (or being seen to dictate), and that capitalised on innovation, discretion and intrinsic motivation while making sure these were all channelled in the appropriate (centrally determined) way. As one interviewee put it, both incentives and changes to mind-set were needed: “to dramatically improve [responsiveness] you would need a collective motivated GP population to do something quite radical. And I don’t see what the overarching incentive is there to do that.”

In light of the framework of the core values of general practice (Section 1.2), elite interviewees’ views about the goals of responsiveness appeared to align with the framework, as outlined in Table 7 overleaf.
In conclusion, this chapter has provided answers to the research question of how responsiveness is defined in policy-makers’ discourse, the values it reflects, and the problem(s) it is said to be able to solve. Elite interviewees defined responsiveness as meeting patients’ needs and providing choice, which arose from changes in society and political priorities. As displayed in Table 7, elite interviewees’ felt that the goals of responsiveness were to: provide personalised care and good customer service; provide continuity of care; consider issues beyond healthcare (such as social care and housing); consider people who are socially disadvantaged; provide flexible technical access close to patients’ homes; listen to patients to find out what their needs are; and attempt to improve the quality of healthcare. There was evidence that policy-makers were making attempts to amplify (Section 1.3.4.2) the shared the values of primary care, and saw responsiveness as a way to attain goals aligned with these core values.

In the next chapter I consider the views of staff with an intermediary role – those responsible for interpreting policy and ensuring it is implemented at the frontline.
5 Strategies for and tensions in responsiveness: strategic staff perspectives

The purpose of this chapter is to explore the views of stakeholders about approaches to the implementation of responsiveness within the context of the wider organisational and operational environment in which GP practices were situated. I present the findings from interviews with staff with strategic roles in GP practices and federations and in mid-level organisations such as public health and CCGs.

First, I describe the staff whom I interviewed. Second, I present interviewees’ views of strategies to implement responsiveness into practice. These included bottom-up soft tactics such as delegation of responsibility, supportive relationships across hierarchies, patient engagement and mobilisation, and cooperation. Targets, monitoring and incentives were also seen as useful strategies to focus attention, allocate resources to areas of most need, and facilitate working together as a community to improve; but, on the whole, these harder tactics were seen as problematic because the extent to which targets and incentives were seen as aligned with values was important. I go on to consider the challenging context within which implementation was taking place and how this impacted on the extent to which staff could successfully plan and deliver responsive care.

5.1 Strategic staff interviewees

I interviewed 12 members of staff between October 2013 and September 2014. The first four interviews were with practice staff in management roles (SS01-SS04) and were conducted as part of the NIHR study. These explored the wider external context within which GP practices operated and the strategies for, and tensions in, delivering responsiveness (see Appendix 14 for the interview guide). Participant SS05 was also based in general practice but did not have time for an interview, so instead answered a short questionnaire based on the interview guide (Appendix 15). Although also ‘frontline’ staff (Chapter 6), their data have been presented in this chapter as the focus
of the interviews was different. Whilst active in general practice, I have termed these interviewees as ‘strategic’ due to their roles and responsibilities for taking managerial and policy decisions at a practice or federation level that impact on systems as well as day-to-day interactions with patients.

The remaining seven interviews were conducted purely for the purposes of this thesis. It became clear through the initial interviews in general practice, the writing of the NIHR project final report, and changes in government policy, that implementing responsiveness may also have become the responsibility of CCGs (i.e. localities) rather than being solely the responsibility of individual GP practices. I felt there was value, therefore, in further exploring the organisational context in which GP practices operated, and how this impacted on the implementation of responsiveness. Thus the interview guide was revised (Appendix 16) and I conducted interviews with individuals working for two CCGs and at one local authority. The aims of these interviews were to elicit the views of senior strategic staff (staff with responsibilities for developing local policies and enacting national policies) about where the responsibility for improving responsiveness lay, what pressures and incentives motivated, or were in conflict with, attempts to improve responsiveness, and how these attempts were affected by national and local organisational contexts.

As CCGs are small organisations, to protect identities I collected minimal personal data and report job families rather than individuals’ job titles (Table 8, overleaf).
Table 8: Strategic staff job families and organisations

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<tr>
<th>Strategic staff</th>
<th>Organisation</th>
<th>Job family</th>
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<tbody>
<tr>
<td>SS01</td>
<td>GP federation</td>
<td>Clinical lead</td>
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<tr>
<td>SS02</td>
<td>GP practice</td>
<td>Practice manager</td>
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<tr>
<td>SS03</td>
<td>GP practice</td>
<td>Project manager</td>
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<tr>
<td>SS04</td>
<td>GP federation</td>
<td>Practice manager</td>
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<tr>
<td>SS05</td>
<td>GP practice</td>
<td>GP partner</td>
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<tr>
<td>SS06</td>
<td>Local Authority</td>
<td>Public health</td>
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<tr>
<td>SS07</td>
<td>CCG</td>
<td>Equalities</td>
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<td>SS08</td>
<td>CCG</td>
<td>Strategy and planning</td>
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<td>SS09</td>
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<td>SS11</td>
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<td>SS12</td>
<td>CCG</td>
<td>Delivery</td>
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5.2 Responsiveness as a way to attain goals aligned with core values

Strategies for responsiveness within localities described by staff appeared to be based in the belief that responsiveness was a way to attain goals aligned with the underpinning core values of primary care (Peters 2015). This was evident across job roles (managers and clinical staff) and organisations (CCGs, federations and practices), as demonstrated by the quotations below. Interviewees spoke of how being responsive was something they had always done; it was entrenched in their history and grew from the bottom up forming the “bread and butter” (SS12, delivery, CCG) of general practice.

“It’s always been a priority. Even when we were back in PCT days, it’s always been quite high up on the [district] agenda to be as responsive as we can […] It’s certainly not a new thing. It’s absolutely been going for a long time and it’s in every document that you read.” SS08, strategy and planning, CCG

“I would say as a team we don’t feel under pressure to do it. It is something that we do.” SS04, practice manager, GP federation
“I don’t think we have bought into it because it was already entrenched. [...] I think it is something we have always done. [...] It has just always been like that.” SS03, project manager, GP practice

Staff in GP practices cited their “vision”, “mission”, “values statement”, “priorities”, and the like, and how responsiveness was a prominent element of their goal to provide a quality service. Responsiveness was “on people’s minds all the time” (SS03, project manager, GP practice), and staff were keen to prioritise it over targets and incentives with which they actively disagreed (those that contradicted the aims of responsiveness, or each other) or simply disregarded (those that they considered unimportant).

“It is core to our vision, mission and values and something we would do anyway.” SS05, GP, GP practice

Interviewees felt that policies and organisational change could be forces for good if changes were aligned with the values held by staff and with what organisations wanted to do. Staff found creative ways to use responsiveness as a way to meet central demands in challenging times.

“I think we have always seen it as a positive aspect to our work. [...] I think we are heading the right way. It is not just ticking the boxes. We have always been a practice that is looking ahead and moving ahead and I think it is paying off.” SS02, practice manager, GP practice

“...there are stipulations that come from higher beings [...], as a practice we take that very seriously and we are always looking ahead to try and work out where we might be in five or ten years’ time and how can we use being responsive as a benefit rather than a thing to do...” SS03, project manager, GP practice

5.3 Soft tactics as strategies for implementation

According to interviewees, effective implementation was grounded in bottom-up, soft tactics (Salamon 2001, Mörth 2004). These tactics supported a shared sense of being
responsive because it was the ‘right thing to do’ (Section 1.3.5.1). Strategies for effective implementation included delegation of responsibility, supportive relationships across hierarchies, cooperation, and patient engagement and mobilisation.

5.3.1 Delegation of responsibility to the CCG
In order to facilitate responsiveness within a locality and demonstrate commitment to responsiveness as a way to attain goals aligned with core values, mid-level organisations were required to take responsibility and to engender a positive organisational culture. This mainly related to the ability of an organisation to embed responsiveness into its day-to-day work and values, even when difficulties arose that were in conflict with the aims of responsiveness or in circumstances that made implementation challenging. The commitment to, and prioritisation of, values and ways in which to achieve the goals aligned with those values (such as through responsiveness) were seen to start with effective CCG leadership.

“I think our CCG has a recognition of the importance of that and a will to improve in that area and I think some of the appointments that it’s made in relation to its leadership and its directors and individuals who take a particular lead in that role.” SS06, public health, local authority

“I think this is about also the leadership taking this more seriously. If they want to do it and they want to prioritise it, it will happen. If the leadership is unclear, it’s vague or makes a commitment on paper or pays lip-service and doesn’t back up what they say they want to do and supporting staff to glean responses and do that into decision-making, then it won’t happen.” SS07, equalities, CCG

As well as effective senior leadership at the level of CEO and directors, other staff roles were seen as key through both the appointment of appropriate staff in the CCG and by ensuring that job remits included supporting general practice to be responsive, for example through community engagement or handling community data by mapping populations.
“...we have a lot of stuff within the clinical system which is real-time, so we can push a button and [...] we know if practices are not recording ethnicity, because it comes out of our system, so we’ll then have conversations that this is important for us to have a citywide view of the changing city.” SS12, delivery, CCG

Other responsibilities of CCGs, according to interviewees, included building trust with practices to encourage change and enabling individuals within the CCG to be held accountable: “It is all of our jobs” (SS10, CEO, CCG). Such responsibilities aimed to create a supportive environment to facilitate practices to become more responsive.

“I think once we align ourselves to that same kind of approach and regime in a supportive way and build that relationship with primary care providers, I think we can go a long way. I think it’s gaining their trust really...” SS07, equalities, CCG

5.3.2 Shared responsibility and supportive relationships across NHS hierarchies

Staff in the CCGs felt that sharing responsibility with organisations in the wider health sector was particularly helpful.

“Certainly in respect of equality and diversity and access issues, I think NHS England have quite a big responsibility in encouraging and supporting GP practices. I think CQC has also got a very big role in that in inspection. [...] I think the Department of Health certain have got a responsibility clearly sort of at the national policy level.” SS07, equalities, CCG

In particular, NHS England was also cited as responsible by several interviewees, through the provision of guidance, contractual arrangements, and performance management; however such national tools appeared to be lacking and thus CCG staff felt it was difficult for practices to keep attention on responsiveness as a priority. Instead improvement was reliant on softer mechanisms including relationship building with, and support from, CCGs.
“I would suggest the area teams in NHS England should be harder on them [GP practices], in terms of their relationship with their contract, but they’re not, so a lot of it falls to the CCGs to do it [in a] more in a supportive way.” SS12, delivery, CCG

Facilitated by positive relationships between CCGs and practices, all interviewees in CCGs agreed that commitment from GP practices was key for success, and it was their expectation that practices should take responsibility for delivering responsive services, in part due to the business/customer relationship. One CCG interviewee spoke of findings from a CCG community engagement exercise that were not accessed (and therefore not used) by GP practices, thus practices were not making use of the support that was being made available to them.

“So whilst we [the CCG] work with public health and to work out where the health need is, and then with the providers about what can be provided, it’s up to the GPs to make sure that those services [...] bring the suitable influence to the design of those services so that their patients [...] can access them, and then it’s up to them also to take that back and embed it within their GP practice.”
SS09, CEO, CCG

One CCG interviewee was also mindful of local limitations within her CCG. In particular she cited a lack of joined up thinking and told of an example where she had done some work to engage with communities that did not lead to change within the CCG. As the quotations, above, demonstrate, it appeared that CCGs were keen to delegate responsibility to other organisations but that, as this interviewee suggested, it was perhaps also necessary for the CCGs to share and/or hold some of this responsibility; responsiveness does not just depend on the actions of GP practices.

“A lot of the findings from [a community survey] were quite interesting, [...] because a lot of them were saying things like patient demand, what people expect of practices, list sizes and how complex people’s needs are, how diverse the areas were [...], whereas my role is just engagement; it would be great if their [the CCG’s] response was ‘right, OK, we really need to do something about
“...from my point of view I think there’s a hell of a lot more we could be doing.” SS11, engagement, CCG

5.3.3 Cooperation: joint working, sharing good practice, working across boundaries

According to participants, effective joint working and sharing good practice was another strategy for improving responsiveness across a locality. Joint working included forming networks or federations and working across sector boundaries. Most participants talked about positive outcomes when GP practices within a CCG area worked together. Interviewees from the GP practices found that working within a network of practices enabled them to be more responsive to their local populations, through sharing good practice and setting up joint services (as advocated in the policies, Sections 2.4.2.2 and 2.4.2.3). In contrast to CCGs appearing to want to delegate most of the responsibility for responsiveness (Section 5.3.2), some interviewees from CCGs were also committed to the network model, citing how they had set up joint training sessions to enable knowledge sharing. Practice staff interviewees shared this view.

“...you are more likely to be successful working as a group rather than individually and we are looking at urgent care and opening on a Saturday rather than them going to A&E. So working in a federation and together is going to be beneficial.” SS02, practice manager, GP practice

CCG staff cited the importance of population mapping (through the collection and analysis of demographic data (Section 5.3.1, page 146)) as a way to find out patients’ needs in order to respond to them. Strategic GP practice staff described how they proactively used these data to work together across practices to plan services. From a market-oriented point of view, whilst this may be a means to increase responsiveness (with positive effects for patients), it may work against the ideals of competition. Indeed it might even be seen as collusion within a ‘cartel’ (Section 4.5.1, page 131), with potentially negative effects for practices in terms of not meeting central demands and missing out on associated funding.
“As a practice we sit in a group of [...] GP practices so obviously if you group that together then you can get a bigger population size to look at and what the need is.” SS03, project manager, GP practice

The ability to share good practice was seen as a benefit to working as part of a federation or network, and also informally within a CCG area. Examples included mentoring and sharing of capacity planning information between practices.

“We are working with other practices. We are mentoring other managers. [...] It is something I have set up locally. I have worked in at least four different practices and tried to turn it around where they are underperforming...” SS02, practice manager, GP practice

As well as peer-to-peer support, practices and CCGs working together to identify best practice was also seen as key; examples included CCGs conducting quality reviews, setting up a PPG forum to encourage joint working and making suggestions for patient survey questions.

“What we did was we set up a forum where the chair of each PPG was invited in. So we’ve got a forum so they can link with each other which they kind of run themselves. [...] So they can network and learn from each other and kind of gather confidence...” SS09, CEO, CCG

As suggested in Section 5.3.2, supportive relationships between CCGs and practices were felt to be important. Staff in the GP practices appeared to find these relationships helpful, e.g. to develop business cases or to apply for “innovative bursaries” to engage with local communities and voluntary organisations. These participants appeared to be saying that financial incentives can work, although there also needs to be care to ensure that they are not linked naively to targets or box-ticking but instead are oriented towards encouraging more innovative approaches.

“[And] also working with the CCG groups and developing services [...] liaising with the CCGs and developing business cases to make sure we get a chance to have these services...” SS02, practice manager, GP practice
This positivity about the relationships between CCGs and GP practices was also apparent amongst public health and CCG staff.

“So locality support is looking after the […] localities we’ve got in the [district], they’re non-geographic, they’re made up of practices who over time have worked well with each other, so they’ve got some history and are working with each other and trusting each other if you like. […] So that’s very much sort of the softer stuff of what we do.” SS12, delivery, CCG

As well as cooperation between practices within a CCG area or between practices and CCGs, engagement with the wider health community was seen as important for responsiveness. For instance, strategic interviewees spoke about how national policies to encourage a movement of activity from secondary to primary care might improve responsiveness to the benefit of vulnerable groups. Joint working between primary and secondary care was seen as essential, as also suggested in the policy documents and by the elite interviewees (Sections 2.4.3 and 4.4.1).

“So when it comes to responsiveness for particular groups […] investing those resources in primary care, that, in effect, is disinvestment in secondary care because those patients will stay at home and therefore we have more money to invest in community services and more district nursing services and more overnight sitting services so it is that kind of cycle. […] You know it is early days but it is all absolutely the right thing to do.” SS10, CEO, CCG

This collaboration between primary and secondary care was seen as important in the local context of an acute trust with financial problems. Rather than punishing the trust for its debt and worsening its financial situation (Peters 2015), some interviewees were keen that CCGs and the acute trust should work in partnership so that they could “deal effectively with the issues” (SS07, equalities, CCG).

The interactions between the health, social care and third sectors were also felt to be important. Interviewees provided examples such as how the difficulties in finances meant that the third sector was best placed to deliver a responsive service, and how working with other organisations (e.g. Healthwatch) meant that work could get done
that otherwise would not have been possible. Others spoke of the work being undertaken to link primary and social care, and the money being invested into this initiative “because it is not a kind of faddist [sic] direction of travel. It is what we should have been doing in the first place” (SS10, CEO, CCG).

5.3.4 Patient engagement and mobilisation

Patient and public involvement processes, whilst indicating how responsiveness had become embedded in day-to-day systems, also demonstrated organisations’ commitment to engendering a goodwill culture with strong core values, according to interviewees. Participants spoke of the importance of consulting with the community (including but not limited to patients on GP practice lists) about people’s needs, including those who are disadvantaged; one participant expressed pride in this: “that’s one of the differences with [the former] PCT. There was a huge amount of investment in engagement, more than you would have found in most PCTs around the country I think” (SS08, strategy and planning). Interviewees felt that both CCGs and GP practices should undertake consultation and engagement activities. Participants felt that their organisations were open to feedback and criticism, and were willing to listen to communities’ views in order to consider how GP practices and/or the CCGs might best respond to felt and expressed needs (Bradshaw et al. 2013), thus enacting their core values.

“We are also going to be going out and having these listening events across the [district] and we’ll target certain seldom-heard groups like travellers or gypsies, Somali communities, LGBT community, and any feedback that we get in respect of GP practice services, we will be feeding that back.” SS07, equalities, CCG

5.4 Targets, monitoring and incentives as strategies for implementation

Whilst shared values and cooperation were seen by strategic staff to be effective tools for successfully improving responsiveness, staff also spoke of the usefulness of targets and incentives (see also Section 4.5.1). Such harder tactics were seen as helpful to focus attention, allocate resources to areas in most need, and facilitate working together as a community to improve.
5.4.1 Alignment with core values

Hard strategies (Salamon 2001, Mörth 2004) were seen to work well when the targets and incentives aligned with providers’ own approaches to achieving core values. Interviewees spoke of how responsiveness, whilst being embedded through a positive organisational culture and used as a way to attain goals aligned with core values, was also facilitated through financial incentives like the QOF and other key performance indicators. Participants were keen to express support for these targets and the associated benefits for patients.

“...I think we have always seen [responsiveness] as a positive aspect to our work. [...] It is just like QOF, although its targets are money-driven, it is benefitting the patients. [...] You are making sure they are coming in and having their checks so there is a benefit for the patient.” SS02, practice manager, GP practice

Some interviewees spoke of how appealing financial incentives were for independent businesses such as GP practices. Others spoke of the long-term positive effects of financial incentives (such as the PPG DES) even once the incentives were removed.

“So not being flippant, but anything to do with resources really focuses GPs’ minds because they are independent practitioners and they’re businesses, aren’t they, in their own right. So that discussion when we introduced this toolkit [...] really did focus their minds on disease prevalence and what it meant for their very, very local population.” SS09, CEO, CCG

Some interviewees spoke of the ways in which being proactively responsive might help their organisations’ difficult financial situations: how responsiveness could be of financial benefit to general practice and how designing new resource allocation formulae could benefit different sectors of the community.

“...we believe primary care is going to come under a lot of pressure coming up and how we respond to that definitely comes down to the way we are, among under things like financial pressures and things, the way we are responsive is a big part of that.” SS03, project manager, GP practice
Not all incentives were financial or managerially driven, however. One interviewee spoke about the power of peer pressure and support to incentivise improvement (see also Sections 4.5.3 and 5.3.3). Using peer pressure in this way is a key feature of a clinical community – a network of interdependent members who share a commitment to improve quality (Aveling et al. 2012).

“So what we have recently introduced over the last couple of years is, for example emergency admissions, in terms of where you are against your peer localities, what the CCG benchmark should be and where each practice is, you know, very specific drilled down information gives the practice themselves the information then to realise that they have to improve. So that’s worked far better than any financial incentives that we’ve had because it’s peer to peer review.” SS08, strategy and planning, CCG

5.4.2 Misaligned priorities

Although targets and financial incentives were viewed as effective by some interviewees (Section 5.4.1), participants were also critical (see also Section 4.5.1). These harder tactics (Salamon 2001, Mörth 2004) were, on the whole, seen as problematic when they either resulted in conflicting priorities, or were misaligned with local efforts to shape service provision in ways that were seen to genuinely reflect their core values. Thus, targets and incentives were viewed by some as being limiting to responsiveness, as conflicting and ineffective, and as sometimes having unintended consequences.

The first way that targets and incentives could be problematic for implementing responsiveness were when the priorities being incentivised conflicted with the aims of responsiveness. Interviewees spoke of a target culture whereby targets and financial incentives aimed at efficiency limited their endeavours to improve responsiveness by prioritising these targets over “general ordinary primary care” (SS09, see the full quote on page 156).

“Other things that would be conflicting [with responsiveness] are mainly just targets, isn’t it, targets not to admit, targets not to refer, targets to keep your prescribing under control.” SS01, clinical lead, GP federation
In some instances, interviewees spoke of how targets, such as efficiency and patient experience (e.g. longer consultation times), could be in direct conflict with each other, and how a small organisation like a CCG could struggle to keep responsiveness on an organisation’s list of priorities.

“...there’s kind of a real drive for efficiency [...] that is being monitored to within an inch of its life. [...] Those are still the things that you have to deliver on and there are some fairly major concerns locally [that] requires an inordinate amount of time and energy and resource. [...] bearing in mind that CCGs have a very, very small staff that’s associated with them, it can be a real challenge to get these important areas at the front in terms of discussions around a governing body.” SS06, public health, local authority

When speaking about these apparently conflicting targets, staff were concerned that responsiveness would not be prioritised even though they regarded responsiveness as essential to delivering on the core values of primary care.

“Well unfortunately it’s symptomatic of the pressures that are there around the need to bring in change and we know that consultation engagement takes time to do it properly. [...] Juxtapose that with [...] the pressure on the acute services, trying to bring down A&E waiting times. [...] What is a priority?” SS07, equalities, CCG

Indeed, staff were keen that responsiveness should not have to compete with other priorities, but rather felt it should be embedded in everything they did. Again, this speaks to the problem of an approach to responsiveness that relies on (or crudely deploys) extrinsic incentives to make change. There are so many incentives, and some are more imperative than others, so perhaps targets are not the best way to promote responsiveness. A different kind of approach is needed to implement a policy of this nature; one that relies much more on a flexible approach to supporting achievement of shared values (Section 5.4.1). This seems to be partly due to the nature of responsiveness itself (as something that cannot ‘just be implemented’, because doing so risks a tick-box exercise that fails to reflect the dynamic and responsive nature of responsiveness), and partly to the specifics of the groups (general practices) being
targeted (with their particular relationship with the NHS, and their particular relationship to their patients, as will be explored in detail in Chapter 6).

“I think those things [equality and diversity strategies] are there but they’re obviously competing against areas such as finance, quality [...] I mean it shouldn’t compete. It should be part of it. That’s how it should operate. I think if I’m just talking pragmatically, I’m not sure that always happens.” SS06, public health, local authority

The second type of misalignment was where targets were directed at responsiveness but in a potentially inappropriate or clumsy way. Thus, even well-meaning targets could get in the way of genuine efforts to be responsive. For instance there was evidence, in the interviews, of a tension between top-down preconceptions of what responsiveness should look like (e.g. short waiting times to see a GP) and allowing GPs space to be responsive to a bottom-up, patient- and practice-led impetus; and that this tension has unintended consequences.

“That [the 48-hour target to see a GP] was just ridiculous, and that did generate the wrong sort of behaviours within practices. [...] I think when they brought in the QOF stuff where they’d got quality points which translated into finance [...] and practices did focus on those to the detriment of just the general ordinary primary care, and I think that also affected their level of responsiveness.” SS09, CEO, CCG

In addition to the problems caused by targets that conflicted with each other or targets that were implemented in a clumsy way, participants also spoke at length about the ineffectiveness of targets for driving values-based practice. Targets were sometimes seen as being clearly misaligned with patients’ needs and wants (for instance incentives for Saturday and evening opening, which patients did not want, according to the interviewees, and so the target was pointless), or unintentionally, by reducing patients to a list of conditions rather than taking a holistic approach (thus the target was, arguably, measuring the wrong thing).
“Many of our other pressures and targets are in direct competition to being responsive. If responsiveness is about an appropriate response to the whole person, our QOF targets treat patients as conditions and symptoms and reward us for actions to tackle these things. Furthermore the whole drive towards downwards pressure on GP budgets mitigates against whole-person planning and produces a heads-down attitude.” SS05, GP, GP practice

Equally, some interviewees were concerned that targets were causing staff to become overworked and under-rewarded – “working harder for less money” (SS04, practice manager, GP federation). Others felt that targets did not work for staff and some expressed concerns about the conflicts targets caused at the level of individual staff, and even suggested that they could have the perverse effect of undermining GPs’ commitment to core professional values.

“…what the GPs were saying was, ‘We need to give more time to patients. In order for us to give more time to patients, we need to be paid more. [...]’, but what I was hearing, you see to my ears all that said was, ‘Well yeah. You can have more time and we can look at multiple needs that patients have, [...] as long as you pay us.’ To me that’s not about compassion. Not every GP will have that attitude and it’s about the value systems that we have.” SS07, equalities, CCG

5.5 Context as a challenge for implementation

In addition to the challenges of targets, and priorities that were misaligned with efforts to provide a service that reflected core values, outlined in the previous section, the context of general practice was seen to undermine the implementation of responsiveness. Broadly these contextual factors could be categorised as conflicting pressures (such as finances, resources and capacity) and organisational change outside of staff’s control (e.g. legislation, choice and NHS reorganisation).

5.5.1 Conflicting pressures

All 12 interviewees spoke about the ways in which finances, resources and capacity limited their ability to be responsive. From a GP practice perspective, there were
practical impacts of the “financial bracket” (SS01, clinical lead, GP federation) in terms of the number of receptionists, doctors and nurse practitioners they could employ. Participants spoke about balancing the finances against what they wanted to do for patients.

“Our planning and prioritisation process has three main poles – our own vision, mission and values, what we know about patient preferences (from questionnaires, patient encounters and meetings) and finance (what we can afford, and what drives what we can afford).” SS05, GP, GP practice

The national policy to shift activity from secondary to primary care, whilst supported in principle (Section 5.3.3), also had detrimental financial effects, according to participants, and hence impacted on patient care and responsiveness.

“You know [our district]’s health economy sits on Jeremy Hunt’s whiteboard in his office according to one of my colleagues who was there a couple of weeks ago. We are very, very strongly being scrutinised on particular elements regarding our acute performance.” SS10, CEO, CCG

Interviewees spoke of a local acute trust with a large deficit which could affect the locality’s ability to be responsive in primary care. Interviewees described the constant battle to keep responsiveness on the agenda when finances prevented them from enacting their values and aspirations.

“[We want to] to influence [the local hospital trust] in the way it delivers its services and the level of resource that it’s taking out of the local health community because it does feel from where we sit, it feels inefficient and so it’s pulling resource which actually if that could be kept in primary care, we could do more about being more responsive.” SS09, CEO, CCG

The interplay between a hospital trust in financial dire straits, rising patient demand and expectations (see also Sections 2.3.2, 4.4.1 and 4.5.5), and a reduction in the primary care budget nationally was seen as problematic by CCG staff. Some staff felt that patients’ expectations were sometimes unrealistic (e.g. 24-hour services comparable to internet banking and supermarkets), and that the only way primary
care could provide for patients who needed healthcare was by “not seeing the not ill patients all the time” (SS10, CEO, CCG). Others spoke of the difference between patients’ wants (which roughly equated to Bradshaw’s felt and expressed needs (Bradshaw et al. 2013)) and needs (Bradshaw’s normative needs (Bradshaw et al. 2013)), as defined by the participants, and how expectations should be managed in the context of running a health system.

“When you start to mean to need, I think it is more about thinking about your role within a larger group, so just because I want to be seen on a Saturday, is that the need of everybody? Because if it is a need of everybody then maybe it should be a Saturday but if it is not, I have to wait my turn because it is more convenient and effective for the health service....” SS01, clinical lead, GP federation

As well as financial implications, the locality from which I drew my participants was experiencing some practical challenges that frustrated efforts to achieve the CCGs’ aspirations to be responsive. Such struggles included a lack of capacity in general practice, both to meet the rising demand, but also in terms of recruitment, according to interviewees. Whilst there was nationally-accepted problem with GP recruitment, interviewees felt that this was likely to have a greater impact in their locality due to the demographic characteristics of the GPs (many of whom migrated from India in the 1950s and 1960s and were now approaching retirement) and the varied (geographically across the locality) and changing (over short time periods) patient population.

“...there’s this demand/capacity interaction all the time, where the demand is just increasing and increasing in primary care, and [this district], with its diverse nature, makes it harder sometimes in terms of being responsive to the right people, in the right time, in the right format, so it’s a big challenge.” SS12, delivery, CCG

The staffing levels within CCGs were also felt to be a limiting factor (see also Section 5.4.2). Interviewees felt that organisations such as CCGs, with such a small number of staff, could not achieve what they wanted to achieve without the help of other
organisations. The reduction in management budgets during the transformation from PCTs to CCGs was also cited as problematic.

“I think it’s just resource, the intentions are there, there are some hot topics out there, like diabetes, that I know that they’re planning to do, they’re just quite slow to get off the ground because with having to be reactive, do things that are coming in that are taking priority, and again we used to have big teams, and now it’s a very small team.” S11, engagement, CCG

CCG staff were also very aware that demand and capacity in one healthcare area, e.g. health checks, were likely to affect demand and capacity in another area, e.g. availability of GP appointments. Interviewees saw it as part of their role to manage these knock-on effects, i.e. preventing an increase in responsiveness in one area having a detrimental effect in another.

“So you look at one area, it’s going to impact another area, so my role is to look at the whole and see what is the impact going to be across the board” SS12, delivery, CCG

With so many conflicting pressures, staff were concerned that responsiveness was “often asked to take a bit of a back seat because we have to be reactive a lot of the time, which is a shame, and you need to be proactive about responsiveness” (SS12, delivery, CCG).

5.5.2 Organisational change

As well as the limitations to responsiveness due to conflicting pressures caused by financial and practical constraints, interviewees described organisational sources of tension that might conflict with the aims of responsiveness, including legislation, competition and choice, and NHS reorganisation.

Senior GP practice interviewees spoke of tensions with responsiveness at the highest level – legislation – and cited legal obligations that frustrated their efforts to be responsive to patients at the point of delivery (see also Section 2.4.2.1).
“...we are not allowed children’s toys. Even if you start playing music you can get into trouble. It is a blooming nightmare. So legislation does not help. On that front I have been told by an infection control nurse that I am not allowed the fish tank that I have in my office because of the potential theory of infection. I have told her ‘no’ and that it is not moving, and I feel it helps patients.” SS01, clinical lead, GP federation

Interviewees gave examples of national priorities being a barrier to responsiveness, one of which was the APMS contract and its apparent short-termism. A long-term, stable contract was seen, by interviewees, as a means to ensure responsiveness, which links back to the reluctance to use contractual levers to increase responsiveness (Section 5.3.1). Contractual arrangements to improve responsiveness were viewed as a blunt tool by the elite interviewees that, if used, might risk undermining the commitment and mind-set that comes with stability (Section 4.5.2.1). Similarly, some strategic-level interviewees were concerned about the short-term nature of some policies and contracts, and how this could affect responsiveness.

“The GMS [general medical services] contracts are in perpetuity contracts. So they’ll run for as long as the GP lives actually, as long as they can work there, but those kind of contracts really do engage a commitment to the local population, whereas these five-year contracts [...] they just don’t have time to build that sort of commitment and relationship with the local community before they find that they’ve got to re-apply for the contract.” SS09, CEO, CCG

Another national example was the move towards the creation of GP federations. Whilst interviewees in general practice spoke positively about federating (Section 5.3.3), some CCG staff appeared to be more circumspect. They spoke of the difficulties in getting single-handed GPs to work together “because they haven’t been able to work with anybody else” (SS12, delivery, CCG), the breakdown of GPs’ tacit knowledge of their communities (Polanyi & Sen 2009), and the consequences of employing a tick-box mentality within larger organisations.

“I think there’s always a problem with trying to corporatise healthcare. You can approach it not just like a tick-box, but you know, is the patient satisfied? You
approach it via some very fixed criteria and head office looks at that and says, ‘Well done’, and sort of pats you on the shoulder…” SS06, public health, local authority

Whilst GP practice staff felt that federating was a positive way to implement responsiveness and a way to potentially mitigate the effects of competition (Section 5.3.3), CCG staff felt that there was a long-standing problem due to competitiveness between practices.

“So we are looking at the more holistic basis. Federation I think is definitely coming, but the question being how far is it going to go? I think they are very embedded in the way they do things and I think you will find that GPs are very protective, and they are protective because in the past there was always a competitive edge.” SS10, CEO, CCG

NHS-wide organisational change was also cited as in conflict with the goals of responsiveness. With staff’s attention drawn towards reorganisation and an upcoming general election at the time of the interviews, participants felt that this distracted them from delivering a responsive service.

“I think any time that we have change, particularly the sort of scale of changes that we have, it creates a kind of disruption in the service and one of the things that invariably suffers at that time, is that people get very focused on sorting out the internal arrangements and that takes the eye off some of the externality, that a more settled system has in place.” SS06, public health, local authority

5.6 Summary of strategic staff participants’ perspectives

Interviews with 12 members of staff in strategic roles in general practice, public health and CCGs revealed that both GP practices and mid-level organisations provided environments where staff were supportive of the concept of responsiveness. There was evidence that strategic staff shared the values of primary care espoused by policymakers, and similarly saw responsiveness as a way to attain goals aligned with the core
values of primary care. Participants felt that organisational commitment was important and prioritisation of responsiveness was seen as key.

As well as identifying responsiveness as important, this chapter has shed light onto the strategies used to facilitate responsiveness and the challenges that are met by staff in CCGs and strategic roles in GP practices and federations. Strategies to implement responsiveness were seen as most effective when they aligned with achieving core values, although they had their limitations. The nature of targets meant that they were prioritised over non-incentivised activities and could shift attention away from “ordinary primary care”. Even when elements of responsiveness were incentivised, they were sometimes in direct conflict with each other. Responsiveness could sometimes become overwhelmed and crushed by conflicting targets, conflicting pressures, and organisational change.

Whilst the focus of targets was on monetary rewards, not all incentives were financial. CCG staff found that appeals to professionals’ intrinsic motivations could be helpful. However, soft tactics were seen, by CCG staff, as more appropriate than targets for promoting and delivering responsiveness on the ground. Neither the usual private sector levers (competition forcing improvements) nor the usual public sector levers (command and control, and incentive-based variants) were felt to be effective, and so alternatives, such as values-based ‘sermons’ (Bemelmans-Videc et al. 1998, Gormley Jr 1989) and, more often, encouragement, ‘soft’ incentives, and making positive use of peer influence were required.

Strategic interviewees did not refer to any responsiveness-specific policies. It is unclear whether this was because I did not ask about this or because interviewees were unaware of their existence. If the latter, it appears that interviewees drew on their or their organisations’ values when describing the importance of responsiveness and the ways in which implementation could (or should) be encouraged. In light of the framework of the core values of general practice (Section 1.2), strategic staff views indicate that that responsiveness might be viewed as a tactic to achieve the core values of general practice.
In conclusion, this chapter has addressed the research question as to how the concept of responsiveness as espoused in policy was viewed and responded to by meso-level actors in organisations with strategic responsibilities. Although they did not reference specific policy documents, strategic staff responded to their perceived need for responsiveness through: accepting responsibility for implementation; working towards supportive relationships with organisations both within and beyond the health sector; and engaging with patients to listen to their views. Strategic staff spoke of the ways in which targets could help and hinder implementation, and the challenges of conflicting pressures and organisational change.

In the next chapter I consider the view from the frontline and present my findings from interviews with GP practice staff.
6 Making responsiveness a reality: general practice staff perspectives

In this chapter I present the findings from the interviews with frontline staff in GP practices. The interviews were conducted as part of the NIHR study (of the 21 interviews, I conducted eleven, see Preface) and I conducted a secondary analysis in the context of my doctoral research questions. The purpose of this analysis was to understand the views of patient-facing staff about the ways in which they were responsive (or not) to their patient populations, and to ascertain how responsiveness policy had been translated into practice.

First, I describe the sample of practices and interviewees who took part in the NIHR study, from whom I collected my data. Staff’s descriptions of their attitudes to responsiveness as a tactic to achieve goals aligned with core values in general practice comprise the second section. Third, I consider how practice staff implemented responsiveness, for their patient population as a whole, and for specific patient groups. I also present the ways in which staff attempted to balance the needs and preferences of patients who have varying expectations with a scarcity of resources. I consider various implementation strategies employed by staff when trying to implement responsiveness, including taking responsibility, cooperation and patient engagement. I discuss the challenges of targets and incentives, and evolving national and local contexts. Finally, I use the case of patient participation groups (PPGs) to demonstrate a practical way in which staff employed patient involvement to help their practices provide a responsive service.

6.1 Participating GP practices

Thirteen primary care organisations (PCOs) within Leicester, Leicestershire and Northamptonshire were recruited for the NIHR study (Tarrant et al. 2014), including GP practices, a walk-in centre, and pharmacies. In collaboration with the PCRN-EMSY, a variety of PCOs were selected with differing key socio-economic characteristics, e.g.
the sample included an inner city practice with a high BME population, a practice in an affluent rural area, a practice in a mixed suburban area, and a practice in a deprived council estate. For the purposes of this thesis I have based my analysis on mainstream GP practices only (n=9). Of these nine, one large inner city practice was part of a Health and Social Care Centre, and one small inner city practice was owned and managed by a large private company (Table 9).

<table>
<thead>
<tr>
<th>Location</th>
<th>Small</th>
<th>Medium</th>
<th>Large</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner city</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Town centre</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Urban</td>
<td>1</td>
<td></td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

*A small practice had fewer than 5,000 registered patients, a medium practice had between 5,001 and 10,000 patients, and a large practice had more than 10,000 patients.

Table 9: The nine mainstream GP practices that took part in the NIHR study

Levels of deprivation for practice populations are difficult to ascertain but the Index of Multiple Deprivation (IMD) score for a practice address acts as a good proxy (Strong et al. 2006). An IMD score is an overall measure of multiple deprivation experienced by people living in an area. It is a composite score based on 38 indicators grouped in seven domains: income; employment; health and disability; education, skills and training; barriers to housing and other services; crime; and living environment. Each domain’s contribution to the overall score is weighted differently, with income and employment deprivation weighted most heavily (Public Health England 2010). The

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22 Mainstream practices excluded a specialist practice for homeless patients.
23 The Health and Social Care Centre provided general practice, social care and community services under one roof.
24 Whilst most GP practices are private companies, this organisation differed in that it aimed to bring together clinical knowledge and business expertise, allowing clinical teams to concentrate on providing locally-tailored high quality care with support from the central office for administrative and corporate functions such as HR, legal services, IT, governance, finance and marketing. At the time of writing, the company held contracts for over 50 surgeries and GP-led health centres, delivered over 120 community outpatient clinics, and saw more than one million patients per year.
The diversity of IMD scores (Public Health England 2016) for the mainstream GP practices recruited to the NIHR study are shown in Figure 5, and these compare with lowest score in England of 2.9, the average of 21.5, and the highest of 68.4 (as at February 2014).

![Figure 5: IMD score (based on data in 2010) for GP practices in the NIHR study](image)

The data available on the Practice Profiles website (Public Health England 2016) were insufficient to display ethnicity for the practices. Information received directly from the practices showed that their registered lists included a variety of ethnicities, for instance practices with high proportions of South Asian patients (Indian, Pakistani, Bangladeshi), practices with a growing proportion of Eastern Europeans, and others with varying proportions of other ethnicities such as Black African, Black Caribbean and Chinese.

### 6.2 Interviewees

Twenty-one interviews were conducted with staff in management or service delivery roles across the nine practices to explore their views on the meaning and delivery of responsive primary care (Table 10, overleaf). Two or three members of staff were recruited from each practice. One of the practices was part of a network of practices run by a large private company, so a member of staff at the company head office was also included in the sample. The number of years that staff had worked in
practices varied: less than 1 year (4 members of staff), 1-4 years (9 members of staff), 5-9 years (7 members of staff), 10 or more years (3 members of staff). Three members of staff defined themselves as South Asian, the remainder as White British.

<table>
<thead>
<tr>
<th>Job role</th>
<th>Gender</th>
<th>18-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
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<tr>
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<tr>
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<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Receptionist</td>
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<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Head office</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td></td>
<td>21</td>
</tr>
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</table>

Table 10: General practice staff interviewee characteristics

Staff were questioned about what responsiveness meant to them in the context of their GP practice, the ways in which their practice could demonstrate being responsive, difficulties in implementing responsiveness, ways in which responsiveness might be improved at their practice, and their views on ways to measure responsiveness (see topic guide in Appendix 12).

6.3 What is responsiveness seen to be achieving?

Members of staff considered responsiveness to be important. I identified three main reasons why staff felt they should be responsive. First, staff appeared to be interested in developing and maintaining good relationships with patients and viewed these relationships as the primary reason to be responsive. Staff cited “old-fashioned” values (S06, practice manager, PCO11), and “old school” training (S09, GP, PCO08). They felt that this stood them in good stead, that patients always came first, and that this had always been the case and would continue to be so. Some practices took a “family-run” approach where everyone helped each other out resulting in what they saw as a high-quality service for patients (S14, receptionist, PCO04). Staff emphasised the
importance of responsiveness through a discourse of patient satisfaction: members of staff wanted patients to feel safe and secure, so that when patients visited the GP practice, they felt assured that their needs would be met. Staff viewed patient satisfaction as an end in its own right – not a means to better ratings from outside authorities, e.g. the PCT, CCG or CQC, nor to give them a competitive edge against other practices that might be less responsive (Section 5.3.3).

“Yes [responsiveness is important] definitely yes, because we want patients to walk through the door, knowing that, as they walk in, they have come to a place where they can be happy, safe, because obviously confidentiality – we are very big on that – and that they get what they came in for and leave happy.”

S14, receptionist, PCO04

Fairness was seen as the second aspiration. Staff understood that each patient list was different, so the priorities and approaches for providing care should necessarily be tailored for each practice to match the specific needs of their patient population. They also recognised that, within a practice, there were diverse groups of patients with differing needs. Staff wanted everyone to receive the same standard of care, regardless of patients’ backgrounds and needs.

“We have got quite a diverse patient population and, if you just look at the waiting room full of patients, they come from all walks of life and with various abilities and disabilities. I think we try to aim to provide the same standard of care to everyone really.” S15, GP, PCO04

Finally, staff also considered business needs to be important. Two members of staff from the same practice and a member staff at its head office (of the large private company that owned multiple practices) felt that being responsive was an effective way to use market mechanisms to retain and grow their patient list “because otherwise you can’t run a business” (S26, receptionist, PCO13) or patients “are going to go elsewhere” (S25, practice manager, PCO13). Thus responsiveness was seen as important as a way to achieve core values but also important as part of a business model based on attracting and retaining customers.
“Yes, well I mean for us, the marker of whether we do a good job is do our list sizes increase.” S27, head office, PCO13

Staff used business needs as a justification to weigh up the various needs of patients within a practice. Staff also used the definition of wants (Bradshaw’s felt and expressed needs (Bradshaw et al. 2013)) and needs (Bradshaw’s normative needs (Bradshaw et al. 2013)) to filter out those needs that they considered to be low priority. This will be considered in more detail in Section 6.4.3.

“I would have thought [responsiveness] means without using the word in the definition, responding to the, hopefully the needs not the wants of our patients. So it’s reflecting on their needs and then trying to see within our budgetary constraints if we can meet those.” S02, GP, PCO01

6.4 Understanding and meeting the needs of patients

Staff were rarely able to describe the concept of responsiveness in a definitive and discrete way. They described what they did, or what they felt they should be doing, and then linked their actions with being responsive, thus describing the concept performatively rather than as a feature of the design of the organisation or systems, or staff’s values or patients’ experiences. My analysis revealed that staff approached responsiveness in two main ways.

First, they tried to ensure that the characteristics of responsiveness, such as providing good customer service and being flexible, were in place so that all the patients on their registered lists could have their needs met. I term this universal responsiveness as it can be applied to all groups of patients (in an equitable way) and requires no additional visible resources to make it work, although there may be hidden costs within the practice budget for items such as a new telephone system or staff training. Second, staff described making extra efforts to meet the demands of patient groups identified as having particular needs – those considered vulnerable or disadvantaged, who possessed certain demographic characteristics, or whom had complex health needs that could be difficult to respond to within the constraints of standard practice policies and systems. This I term targeted responsiveness as it requires proactivity on
the part of the practice and its staff. To be responsive in this way, the practice and its staff must make extra efforts, potentially at cost, to meet the needs of these recognised groups. These two types of responsiveness are not mutually exclusive; most staff described both as principles underlying the delivery of services in their practices. I consider each in turn.

6.4.1 Universal responsiveness
My analysis revealed that staff perceived universal responsiveness to have two explicit characteristics of service design and delivery: providing a good customer service (see also Sections 1.3.1.1 and 2.3.2); and allowing patients to access services in a flexible way (see also Sections 1.3.1.1 and 2.3.1). One interviewee also felt that the practice environment was important.

6.4.1.1 Customer service
Staff described high quality responsive customer service in terms of the types of services provided. They referred to various traits of an effective client-facing organisation, such as answering queries in a timely way, giving advice when asked and sometimes proactively, and dealing with complaints and informing patients of the outcomes. Whilst these traits may not necessarily be cost-free, they would usually form part of the expected running costs of a practice.

“So responsiveness is dealing with the problem I think as fast and as promptly as you can.” S03, practice manager, PCO08

Interviewees also described the attitudes that are required of the practice staff to ensure that good relationships with patients were built and maintained. Staff felt that they should be willing to be flexible, particularly when people are facing difficulties, and should always treat people as individuals rather than as a problem that needs to be neutralised (contrast with the language used in the excerpt above where solving the problem took precedence over providing individualised care).

“I can see [staff] saying the wrong thing, doing the wrong thing, and if they were on the other side of the counter, they would get annoyed by it. [...] Things they perhaps shouldn’t do, [...] saying ‘no’ to patients which, if you treat them
as a customer, you just don’t say ‘no, I don’t do that’, or ‘I can’t help you’ but ‘I will find someone who can’....” S01, practice manager, PCO01

6.4.1.2 Flexible access

Members of staff felt that offering a degree of flexibility and being proactive in helping patients to get appropriate care was an important element of responsiveness. To enable this to work successfully, staff suggested that practices should have appointment systems that allowed patients to book appointments that suited them. They also felt that knowledgeable staff should be able to help patients to access services outside of the GP practice and that staff should be able to signpost patients effectively.

“I would say a patient would ring the surgery and expect to be seen within a reasonable time frame; we do have on the day emergency bookings but we also have book ahead appointments...” S14, receptionist, PCO04

However, some practice staff felt that there should be a limit to their flexibility as they felt that not all patient expectations were legitimate or reasonable – only normative needs were considered legitimate (Bradshaw et al. 2013).

“...we will never meet patient demands which are becoming increasingly more and more, I can’t think of the word, they are becoming more outrageous to be honest with you.” S20, practice manager, PCO10

6.4.2 Targeted responsiveness

In addition to universal responsiveness, members of staff felt that specific groups of patients may be disadvantaged in their access to, and experience of, general practice, and that extra effort was required on the part of the practice to provide appropriate and accessible services targeted at these groups. In these accounts, staff considered responsiveness to be about how the practice met the needs and preferences of particular groups of patients, with the aim of responding to diversity and/or reducing inequalities (see also Sections 1.3.1.2 and 2.3.3.2).

“...there is such a diverse range of disabilities so whereas [...], generalising, the Romany population [...] don’t have good literacy rates and can’t speak English
so we know what to do about that, with people with disabilities it’s covering such a huge scope, [...] so it’s maybe that education [for staff] about the range of issues that may be faced, that may challenge [...], to make sure that we try and consider things from the perspectives of every one of our patients” S27, PCO13, head office

Staff defined groups of patients who were deserving of particular attention according to their: characteristics; illnesses, conditions and disabilities; and situation, location and lifestyle. I consider each in turn.

First, all members of staff talked about meeting the needs of patients with diverse characteristics: older people; people from a BME background with associated cultural differences; non-English speakers; people with low literacy; vulnerable people, including those with low social skills or memory problems; lesbian, gay, bisexual or transsexual (LGBT) people; men; women; pregnant women or mothers with young children; and young people and children. These groups cover 100% of the population, so it is worth noting that there was a very expansive notion of the groups that might have particular needs. Staff felt that these groups were deserving of extra efforts from the practice to ensure their needs were met.

“Personally I would like to be more responsive to the elderly. I think they have very complex medical needs and are often not as appropriately demanding on a service as they should be, they should be calling more often but they are of a nature where [...] they will forever apologise for asking for a home visit when it’s perfectly acceptable to ask for one.” S02, GP, PCO01

Second, most members of staff felt that the needs of patients with certain illnesses, conditions and disabilities should be taken into account in attempts to be responsive. These included patients who are blind, partially sighted, deaf or hard of hearing, have a physical disability or a learning difficulty, suffer from mental illness, have problems with drug use or alcoholism, and have specific conditions such as cancer, diabetes or epilepsy.
“...our receptionists are brilliant. We have got a lady, a blind lady who has a guide dog, and although she knows the practice very well because she has been coming here for years, receptionists will put a note on the screen to say to actually go out into the waiting room to fetch her, or they will actually walk her round to your room and things, so things like that I think, works...” S15, GP, PCO04

Third, most members of staff referred to how the situation, location and lifestyles of patients affected their views of the responsibilities of the practice to focus on meeting specific needs. Groups who were seen to face particular problems and be deserving of extra effort from the practice, including those who were carers or were living in deprivation or were homeless, immigrants, sex workers, travellers and ex-prisoners, were all in particular need of responsiveness.

“Initially I set up the carers register [...] and now we have a specific carer support worker so any GP can refer to [individual], she comes in every Wednesday and she takes it from there, contacts the carers, and basically they have an assessment she lets them know what the benefits are due to them, where they can go for support, so that’s been really good.” S20, practice manager, PCO10

In some cases staff cited specific ‘exceptional’ policies where staff were permitted to bend the rules to be more facilitative and supportive towards those they perceived as most needy and deserving (e.g. people with cancer, the elderly), whereas less flexibility was exercised for the general patient population.

“Well we all see under-ones, if a mum rang up and said, ‘my baby is poorly’, we would ask how old they were and if they were under one, they would be put in, even if there wasn’t an appointment.” S06, practice manager, PCO11

6.4.2.1 Opposing views

Not all members of staff felt that targeted responsiveness was necessary (quotes in this section are unlabelled to further protect identities). Some explicitly expressed their conviction that responsiveness was for everyone and that consideration for
different patient groups was not a principle that governed their behaviour. They felt that all patients were equally entitled to a high quality responsive service and saw no need for exceptional policies for certain patient groups. In these cases, staff appeared to hold overlapping views of responsiveness: to enable them to provide a universally responsive and inclusive service to everyone, they perhaps had to treat people differently, according to their needs.

“I certainly don’t have a specific focus group for that [gay, lesbian and bisexual] community. Those with disability, again, we provide exactly the same service to everyone else really.”

One member of staff did not accept responsiveness as a legitimate goal and he felt that the majority of practices like his that “are close to the national averages, in all parameters” should have no need to be responsive to particular groups of patients. However, he compared general practice to a supermarket chain, and expressed the misperception that such companies employ a one-size-fits all approach, when in fact they understand that their populations vary:

“…the NHS seems to take an odd view [...] that every locality is different, where if you compared it with say other national organisations like retailers, they don’t take the view that every locality is different. Every branch of Tesco is going to be [the same as] every other branch.”

It is unclear why this practice was an outlier (in addition to the practice manager, the receptionist was, at best, indifferent about responsiveness), but I would suggest that a combination of its rural habitat and thus predictable patient population, coupled with the strong views of the practice manager gave rise to a practice culture that was apparently incompatible with the goals of responsiveness.

6.4.3 Tensions in delivering responsive care

Staff spoke of tensions in the delivery of responsive care within their GP practices: how to balance the needs of the many (universal responsiveness) with the needs of the few (targeted responsiveness), and how to manage patients’ expectations.
First, as well as making decisions about which services to provide in their practices, staff felt they needed to decide to whom these services should be provided. With a limited budget and limited time available, staff had to trade off the needs of their broad patient population against the needs of specific patient groups. Staff were not necessarily wedded to either universal or targeted responsiveness but appeared to be continually negotiating a balance between the two (Figure 6, overleaf), questioning the legitimacy and priority of claims on their time and resources (Sections 4.4.1 and 6.4.1.2), and whether providing for a need was incentivised through targets or other means.

When making these judgements, staff recognised that their decisions about where to invest efforts could be affected by patients who were very vocal, e.g. members of the PPG. However, some staff were aware that the most vulnerable patients could be easily overlooked, and made special efforts to listen to them or to predict their needs.
“...people with disabilities are probably overlooked in general, by the PCTs we work with, as a hard-to-reach group, I guess because there aren’t pockets of them, like in various geographical areas you know that is your target group that you need to be managing.” S27, head office, PCO13

Given these tensions, staff had to make decisions about how to distribute resources to provide for these sometimes competing needs. Meeting the needs of the many could mean struggling to turn their time and resources towards meeting the needs of the few.

“...next year the budgets are being cut by about 5% for referrals so that means, how would it be done? Should it be done by making everybody wait basically three weeks longer? Or should [...] you just turn down certain categories of referrals? Disallowing them for debatable reasons?” S07, practice manager, PCO12

However, staff also described how they felt that some recipients of targeted responsiveness were (either unintentionally or deliberately) thwarting staff’s efforts to be responsive to them. They described how these patients might lead chaotic lifestyles or not understand the systems, or how they may be travellers or those who reside in the area for only a short time. Staff felt that patients who were demanding, aggressive or rude could hinder responsiveness, as could patients who did not attend their appointments or did not follow rules or read signs.

“...we try to address patient privacy by putting up the sign in reception, you know, ‘queue here’ [...]. But a lot of people take absolutely no notice, whether they can’t take in what they have read or, I don’t know, but you have to ask them, ‘would it be alright if you just stood back, because potentially you are causing this person embarrassment...’” S01, practice manager, PCO01

Such situational or behavioural traits may have fed into the processes with which staff engaged when prioritising patients, basing their judgements about who is the neediest and the most deserving of special treatment on these perceived negative traits (labelled as legitimacy in Figure 6).
“They want an appointment today [...] and their attitude is we have to give it because we are there to serve them. [...] It annoys me. It annoys me because we are trying to offer the best service, and we don’t need to get abused every day. And we do, on a daily basis.” S25, practice manager, PCO13

Second, where patients’ expectations were seen as unrealistic or, even where legitimate, it was not always possible for the practice to respond to these expectations, owing to practical or resource constraints.

“Well I don’t think we are very responsive and I don’t see how we can do better. [...] They want too much. [...] Yes, they want too much or maybe their expectations aren’t unreasonable, people pay their taxes, they feel they have this free service and there is no limit placed to anything, which is unrealistic.” S07, practice manager, PCO12

Practices’ responses to these expectations are explored further in the following section.

6.5 Implementation strategies

Staff spoke of how they engaged with several approaches to implementing responsiveness in their practices. Although not made explicit in their accounts, practice staff appeared to take full responsibility for being responsive to their populations. They spoke of various approaches to enacting this responsibility: working in teams both within and outside of the practice; using targets as a way to benefit patients; and working with patients to improve and demonstrate responsiveness. However, these strategies were not always unproblematic and staff faced challenges with operationalising them.

6.5.1 Taking responsibility and working together

In contrast to the elite and strategic staff accounts, staff at the frontline in general practice did not give examples of how legislation, localism and patient choice enabled responsiveness. However, they provided numerous examples of cooperation and the benefits of a good staff culture, such as sharing good practice and working in teams, both within and beyond the practice (see Sections 2.4.2.2, 2.4.3, 4.5.2.1, 4.5.3, and
Staff were of the opinion that a positive practice culture facilitated improvement in responsiveness. Staff felt that, to enable a supportive and effective practice culture, they had to be creative and honest, and share good practice with each other including those at other sites within a federation or group of practices.

“If you have got good practice on something in your surgery, because they [the company] have got so many surgeries now, and some are quite bad, up north and things, they do ask us, ‘what do you do in this situation?’, to then try and implement that at other sites.” S25, practice manager, PCO13

Interviewees described how practices needed skilled professional staff – those who were in their jobs for the right reasons (who had high levels of intrinsic motivation, see also Sections 2.4.2.3, 4.5.2, and 5.4.1), and who were well-trained and committed. Analogies such as family and community were common in staff accounts.

“…we are a family, that is how we like to think of it, and I have always said that reception is the kitchen in the house, because everybody seems to go into reception, doctors, visitors, other people, all sort of culminate into reception [...] If it’s a good surgery, and I have to say this is one of the best [...], it’s over the years, the bonds form and it just happens.” S14, receptionist, PCO04

Equally, a lack of interpersonal skills and good practice culture hindered responsiveness, according to the interviewees. Examples included differences between the cultures of the patients and the staff who provided the service and hence staff having difficulties engaging with a cross-section of patients. Staff who lacked skills or training in communicating, or who lacked confidence, faced difficulties in practising responsiveness.

“We have got different levels of confidence and ability in the practice managers and when you are talking about [lots of] sites, obviously there are some that probably aren’t as responsive to their patients as any one of us would hope that they would be.” S27, head office, PCO13
As well as interpersonal qualities, staff spoke of systems that could facilitate responsiveness. These included having contracts and/or good relationships with helpful external organisations (pharmacies, social services, etc), allowing free movement of patients between practice sites in a federation or network of practices, implementing effective information flow systems, planning in advance, and having active training programmes for staff. These systems were not in place at every practice. Systems worked best when staff were proactive, persistent, and worked together.

“...the nurse has got access to all three sites, it is like last week when our nurse was off, and the patients needed travel vaccinations and they were going before the nurse comes back, we sent them to the other surgery, and the nurse just logged on to [that site]...” S16, receptionist, PCO06

In contrast, a lack of cooperation and support was cited as antithetical to responsiveness, especially if that lack of support was across hierarchies.

“...the health authority. They are a very difficult bunch to deal with. [...] I don’t feel like I have got much support, they are asking for something but not willing to cooperate with me and help when it’s something that I don’t really know anything about.” S20, practice manager, PCO10

6.5.2 Targets and context

Staff provided very few examples of where targets and incentives had a positive influence on responsiveness. However, one member of staff spoke of their satisfaction when a target was reached, illustrating how targets can focus attention on working to address important issues (Section 5.4.1). Another expressed their disappointment when targets were missed, demonstrating the effort that staff put into meeting such targets (sometimes leading to staff burnout, Section 5.4.2). One interviewee felt that targets could be good for patients, but that resources to meet those targets were scarce:

“...sometimes the paperwork is so horrendous, you need to really employ somebody else to do some paperwork for you and you haven’t got that resource, so it puts more pressure and strain.” S03, practice manager, PCO08
More often, staff spoke of problems in terms of “silly” rules and targets (S07, practice manager, PCO12), especially in the context of spiralling costs and a lack of time and resources. These staff members felt that responding to external impositions impeded responsiveness to their local communities.

“We have got evening surgeries for people who work, because we are having to do that, government wants everyone to open late, and for us it doesn’t work. We get so many patients who don’t turn up in the evening [...] there is no need for it, we are only doing it because the government wants us to do it.” S09, GP, PCO08

An interviewee at one practice described how they reacted to such a target, demonstrating local creativity, but perhaps not in the way that the policies and elite interviewees would have anticipated (Sections 2.4.2.3 and 4.5.2.2):

“...that was the first thing we stopped when we came here, because we thought this is stupid, it might be what the rules want but it’s just stupid, it’s like somebody telling you to drive on the wrong side of the road, it’s stupid, really is.” S07, practice manager, PCO12

Thus, despite being a prominent feature of the previous two chapters, incentives seemed to be largely absent from frontline staff’s accounts, providing further support to a key finding of this thesis: that there are alignments and misalignments between different tactics that encourage responsiveness at different levels, and often an incongruence between the tactics that should, in theory, all be acting as enablers.

Frontline staff also described similar contextual barriers to responsiveness as the strategic staff, namely the conflicting pressures of finances and resources and the organisational change (Section 5.5).

“...it changes, it’s like shifting sands [...]. The PCT give new rulings and new ways of doing things, it changes, and you have to meet the changes. And it is difficult sometimes, and it is difficult to meet them at the timeframe you’re asked to meet them, but we have to do that.” S14, receptionist, PCO04
Staff also blamed workload and environmental barriers – small buildings were unable to cope with increasing list sizes and rising demand. In addition, at the time of the interviews (March – July 2011), the NHS was undergoing a process of restructuring which staff felt was counter-productive to a responsive service.

“I think the biggest brick wall is the pace of change that is happening in the NHS, it’s that is definitely a big brick wall because we are trying to deliver a good service but at the same time there is, we are having to make sure that we are complying with all the changes that are happening.” S09, GP, PC008

6.5.3 Patient education and shaping patients’ behaviour

Alongside taking responsibility, cooperation and targets, changing patients’ behaviour was seen as important for responsiveness. A prominent example was explaining to patients about the unfeasibility of providing for all their desires (such as seeing the doctor of their choice at short notice). Staff felt, in these circumstances, that it was important to educate patients about what was feasible, both in terms of budget constraints and limitations due to national and local systems. In times of austerity and budget cuts, staff wanted patients to understand that their expectations were not always realistic, so staff made efforts to re-align expectations to what they considered to be reasonable. Staff felt that there would be positive knock-on benefits of freeing up resources to be more responsive to other patients. These educational approaches were not always successful, and some interviewees felt it was difficult to align expectations (Bradshaw’s felt and expressed needs (Bradshaw et al. 2013)) with what the practice viewed as legitimate needs (normative needs (Bradshaw et al. 2013)).

“...there is that fine line between need and expectation, then again, need and expectation sometimes do meet in the middle. [...] It’s difficult to explain to people that actually there are lots and lots of appointments however they are filled by other patients [...] I guess that goes in some way to understanding the health needs of others as well as the health needs for yourself and as a community and as a whole as opposed to an individual.” S17, GP, PC010

Staff also wanted to educate patients about appropriate ways to access and use the services they provided, e.g. by triaging patients, and giving same-day appointments to
those who needed it and convenient appointments in the future for those who could wait. Staff described how some patients (often but not exclusively migrants) did not understand how general practice operated. Staff also explained how they made efforts to reach the patients that they considered to be potential inappropriate users of services, highlighting how patients could make life easier for both themselves and the practice. Conversely, they also wished to encourage patients to take up services that were under-used by particular groups of patients. Whilst these educational interventions might not be part of responsiveness per se, staff felt that education was necessary to facilitate a responsive service.

“We also work well with [a local organisation]. They have a magazine, so we have regular features in there how to make appointments, how to get their prescriptions and I think that’s getting information out to patients, how we can help them, and how they can help us.” S09, GP, PCO08

Staff reported that patients could help to facilitate the provision of a responsive service through being a good patient – a patient who provides positive feedback or is willing to be educated, or a patient who has been successfully educated about how to make the best use of the practice’s services, as described above. All of these efforts feed into the challenge of assessing the legitimacy of a patient’s claim on staff’s time and resources (Figure 6, page 176).

Due to its complexity, patient and public involvement as a facilitator for responsiveness through patient feedback and PPGs is considered separately in the following section.

6.6 Achieving responsiveness through patient and public involvement

In their interviews, staff spoke extensively about how patient and public involvement could enable responsiveness. Patient and public involvement can be used as a way to understand patients’ needs (as included in the definition of responsiveness), but it can also be about understanding how best to meet those needs. Due to its complexity (confirmed in the literature (Li et al. 2015)), and prevalence in policy (Section 2.4.5),
the elite interviews (Section 4.5.5), and strategic staff interviews (Section 5.3.4), I have devoted a stand-alone section of my findings to it rather than considering it alongside other facilitators in Section 6.5.3.

Staff accounts demonstrated that patient involvement is a valuable strategy when it involves working collaboratively and building relationships based on shared commitment to working towards enacting their values through responsiveness. Staff felt that, to be responsive, practices should involve patients by: listening to their complaints and suggestions; engaging with the local community and providing information; and setting up and working with PPGs. PPGs are of particular interest as they are given as examples, in some policy documents, of an incentivised way to be responsive to patients (i.e. the DES in 2008 (NHS Primary Care Contracting 2008a)) and, amongst patient involvement enthusiasts (e.g. NAPP) as fundamental for improving responsiveness (Box 2008, National Association for Patient Participation 2016). PPGs provide a case study of whether and how something that is externally incentivised can be made to be compatible with responding to the bottom-up impetus from patients, which is a key tension throughout my findings. In the following sections I consider how these can be reconciled effectively and the extent to which they conflict with each other.

6.6.1 Listening to patients and community engagement

According to staff, listening to patients involved two-way conversations. Staff described activities such as actively monitoring and seeking feedback (although they acknowledged that sometimes those they wished to hear from were those whom were unlikely to engage in this way, e.g. people with learning disabilities). These activities could take the form of asking patients to complete an evaluation card after their consultation, distributing formal surveys, engaging in opportunistic conversations with patients, or providing an anonymous suggestion box for patients to post their complaints and suggestions. Examples of everyday suggestions from patients included:

25 The remit of patient participation groups (PPGs), sometimes known as patient reference groups, varies between practices. However, the National Association for Patient Participation (NAPP) provided sample terms of reference which describe the ways in which a PPG can support a GP practice (Appendix 19).
changing the appointment systems; putting a clock up in the waiting room; and installing chairs in the waiting rooms that were suitable for people with back pain.

“[The GP Patient Survey] shows us areas where we need to work on, again one thing that always comes up is the access to the phones and we are looking into getting extra lines put in and having a direct service so you get directed to different places for different issues...”  S04, practice manager, PCO06

When systems were modified or reconfigured in response to complaints or suggestions from patients, staff felt it was important to tell patients about these changes so patients could adjust their activities accordingly. Another tactic cited by interviewees was having staff available within the practice for patients to approach informally. Some staff were not afraid to make themselves vulnerable to these opportunistic complaints from patients, and armed themselves with strategies to respond on the spot.

“...I have actually been accosted many a time when I walk out, because I am not afraid to actually walk out into them and be picked up. [...] Whenever I get a complaint that says ‘can’t get through’, that kind of thing, I immediately use [these leaflets] to show them this new service and they think, ‘oh great we have got an answer’ and I can actually turn a complaint into a useful method of transmitting the news...” S01, practice manager, PCO01

As well as employing listening and responding tactics within the practice environment, staff reached out to the wider community and worked with other organisations (Section 6.5.1) to assess patients’ needs and to take into account the demographics of the local area.

“...the key thing there, again, it’s about engaging with the PCT and then the local community, so we work very closely with the bail hostels, and with the prison, with the housing association, to support... Everybody supports each other in trying to take care of these patients.” S27, head office, PCO13

6.6.2 Patient participation groups

PPGs featured prominently in staff’s accounts of using patient engagement and involvement to be responsive: in response to top-down targets for financial reward
and expectations from performance managing organisations; and bottom-up as a way to engage with patients to find out what they wanted and needed. However, narratives of working with PPGs suggested that their role in promoting responsiveness was not unproblematic. First, there were issues for the practices in ensuring that the PPGs were representative of their patient populations. Second, the assumed roles of the PPGs and the relationships between PPGs and practices affected their ability to be responsive; following policies and meeting targets was relatively easy but ensuring that a PPG was effective in contributing to the realisation of responsiveness was not straightforward.

6.6.2.1 PPG representativeness

Some practices were aiming to be inclusive and successfully made attempts to include the diversity of their practice populations. These PPGs involved people who had disabilities or specific health needs, or who might not usually volunteer, e.g. young people and new parents. Whilst they may not have been entirely representative, these groups were seen by staff to possess tacit knowledge of the patients on the practice list and, in the views of staff, had made efforts to ensure that membership had been drawn from the breadth of patient demographics.

“I think typically it’s the sort of patients that we maybe want to hear from more that don’t put themselves forward for that sort of thing. So I suppose it’s ways of looking at different groups to get involved in that sort of thing would be quite helpful.” S15, GP, PC004

On the other hand, some interviewees were disappointed that their PPGs were unrepresentative of their practice populations which they felt rendered the PPGs as unproductive. Such PPGs comprised a homogenous membership which staff felt may be viewed as biased or ineffective. Similarly, a practice manager described a previous PPG she had set up which, she felt, had an overly-demanding membership and a chair who expressed racist views, and accused the manager of being racist when she said no to his requests. This practice manager expressed concern about setting up a new group at her current practice because of her previous experience. She felt that such a group may have proved to be more of an obstacle than a helpful source of suggestions for
improvement. Whilst practices like these had managed to achieve the target to set up a PPG, the groups’ usefulness, both as a way to be responsive and to demonstrate being responsive, was questionable.

### 6.6.2.2 PPG roles and relationships with practices

The roles and subsequent achievements of the PPGs varied between practices, as did the nature of the relationship between a given practice and its PPG. I developed a classification of PPG roles as a helpful way to characterise the various functions of the PPGs described in the staff’s accounts. The classification includes roles that were participative, complaining, channelling, consultative, and disseminating. These roles have emerged as part of the PPGs’ relationships and negotiations with their practices, as viewed by practice staff. Staff described the ways in which their practice and PPG interacted with each other and negotiated needs and expectations. These functional categories of PPGs’ roles are by no means exclusive; indeed one PPG might exhibit two or more roles, and these roles can overlap (e.g. complaining as a form of being participative that can bring about changes). In addition, the classification may not be exhaustive due to the small sample size; indeed it is based on the views of staff, and excludes the views of the PPG members and of the wider patient population. The classification does not address the role and remit of the PPGs, nor the activities they employed (see, for instance, Pollard et al. for a descriptive study of PPG members’ views (Pollard et al. 2014)). It also does not seek to describe the wider structures of PPI within the NHS (e.g. see Gibson et al. for ways in which the nature of PPI can be conceptualised within a four-dimensional framework (Gibson et al. 2012)). Rather it suggests some ways in which staff may perceive the value of PPGs as a means to improve the responsiveness of their GP practices, and it may be a useful way to characterise some of the possible ways in which staff experience PPGs operating in the context of responsiveness in general practices. The classification is summarised in Table 11, overleaf, after which I explain each role in turn. The relationships between the PPG roles, practice staff, and the registered patient population are depicted in Figure 7 (p189).
<table>
<thead>
<tr>
<th>PPG role</th>
<th>Characteristics</th>
<th>Example(s)</th>
</tr>
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| Participative | - PPG works in partnership with the practice for mutual benefit  
- There is effective two-way communication | “And so for us one of the key things [...] is to engage with the patients, [...] one of the first things we will do, we have a patient group set up, if not, you know we can have an open forum so they can all come, we set up patient groups and then we get their feedback about how they want their service to run, because as I said before there is no one-size-fits-all model. [...] we need to set up that channel of communication, directly with the patients [...] That’s been quite powerful.” S27, head office, PCO13 |
| Complaining  | - PPG’s primary aim is to complain to the practice  
- Practice and/or PPG harbours a ‘them and us’ attitude | “I did start it, and it was fine, but it turned into more of a complaints forum, which was something we desperately tried to get across to them that is not what it is. It is more of a how can we help you and how can you help us sort of thing…” S20, practice manager, PCO10 |
| Channelling  | - PPG acts as an information flow system between patients and the practice  
- PPG conducts patient surveys  
- PPG negotiates with staff | “…panel members have agreed that their details can be passed on to other patients if they want them to raise particular points.” S12, practice manager, PCO05  
“...we have a patient forum and they meet say once a quarter, and then again we will listen to them, do you have any comments but they also, help us, so when the patient questionnaires, being held, patient forum will come in and help us with that.” S14, receptionist, PCO04 |
| Consultative | - PPG operates at arms-length, akin to a focus group  
- Practices choose which issues to act upon | “…they put together everything they feel that is wrong about it, [a doctor] then goes and meets with them and we try and address some of the issues. So I mean simple things [...] one of them was we would like a clock in reception. So I thought well that’s an easy fix. So I did that in 10 minutes you know got somebody to put it up the next day so that was done and oh, they are listening to us.” S01, practice manager, PCO01  
“...they want a picture of us all up in the waiting room [...] so we did that, [...] anything they sort of ask we, we have tried to implement” S06, practice manager, PCO11 |
| Disseminating | - PPG as a recipient of education from the practice  
- PPG promotes the services available to patients  
- PPG advertises changes made by the practice | “They meet, basically most of their interest really is access and that is what they need and again once we explained to them about how the system works again, ‘oh I didn’t know that’, and off they go [...]” S03, practice manager, PCO08 |

Table 11: Classification of staff perspectives of PPGs’ roles
Some staff were keen to foster communication so that PPG members and practice staff could work together to improve the practice. PPGs that played participative roles were constituted to operate in partnership with the practice. According to staff, their remit was to encourage two-way communication, providing advice and support to the practice and working with them for the mutual benefit of the practice and its patients. This participative role is one viewed as ideal in the policy documents (as ways to both communicate with (Section 2.4.5.1) and delegate responsibility to (Section 2.4.5.2) patients) and, to some extent, by elite interviewees (Section 4.5.5).

“Then we set up or asked the patients whether they would be prepared to set up a patient participation group, which we set up, which meets every month. And the remit of the group was made very clear at the beginning: it’s a group to improve the communication and respect both ways.” S02, GP, PCO01

One practice manager admitted that a PPG at her previous practice had turned into a complaints forum rather than holding onto its original remit of “how can we help you and how can you help us” (S20, practice manager, PCO10), and so was somewhat
reluctant to try again. The shift from being participative to *complaining* appeared inevitable to this practice manager. Another manager, at PCO13, a practice owned by a large private company, acknowledged that PPGs were necessary, and indeed were company policy, but regretted having to be involved.

“Some of them just come to moan, but you are going to get that every PPG. [...] I do have to attend every one (laughs) unfortunately. [...] Yes, sometimes after a hard day you just think ‘oh I don’t want to go and sit in there for 2 hours’ (laughs).” S25, practice manager, PCO13

Staff described other PPGs that were set up to be more of a conduit for patients to pass on their suggestions and complaints, taking on a *channelling* role. A GP described his practice’s process whereby patients could email the PPG, emails were discussed at meetings and, when the practice needed to reply, the email was forwarded to the GP for a response. Other PPGs used similar but less formal processes whereby members of the group sought patients’ views and fed these back to the practice through the group meetings. Whether formal or informal, these channelling roles involved acting as an information flow system between patients and the practice, gathering patients’ views and feeding them back to practice staff. The practices then dealt with the issues and sent their responses back to the patients through the PPGs.

“The other thing we have worked hard with is the patient participation group in the practice. We run every two months, and they have been great in [...] telling us how they have observed our practice and what other people have been saying, so they are giving us feedback.” S09, GP, PCO08

PPGs with this mediatory role were sometimes encouraged by staff to conduct surveys with the wider patient population. Using PPGs in this way had a dual benefit, according to staff, of gathering patient views on behalf of the practice and in helping PPG members to feel involved.

“...we spoke to the PPG and we said, you know, ‘what are your thoughts, would you like to petition the patients for us, or questionnaire the patients’, so actually
it was involving patients in getting that feedback from other patients, which I think is really valuable.” S27, head office, PCO13

As well as channelling or collecting the views of other patients, PPG members also shared their own views and suggestions, which staff felt was valuable. In some instances, staff described how they haggled with the PPG when their demands were perhaps unachievable, to meet their needs in a creative way. Staff were also pleased to receive positive feedback.

“...the patients said that they wanted to keep the walk-in element, and then so we met again after they had done the survey, to try and come up with a solution to try and reduce the wait for pre-bookable appointments, and so what I negotiated with them in the end ((laughs)) we said, ‘ok what we could do is get a nurse practitioner in’ because obviously it does come down to finance at some point as well.” S27, head office, PCO13

In some practices, PPGs seemed to have a purely consultative role, akin to focus groups. Examples included where practices conducted a listening exercise with the PPG to understand the issues that were important to the group, and hence the wider patient population, and acted on these issues as they saw fit (the issues they considered normative (Bradshaw et al. 2013)). This role draws parallels with expectations of the strategic staff for patient involvement: CCG staff felt it important to engage with and listen to patients to find out their needs (Section 5.3.4).

“...they wanted hand gel things in the toilets so we got them, so that has been responsive.” S06, practice manager, PCO11

Disseminating PPGs were described by some staff primarily as tools to educate patients about what was reasonable to expect from the practice, and about changes that the practice had made, e.g. to appointment systems or opening hours, or when new services became available. The role of disseminating involved a PPG participating in efforts to educate patients, to promote the services available, and to advertise any changes a practice had made. Communication in PPGs that fulfilled this disseminating role was in the opposite direction to those in the channelling role. The disseminating
role of PPGs is comparable to the views of some of the elite participants who felt it important to educate patients to take responsibility for accessing healthcare appropriately (Section 4.5.5).

“...we have used the PPG to update the computer monitor downstairs with ‘did you know’ comments, like ‘did you know the practice has evening opening?’, ‘did you know that we do not close at lunchtimes?’” S02, GP, PCO01

6.7 Summary of frontline staff participants’ perspectives

My analysis of interviews with 21 members of staff (clinical, managerial and administrative) at nine mainstream GP practices in the East Midlands revealed that general practice staff engaged with the concept of responsiveness. As for the policy-makers (Section 4.6) and strategic staff (Section 5.6), they considered it a way to attain goals aligned with core values and an important way for their practices to meet the needs of their patients.

The ways in which staff operationalised responsiveness could be categorised as two types: universal and targeted. Universal responsiveness involved the provision of a high quality service for all patients and meeting their needs. Targeted responsiveness involved targeting groups of patients who were judged to have the greatest need. Staff appeared to employ both approaches, although these approaches were perhaps grounded in different views of equality: the universal approach in terms of sameness (providing the same service to everyone, championing fairness and equity) and the targeted approach in terms of difference (using different ways to provide the same level of service for different patients, championing the reduction of inequalities). Staff had to make judgements as to whose needs were the most legitimate and which patients were the neediest (Figure 6, page 176).

When seeking to implement responsiveness, staff appeared willing to take responsibility for their practice list, and in some cases, the wider local community. Working together in teams, both within and beyond the practice environment, was seen as key. On occasions, external targets could be helpful to patients, but more often, targets were problematic in terms of resources and inappropriateness. The
approaches to implementation that I described as softer tactics in previous chapters were frontline staff’s main strategies for effective implementation.

Engaging with patients was seen as important in staff accounts. This included consulting with, listening to, and educating patients – the definition of responsiveness includes working with patients to understand and meet their needs and expectations, the implication being that expectations may need to be managed. Patient-initiated factors, such as being willing to be educated (which may be viewed as paternalistic (Minogue et al. 2016)) were also cited as helpful. I used the case of PPGs to demonstrate a particular kind of engagement with patients.

As for the strategic-level interviewees, frontline staff did not refer to any specific responsiveness policies. One participant spoke of a LES and a DES, but did not relate them to responsiveness directly – she was making the point that signing up for them created additional bureaucratic work, although they could also be good for patients. Given that interviewees were not asked about specific policies, and that the topic guide included an explanation of the DH’s definition of responsiveness, I cannot directly infer from where participants drew their views. As for the strategic-level interviewees, perhaps they drew on their experiences within their (and other) general practices, and the prevailing culture of making attempts to be patient-centred and to listen to patients’ views. Regardless of how they formed their opinions, frontline staff views about the goals of responsiveness appeared to align with the core values of general practice (Section 1.2), as outlined in Table 12 overleaf.
Table 12: Alignment between core values and frontline staff goals for achieving responsiveness
(brackets indicate tactic as opposed to definition)

In conclusion, this chapter has attended to the research question about how the concept of responsiveness as espoused in policy was viewed and responded to by frontline service providers. Although interviewees did not refer to specific policies, staff described responsiveness as important to general practice in terms of forming good relationships with patients, providing a service that is fair to all, and for the benefit of their business needs. Staff defined responsiveness as providing: flexible access close to patients’ homes; a high quality service regardless of patients’ backgrounds; personalised care; links with organisations beyond healthcare; continuity of care; and good customer service. According to staff, a key part of being responsive included balancing the needs of all with the needs of those who may find it difficult to engage with services. Teamwork and engaging with patients were seen as tactics for effective implementation.
In the next chapter I will bring together the themes from the literature, policy documents and interviews to discuss the implications for responsiveness in general practice given the current challenges in primary care.
7 Discussion

This chapter draws together the findings from the literature and from my analysis of policy documents and interviews to discuss the implications of my work for general practice and healthcare more widely. First, I consider how I have addressed the research questions. I then examine the tensions between responsiveness policy and how it is enacted on the ground, and situate my findings in the current policy context focusing particularly on new models of care. I go on to discuss how my findings relate to core values of primary care and the values literature more broadly. I end with an outline the strengths and limitations of my work and suggestions for future research.

7.1 Revisiting the research questions

In Chapter 1 I introduced responsiveness in general practice as an example of how a policy can be developed and implemented in the public sector, and argued that responsiveness can be viewed as a policy goal that is aligned with primary care values. I explored the ways in which it has been interpreted in the literature: as an aspect of service quality; as a way to reduce inequalities and meet the needs of diverse groups; and as part of the consumerist and patient involvement movements. By viewing responsiveness as a complex, policy goal that is aligned with values, and as a concept with enduring prominence in primary care policy, I positioned responsiveness as an initiative worthy of research focused on issues of implementation into practice.

The analysis presented in Chapter 2 addressed the policy element of the first research question: How is responsiveness defined in policy documents and in policy-makers’ discourse, what values does it reflect, and what problem(s) is it said to be able to solve? The documents defined responsiveness as meeting patients’ needs (reflecting the core values of general practice (Table 2, page 20): technical access, good customer service, coordination of care, and a suitable physical environment (Section 2.3.1)). According to the documents, responsiveness was intended to solve problems relating to rising patient expectations and inequalities. Thus the goals of responsiveness were
to meet patients’ expectations for quality (through the values of patient-centredness and personalisation, and treating the patient as a consumer (Section 2.3.2)) and to provide an equitable service by ensuring fairness to all (the value of population perspective), including marginalised and vulnerable groups (Section 2.3.3)). Chapter 2 also attended to the second research question: What specific policies have been implemented in England since 1996 to address the issue of responsiveness? Seven documents were identified: six such policies were published in 2008/9 at a seminal moment for responsiveness policy-making, and a seventh document was published in 2014 (Section 2.2 and Appendix 2).

Chapter 4 addressed the policy-maker element of the first research question: How is responsiveness defined in policy documents and in policy-makers’ discourse, what values does it reflect, and what problem(s) is it said to be able to solve? I found no discernible dissonances between the text in the documents and the discourse of the elite participants. There was evidence that policy-makers were making attempts to amplify (Section 1.3.4.2) the shared the values of primary care, and saw responsiveness as a way to attain goals aligned (Section 1.3.4.1) with these core values (Section 4.4.2). Elite interviewees’ defined responsiveness as meeting patients’ needs and providing choice, prerogatives which arose from changes in society and political priorities. Responsiveness was seen as involving patients to find out what their needs are, and then providing for those needs. Providing flexible technical access close to patients’ homes (the value of access) was a prominent aspect of being responsive. Responsiveness was seen as a way of solving problems related to: personalised care and good customer service (the value of continuity of care); consideration of issues beyond healthcare, such as social care and housing (the value of coordination); consideration of people who are socially disadvantaged (the values of patient-centred care and population perspective); and an aspect of high quality healthcare (Section 4.3). Elite participants’ definitions of responsiveness resonated strongly with those espoused in the policy documents (which is perhaps unsurprising given that most participants were involved in policy formulation or promotion), but participants’ focus was perhaps tilted in favour of listening to patients and providing flexibility, especially for patients who may struggle to access primary care. Interviewees were acutely aware
of the tensions that arise when implementing policy goals aligned with primary care values due to the top-down approach of centralised targets (Section 4.5.1).

Chapter 5 addressed the third research question: How do meso-level actors in organisations with strategic responsibilities view and respond to the concept of responsiveness as espoused in policy? Although they did not reference specific policy documents, strategic staff responded to the perceived need for responsiveness through: accepting responsibility for implementation; working towards supportive relationships with organisations both within and beyond the health sector (the value of coordination); and engaging with patients to listen to their views (the values of patient-centred care and population perspective) (Section 5.3). Strategic staff also spoke of the effects of values (mis)alignment between central government (in the guise of DH and the NHS) and local organisations (CCGs, providers) in the ways in which targets could hinder or help implementation, and the challenges that arise through conflicting pressures and organisational change (Section 5.5).

Chapter 6 attended to the fourth research question: How do frontline service providers view and respond to the concept of responsiveness as espoused in policy? Again, interviewees did not refer to specific policies, but described efforts to implement responsiveness in their service through providing: flexible access close to patients’ homes; a high quality service regardless of patients’ backgrounds; personalised care; links with organisations beyond healthcare (coordination); continuity of care; and good customer service, all of which align closely with the values of primary care (Section 6.4). They hoped to form good relationships with patients, provide a service that is fair to all (population perspective), and meet their own business needs (Section 6.3). Staff provided accounts of their day-to-day work of ‘doing’ responsiveness through balancing the needs of all with the needs of those who may find it difficult to engage with services. Thus teamwork and engaging with patients were seen as effective strategies to help staff to explicitly think through these tensions rather than accepting that the enactment of primary care values is unproblematic (Section 6.4.3).
The remainder of this Discussion has three main sections where I attend to the fifth set of research questions. First, I consider ‘What are the key challenges to implementing responsiveness in primary care?’ where I further discuss the tensions between universal and targeted responsiveness. Second, I attend to the question ‘Does the concept of responsiveness add value to efforts to implement goals aligned with core values in primary care?’ where I reflect on responsiveness as a tactic to enact the core values of general practice and discuss the implications for general practice in the context of new models of care. Third, I consider the question ‘What are the lessons for using tactics to achieve goals aligned with values?’ where I suggest that my findings may have implications beyond responsiveness in primary care. I end the Discussion with consideration of the strengths and weaknesses of the study and suggestions for further research.

7.2 Tensions in the meaning and implementation of responsiveness

This section attends to the first of the fifth set of research questions ‘What are the key challenges to implementing responsiveness in primary care?’

Analysis in Chapter 6 revealed that responsiveness manifests in two main ways when frontline staff plan and provide services to patients. I have termed these ‘universal’ and ‘targeted’ responsiveness. Universal responsiveness can be conceptualised as being mindful of fairness and quality, with a focus on the population level (perhaps within a registered practice list, federation, or a wider CCG area) (Section 6.4.1). Being universally responsive can help staff to provide a service that meets everyone’s needs in a way that is fair, equal and patient-centred, in line with policy literature that suggests that the public tend to want policies that are fair and that treat people in an equitable manner (Sen 2009) (Section 1.3.5.1). Examples of universal responsiveness related to, for example, providing good customer service to each patient as they engaged with general practice, which may be influenced by the use of discretion at the frontline staff (Rawls 2001).

Targeted responsiveness, which operates alongside universal responsiveness, can be conceptualised as a way to reduce inequalities. Manifestations of targeted
responsiveness in my data were directed at groups of patients with particular needs (Section 6.4.2). These might be patients who are vulnerable, seldom-heard or underserved. They might be patients with particular characteristics (protected or otherwise) or who have complex health needs, access needs, needs for cultural understanding, language needs, etc., who would therefore benefit from being treated differently from other patients. I found examples of targeted approaches to responsiveness which were focused on individual patients, and examples of targeted approaches at the locality level. These included practices that provided for a diverse population but were able to effectively support patients with specific needs (for example, through having well-trained staff to deal with patients with differing needs); and practices that offered targeted clinics or services (e.g. an afternoon a week for Somali patients). At locality level, this could include coordination between a group of practices (e.g. a practice within a federation or CCG providing a specialist service for homeless patients 26 (Tarrant et al. 2014)). One of the goals of targeted responsiveness is, therefore, to reduce inequity through investing in the services provided to disadvantaged groups, according to frontline staff.

The inequalities literature depicts responsiveness as a duty of providers and as a way to meet the needs of patients across different patient groups (Box 2008, Cross et al. 2006) (Section 1.3.1.2). This core duty is also evident in the policies (Section 2.3.3). However, neither the responsiveness literature nor the policies acknowledge the potential for tension between fairness and reducing inequalities, 27(Whitehead 1991) whereas frontline staff were acutely aware of inequalities amongst their patients (Section 6.4.2), and of the challenges that can arise when trying to practise both types of responsiveness (Section 6.4.3 and Figure 6, page 176). When attempting to balance the needs of the many with the needs of the few, staff may have labelled patients as deserving or undeserving (Handler & Hasenfeld 2006, Abbie Erler 2012), thus contributing towards stigma (Section 1.3.5.1). Weighing the targeted approach with

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26 The data from the practice for homeless patients were not included in my sample but are included in the NIHR report.
27 Whilst this provides an obvious example of the difference between equality and equity in healthcare, this is a large literature and is not considered here.
the potential for stigma is an ongoing challenge for policy-makers and may depend on the ideology, culture and politics of decision-makers (Peters 2015).

Other challenges I identified included differing views of each type of responsiveness, with some frontline staff preferring one over the other and questioning the legitimacy of their non-preferred type. I found that some staff apparently believed in both but struggled to find the resources to provide them; there were also tensions due to financial, resource, or capacity constraints. As suggested above, although the need for both universal and targeted responsiveness was acknowledged in the policies, the responsiveness literature, and the elite interviews, there was neither acknowledgment of the tension between them, nor practical advice on how to resolve this tension. This gap warrants further research.

This tension is also present in the literature on core values, particularly the value of taking a population, family and community perspective, which includes recognition of the need to provide an equitable service for all, including vulnerable and disadvantaged groups (Section 1.2.5). Indeed, the value of clinical freedom, comprehensive care and excellent generalism acknowledges that provision of a service that is fair across the population whilst avoiding inequalities amongst disadvantaged group should be weighed and balanced, and allows for flexibility in making difficult choices between competing priorities (Section 1.2.3).

These challenges are also evident in the Declaration of Alma Ata (International Conference on Primary Health Care 1978). This declaration, a proceeding from the International Conference on Primary Health Care held in the USSR in 1978, sought to address many of the challenges still faced by general practice today and evidenced in my findings: inequalities in health status; the importance of PPI; the use of measurement and targets; social justice; universal access; inter-agency partnerships and coordination between sectors; efficient working relationships between primary and secondary care; education of communities; comprehensive care for all whilst giving priority to those most in need; multi-disciplinary team working; responding to the expressed needs of the community; and the release of additional resources. My analysis provides evidence that it can be difficult to reconcile these different
challenges, which are ostensibly part of the same issue of access, equity and responsiveness, and speaks to how complex and multifaceted an issue it is. The Declaration also provides further evidence that, as claimed by the elite participants (Section 4.4.2), the goals of responsiveness have existed for much longer than the timeline I examined.

7.3 Why is responsiveness helpful? Responsiveness as a tactic to enact goals aligned with core values of general practice

This section attends to the second of the fifth set of research questions: ‘Does the concept of responsiveness add value to efforts to implement goals aligned with core values in primary care?’ By considering how the findings relate to the literature on core values in general practice, I argue that responsiveness can be conceptualised as a means of achieving these core values. I also reflect on the implications in the current policy context.

7.3.1 Alignment of findings with core values of general practice

As evidenced in Section 7.1, the ways in which responsiveness is espoused in policy, interpreted by policy-makers, strategic and frontline staff, and delivered by strategic and frontline staff reflects the core values of general practice (Section 7.1). Table 13 (page 204) provides a comprehensive overview of the alignment between the values of general practice, and the various aspects of responsiveness in policies, interviews and the responsiveness literature. Policies include calls for patient-centredness, personalisation and customer service as important aspects of responsiveness. Likewise, my interviewees spoke of the importance of relationships, mainly through good customer service. Continuity of care does not form part of the literature on responsiveness, but is a prominent feature in the literature relating to the values of general practice, and in the policies and policy-makers’ accounts, as a way to be responsive. Comprehensiveness, as defined in the literature on core values of general practice, relates closely to the concepts of universal and targeted responsiveness (Section 7.2). Coordination of care featured strongly in the literature on the core values of general practice and in my empirical findings. Ensuring a population perspective was found to be a key part of responsiveness by ensuring fairness across
the population and an equitable spread to all population segments. Accessibility to
general practice (which I term ‘technical access’ (Section 1.3.2)) is seen as a core value
in the literature and also features heavily in the responsiveness policies and my
empirical data. The value of patient-centred self-care skills is more prevalent in the
literature on responsiveness, the responsiveness policies and my interview data, than
in the values literature. However, in this literature, responsiveness is related to the
shift towards consumerism and patient participation, transferring responsibility away
from the provider and deferring responsibility to patients. Finally, also mentioned on a
small scale in the literature on core values is quality and safety, which draws parallels
with the policy documents, the responsiveness literature and in general practice staff
accounts of patient involvement and engagement (Section 6.6).
<table>
<thead>
<tr>
<th>Core values of general practice</th>
<th>Policy goals for responsiveness</th>
<th>Elite interviewees’ goals for responsiveness</th>
<th>Frontline interviewees’ goals for responsiveness</th>
<th>Literature goals for responsiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-centredness, whole-person care</td>
<td>Patient centredness, personalisation, customer service</td>
<td>Personalised care, customer service</td>
<td>Customer service, good relationships</td>
<td>Customer service</td>
</tr>
<tr>
<td>Continuity of care</td>
<td>Preservation of continuity of care</td>
<td>Continuity of care</td>
<td>Continuity of care [mentioned by just one interviewee]</td>
<td>N/A [although it could be argued that continuity forms part of the expectations of patients for a quality service]</td>
</tr>
<tr>
<td>Clinical freedom, comprehensive care, excellent generalism</td>
<td>Ensuring equitable service for all, including vulnerable groups</td>
<td>(Balancing incentives and penalties as tactic)</td>
<td>Balancing fairness for all with fairness for disadvantaged groups</td>
<td>Balancing fairness across the population with avoiding inequalities</td>
</tr>
<tr>
<td>Teamwork, coordination of care, advocacy</td>
<td>Coordination of care (teamwork and partnership working as tactic)</td>
<td>Consideration of issues beyond health</td>
<td>(Teamwork as tactic)</td>
<td>N/A [although it could be argued that teamwork is required for any successful organisation]</td>
</tr>
<tr>
<td>Population, family and community perspective and orientation</td>
<td>Equitable service for all, including vulnerable groups</td>
<td>Consideration of people who are socially disadvantaged</td>
<td>Services for all, including vulnerable groups</td>
<td>Fairness across the population with equitable spread to all population segments</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Technical access</td>
<td>Flexible technical access close to home</td>
<td>Flexible technical access</td>
<td>Flexible technical access</td>
</tr>
<tr>
<td>Patient-centred self-care skills</td>
<td>(Patients taking responsibility for their health as tactic)</td>
<td>Listening to patients</td>
<td>(Education of patients, and engaging with and listening to patients as tactic)</td>
<td>Consumerism and patients taking responsibility for asserting their needs</td>
</tr>
<tr>
<td>Safe and high quality</td>
<td>Consumerism</td>
<td>Aspect of quality</td>
<td>Meeting patients’ expectations, where staff felt it appropriate</td>
<td>Service quality</td>
</tr>
</tbody>
</table>

Table 13: Alignment between core values literature, policy, elite, staff and responsiveness literature goals for responsiveness (brackets indicate tactic as opposed to goal)
7.3.2 Responsiveness as a tactic to achieve core values in general practice

Although my policy timeline starts in 1996, the Declaration of Alma-Ata (International Conference on Primary Health Care 1978), as mentioned in Section 7.2, demonstrates how responsiveness has been considered by some as an aspiration for primary care for far longer. Even earlier, in 1948, the NHS was founded on three core principles: comprehensive care for all (arguably universal responsiveness), free at the point of delivery, and based on need (arguably targeted responsiveness) (NHS Choices 2015), which were later incorporated into the NHS Constitution (Department of Health 2015). These founding principles also include many aspects of the core values of general practice and of responsiveness (Box 1, page 12). Although there is a certain level of equivalence (Table 2, page 20), there is disagreement in the literature about which other values comprise the ‘core group’, as demonstrated in Section 1.2. For example, Starfield et al. (2005) advocate access, long-term person-focused care, comprehensive care, and coordinated care; Pringle suggests patient-centred care, continuity of care, teamwork, clinical freedom, a population perspective, and local accessibility (summarised in a BMJ commentary (McWhinney 1998)), whilst Marshall (2009) proposes generalism, whole-person care, and advocacy. Marshall’s values are of particular interest, as he separates them into two groups, core and traditional, and explains that:

"These are what I see as being the core values of general practice in the future. [...] You will notice that I haven’t mentioned some of the values that general practice has traditionally held dear – a focus on families, longitudinal and personal continuity, first-line care for example. Focusing on my three core values doesn’t mean that these traditional ‘values’ are unimportant.” (Marshall 2009)

I am claiming that responsiveness can be conceptualised as a way to achieve core values, in a similar way to which Marshall (2009) suggests that his traditional values “perhaps can be better seen as ‘tactics’ that help deliver the three core values, rather than as core values in themselves” (Section 1.2). Thus, we can think about responsiveness in terms of its utility rather than as a means by which we define
general practice (Ridd 2009). At the heart of responsiveness is a recognition that, while the core values are important, the ways in which these are translated into practice to meet the diverse needs of different patient groups (and different individual patients) will vary significantly. What GP practices need to do to deliver the core values will depend on an understanding of their local population and how they can meet their needs, e.g. what does good access look like? The delivery of good access will be different for, for example, a young single person who works full-time, a disabled mother, or an older non-English speaker without transport. Thus responsiveness can be viewed as a way to achieve a primary care system that delivers on core values through understanding the diverse needs of the local population. This argument for a flexible approach rather than a one-size-fits-all service is evidenced in policy (segmenting populations, Section 2.4.2.3) and by policy-makers in their definitions of responsiveness (Section 4.3).

Whilst responsiveness does not provide an answer to the question of how to balance particular individuals’, groups’, and whole populations’ needs against one another (i.e. how to reconcile universal and targeted responsiveness), responsiveness can help to alert staff to this issue about which mindful decisions should be made, rather than taking for granted that the implementation of responsiveness will be straightforward. I argue that responsiveness helps staff to start to think through the tensions and challenges of universal and targeted approaches, rather than accepting that the enactment of primary care values (such as population perspective and patient-centred care) will be unproblematic and will benefit all equally. Its status as a tactic to achieve goals aligned with core values means it could be used as a prompt for policy-makers or staff members when trying to develop ways to demonstrate other core values. For example, when seeking to find ways to provide good access or continuity, policy-makers and staff could ask themselves, “How is this being responsive to patients?” This is the added value that responsiveness brings (attending to the research question ‘Does the concept of responsiveness add value to efforts to implement goals aligned with core values in primary care?’), although further research is needed to explore ways in which to address the challenges described above. Another challenge, hitherto unexplored, is that the values of primary care have multiple touchpoints throughout
the NHS, which makes it more difficult to pin them down for ‘implementation’ (e.g. coordination may encompass primary care, social care, secondary care, the third sector). Thus how can a policy goal aligned with values, such as responsiveness, be implemented given its extensive reach which touches so many parts of the healthcare system? Next, I examine the current policy context for general practice and consider a promising model for implementation that may attend to this question.

Calls for responsiveness in general practice continue to feature in policy and practice beyond my timeline (which ended in October 2014). Its continued prominence in policy and guidance, coupled with support from practitioners across all levels of the NHS hierarchy, as evidenced in my data, supports my claim that responsiveness is, and should continue to be, a priority for leaders and frontline staff in general practice. At the macro-level of the NHS, Simon Stevens’ Five year forward view in 2014 (the last document I analysed) set out an ambitious plan to transform the NHS through new models of care (Care Quality Commission et al. 2014). The subsequent General practice forward view in 2016 (NHS England 2016b) sets goals for an investment in primary care, expansion of staffing, reduction of workload, improvements to infrastructure, and care redesign. Prior to this, guidance was available for primary care to implement the Forward view (NHS England 2014) much of which drew on aspects of responsiveness and “goes with the grain of what most people in the health service think, and what is being proposed for the next five years”, according to Simon Stevens (Roberts 2015). For instance, the guidance: advocates a move away from top-down planning processes towards local area plans to develop and progress local visions for health and care of local populations (also evidenced in my policy and interview data, e.g. Sections 2.4.2.3 and 4.5.2.2); calls for CCGs to reduce local inequalities (Sections 5.3.1 and 6.4.2); promotes a focus on community engagement (e.g. Sections 4.5.5, 5.3.4 and 6.6); and encourages prototyping of multispecialty providers. Change on this scale, according to the guidance, “cannot be mandated nationally. The future direction for a CCG or NHS provider can only be developed and implemented by its own leadership, in conjunction with partner organisations, patients, communities and staff. We are strongly encouraging all local areas to develop a shared vision of health and care for their populations in the context of the strategic choices outlined by the
Forward View” (p.11) (NHS England 2014). Thus, responsibility for this transformation appears to lie firmly with the meso-level (CCGs and providers).

Given this context, one possible way that responsiveness might be implemented effectively is through the primary care home (PCH). With support from the national programme of vanguard sites to test new models of care (NHS England 2016c), the PCH was piloted in 15 vanguard sites in the UK (National Association of Primary Care 2016b, NHS Confederation 2016). The PCH is characterised by: provision of care to a defined, registered population of between 30,000 and 50,000; a combined focus on personalisation of care with improvements in population health outcomes; an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care; and aligned clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards. The PCH has been promoted by the NAPC for 20 years and is rooted in the amalgamation of the US models of accountable care organisations and the patient-centred medical home (National Association of Primary Care 2015a, McClellan et al. 2010). According to its advocates the PCH also provides unique additional benefits to other multi-speciality community providers “...by focusing on: a defined registered population proportioned to maintain personalised care from an inclusive interprofessional team; delivery of high quality clinical care across local organisations; and driving behavioural and cultural change” (National Association of Primary Care 2016b). These aspirations draw parallels with universal and targeted responsiveness: to provide individualised care across populations. Indeed, responsiveness is mentioned explicitly in the NAPC primary care home paper (National Association of Primary Care 2015a) in the context of balancing the provision of personalised care, responsive to the need of an individual, with population health planning and provision (see also Sections 2.4.2.3 and 5.3.3). This aspiration aligns with the balancing the core values of patient-centred and comprehensive care, using the tactics of universal and targeted responsiveness (Section 7.2). In addition, the PCH model includes explicit acknowledgement of the potential tension between these different objectives in a way that was not apparent in the responsiveness policies I analysed and presented in Chapter 2. Advocates of the PCH claim that both personalised care and population health can be achieved...
(National Association of Primary Care 2015b). They suggest that a PCH can strategically plan for its local population’s needs, and by providing extended care to registered patients (including care from GPs, practice and community nurses, mental health services, diagnostics, and a range of other health, social care and third sector personnel), more episodes of care can be completed within a PCH, rather than in secondary care. They are aiming for an organisation small enough such that staff and patients know each other personally, whilst large enough to take a strategic view of the population’s health needs within a registered organisation. The process of developing a PCH is conceptualised as involving a collaborative approach between the CCG and provider organisation (Care Quality Commission et al. 2014). An evaluation of the PCH model has suggested that its impact is positive, and further sites have adopted the model with more in the pipeline (National Association of Primary Care & PA Consulting Group 2017). Scaling up at pace such that it can achieve the aim of becoming the core delivery model for health and social care services in the NHS (National Association of Primary Care & NHS Confederation 2016), however, will be challenging.

The Nuffield Trust has provided an evaluation of case studies of large-scale general practice, with examples of responsiveness in action (Rosen et al. 2016), which may speak to the challenges of upscaling the PCH model. The report examines the factors affecting the evolution and impact of large-scale general practice on staff, patients, the wider health economy and the quality of care. They suggest that “Emerging organisations must find ways to harness the benefits of larger scale while preserving the localism and ‘expert generalism’ of general practice” (p.2). The authors found that successful sites achieved sustainable change, in part, through agreeing their values, akin to values alignment (Branson 2008) (Section 1.3.4.1) and refining their goals over time. Recommendations from the report includes the need to engage with patients to design services that address diverse needs and preferences (e.g. Section 6.6), including rapid access to and continuity of relationships with clinicians. This provides further evidence of the close alignment with the core values general practice, in particular comprehensiveness, which takes into account the tension between the universal and targeted responsiveness (Section 7.3.2).
7.4 What are the lessons for implementing policy goals aligned with values?

Having attended the question of added value, here I reflect on the implications of my findings and what they might mean for the implementation of values-based improvement in healthcare more broadly, thus attending to the final research question: ‘What are the lessons for using tactics to achieve goals aligned with values?’

7.4.1 Values amplification as a way to prioritise values

Throughout the policy documents I studied, responsiveness remains a key feature: it manifests with different names and in different forms but it is present throughout as a worthy aspect of general practice. Although responsiveness has been adjusted in name and form over the years according to the prevailing political culture and identified priorities of the time, its presence as a tactic to achieve value-based goals remains. However, it is still being reshaped and reimagined to align with the preoccupations of any given policy moment, such that it becomes a public problem worthy of policymakers’ attention (Burstein & Bricher 1997).

The views of the elite informants concurred with the findings from my analysis of policy documents and with the theory of value amplification (Section 1.3.4.2). Interviewees described the goals of responsiveness as worthy of protection (Rokeach 1968, Turner & Killian 1972). Many elite interviewees felt that the origins of responsiveness were situated further into the past than my sampling frame, and that responsiveness stemmed from previous work undertaken by the WHO, DH and others (Section 4.4.1), such that it may have become taken for granted (Zijderveld 1979). It was seen as an enduring a way to attain goals aligned with core values in general practice, and as something that patients could (and should) legitimately expect and that was worthy of amplification (Snow et al. 1986). One example of this, is that responsiveness experienced the benefits of its novel (re)beginnings as an incidental finding from a public consultation about patients’ priorities for the NHS. In this consultation, responsiveness was identified as a priority alongside access: one elite participant felt that the political aim at that time was to improve access, but he also felt that responsiveness was important in order to improve the quality of general practice.
practice (Section 4.4.2) and was therefore attempting to rework the meaning of this accepted value of quality in order to legitimise policy change (Béland 2009). Thus the policy-maker was also using access as a way to solve another problem (lack of responsiveness) that he had been hoping to address for some time (Section 4.5.1), and was arguably playing the role of an opportunist described by scholars as someone who uses the implementation of an organisational innovation as “a chance to do something (rebuild, expand, renew), often something that had already been planned or was developing” p.70 (Pope et al. 2006). This opportunistic behaviour aided the value amplification at that time (Section 1.3.4.2).

Thus my findings have demonstrated how value amplification can help to prioritise policy goals that are aligned with values. Policy-makers can choose to attend to such goals as opportunities arise, and can reimagine goals such that they become a solution to a problem that is worthy of attention.

7.4.2 Values alignment as a way to realise values in practice

Values alignment (Limerick & Cunningham 1993, Posner & Schmidt 1993, Sullivan et al. 2001) was also evident in my findings. Interviewees were in agreement that responsiveness was necessary to provide for a society that was becoming more consumer-led, where patients made choices and had high expectations. What was particularly interesting, and critical for making sense of accounts of implementation (as suggested in Section 1.3.4), was the alignment of the values espoused in policy and by policy-makers (Sections 2.3.2 and 4.4.1) and the local (shared and aspirational) values of staff in CCGs and GP practices (Sections 5.2, 5.5, 6.3 and 6.4.1.1). Values alignment bodes well for implementation (Exworthy et al. 2002). Indeed, Branson claims that “values alignment may not just be an important integral part of organisational change strategies; it could well be the bedrock, the foundation, on which all truly successful organisational change depends” p.392 (Branson 2008).

An additional and related facilitator for responsiveness may have been the enactment of values-centred leadership (Kernaghan 2003, Grojean et al. 2004) (Section 1.1.3). Leaders at the highest level, such as the ‘policy entrepreneur’ and charismatic leader (referred to in Section 4.4.2, and above, in Section 7.4.1) can work to help shape
decisions about policy (Helms 2012). This leader (and others) promoted, exemplified and practised values-based behaviour (Kernaghan 2003). Through times of organisational change, where staff were expected to increasingly operate in complex networks rather than hierarchies, this values management may have offered an additional and complementary method of coordinating diverse and often competing belief systems (Paarlberg & Perry 2007).

I suggest that the agreement between policy-makers and frontline staff, alongside values-based leadership, helped to make responsiveness legitimate, and that lack of values alignment between policy-makers and the frontline, which is often a problem in policy implementation, is not a feature of the story of implementing responsiveness into primary care in England. Instead, the behaviours promoted in the Living the values report (NHS Institute for Innovation and Improvement 2009), such as implementing strong leadership that can encourage a social movements approach (Snow et al. 1986) where values are ‘discovered’ rather than imposed (Lee et al. 2005, Collins & Porras 1996), embedding values within organisations, and ensuring strong alignment between espoused and lived values (Section 1.1.4), were prevalent.

Instead, and also in line with the literature (Kraimer 1997, Pant & Lachman 1998, Enz 1988), my data demonstrate that problems in implementation can arise when implementation approaches are misaligned with the achievement of goals aligned with core values. Interviewees spoke of the potential for tensions that may arise when embedding core values into practice, e.g. when the activities that were subject to targets and incentives imposed by central government were seen to be in conflict with the aims of responsiveness, or when targets were clumsily applied. This could create a service that would not meet patients’ needs and where staff experienced overwork and burnout (Section 5.4.2). According to frontline staff, the interaction between contradictory and inflexible targets (Frey & Jegen 2001), the conflicting pressures of finances and resources, and incessant organisational change could result in the provision of an unresponsive service to patients (Section 6.5.2). In these instances problems can arise when targets are prioritised over good patient care which can get ‘crowded out’ in the presence of numerous monetary incentives (Frey 1994, Frey & Jegen 2001) (Section 4.5). Such incentives do not align comfortably with the voluntary
nature of values (Section 1.1.1). However, responsiveness is currently a target for
general practices: along with the other key lines of enquiry of safe, effective, caring
and well-led care, responsiveness is listed as one of the criteria by which general
practices are regulated, inspected and rated (Care Quality Commission 2016c). Such
incentivisation may have unintended consequences (e.g. Sections 4.5.1, 5.4.2 and
6.5.2).

A target culture, coupled with incessant political change and the reorganisations that
ensue, act together to distract staff from providing a service that is responsive to
patients. The challenge is finding a way to insulate timeless, durable, core values from
efforts to incentivise those more transient objectives that are not necessarily seen as
intrinsically worthwhile by general practice staff themselves, but which nevertheless
need to be done (e.g. for political, economic or social reasons). My findings
demonstrate the dangers that come with the way responsiveness is invoked in support
of different, perhaps less durable, themes in policy, such as competition and choice
(e.g. Sections 4.5.2 and 5.4.2, amongst others). It can be contaminated by these
policies, both in the way responsiveness is perceived, and in the way that policy-
makers seek to enact it (by introducing an incentive, or putting forward a target),
particularly if implementation approaches are seen by staff as diverting efforts away
from values-based practice. Core values need to be insulated from these centralised
actions. Further research could reflect on whether and how these tensions might be
resolved.

According to the policies (particularly the earlier policies), there was a need to increase
capacity to improve equity in general practice in poorly-served areas, and during what
was a time of national and international economic expansion, including sharp
increases in resources available to the NHS, “it becomes easier to think in terms of
spending resources to deal with problems” (p.64) (Hilgartner & Bosk 1988). This
additional capacity should have, according to the documents, provided support for
marginalised patient groups, thus allocating resources more fairly so as to positively
impact on, for instance, BME patients (Section 2.3.3), thus providing targeted
responsiveness. In general, the elite informants wanted their policies to have an
impact through making efficiency gains and re-prioritising investment (and financial
incentives and penalties) but they acknowledged that by having policies to improve access, there needed to be a corresponding increase in capacity: without additional capacity, a responsive service could not be delivered.

At a strategic level, staff in CCGs were acutely aware of conflicting pressures in finances, resources and capacity, and how these limited responsiveness in general practice (Section 5.5.1). Whilst they agreed with the principle of moving services from secondary to primary care, problems were caused by the lack of additional resources. It became apparent, from the interviews, that the extra resource pumped into the system in the early years of my timeline quickly became part of the necessary running costs of general practice (to meet increased demand, including, perhaps, ongoing efforts to be universally responsive), leaving little or no capacity for further expansion of services to support the transfer from secondary to primary care. These interviews were carried out in “[t]imes of recession or of slow growth and slowly rising living standards with reduced public resources, [which] result in downgrading the significance of non-productivity linked social problems and discourage actions to deal with them” (p.64) (Hilgartner & Bosk 1988).

There are several examples of care models that attempt to take into account the conflicting values that are evoked when attempts are made to implement elements of responsiveness. Proponents of these models claim that values conflict can be challenged, e.g. between ease of access and a focus on population health management (Smith et al. 2013), patient involvement and personalised services (Joint Commissioning Panel for Mental Health 2013), and integrated services (Mullan & Epstein 2002), which is particularly helpful in a climate of increasing demand and a lack of additional resources (Jani 2016). Of particular interest is ‘values-based practice’ (Sefton 2016) which is based on the premise that staff and patients have mutual respect for differences of values (Woodbridge & Fulford 2004, Petrova et al. 2006). It is not an outcomes-based approach, but rather a process of working with complex and conflicting values to achieve a clinical (or non-clinical) decision. Various tools are

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28 Complex values can mean different things to different people, whereas conflicting values conflict within or between individuals.
available, such as the *Values-based practice decision making protocol* (Woo 2014) to enable an effective values mapping of the stakeholders involved, the alignment and/or conflict of stakeholders’ values, and practical exercises for strengthening alignment and looking for common concerns between conflicting views. Woo (2014) claims such a tool can be used for team decision making, conflict resolution and policy analysis, and is potentially a promising tool to resolve the tension between universal and targeted responsiveness, and forms a suggestion for further research. In its guise as a policy analysis tool, it may also have merit in terms of addressing the tension between values and targets for policies other than responsiveness, through application of Childress & Beauchamp’s (2009) principle based reasoning framework advocated by Woo (2014): the consideration of beneficence, non-maleficence, autonomy, and justice (Childress & Beauchamp 2009) may help to form an explicit base for further discussion, which again, warrants further research.

In summary, a key finding from my research is that values alignment is facilitative for the implementation of values-based policy goals, under conditions where healthcare systems have sufficient capacity, and where an environment is created where soft tactics can flourish (Section 5.3) such that staff can work together (Sections 5.3.2, 5.3.3 and 6.5.1) and with patients (Sections 5.3.4 and 6.6). However, realising these values into practice can be thwarted by lack of capacity, pressures on service delivery, and implementation efforts that direct attention away from values-based practice, including misaligned targets and incentives. Even when values are aligned from policymakers through to those involved in organising and delivering services, it is not in itself sufficient to drive implementation. In addition, my research has also revealed that there may be hidden tensions that present problems for the implementation of policy goals aligned with values, where staff delivering care have to work to resolve and prioritise values as applied to populations and to discrete groups or individuals.

As suggested through this section, I argue that lessons can be learnt about responsiveness in primary care that may impact on healthcare more widely in relation to other policy goals that are aligned with values. New models of service design may offer a more promising way forward for building core values into the delivery of
primary care, as opposed to relying on implementation tactics to drive change in the context of existing service models.

7.5 Strengths and limitations

There were several strengths to this study. I was able to access many different perspectives on responsiveness in general practice. These included the formal, public-facing policy documents, resulting from an occasionally opaque policy-making process undertaken by the elite interviewees (and others). The interviews with policy-makers provided an insight into what happened ‘behind closed doors’ and helped to explain why aspects of the prospective policies were included or excluded from the final versions. At the other end of the policy-implementation spectrum, I interviewed practice staff – the people expected to turn responsiveness into reality for patients in general practice. In addition, I spoke with CCG staff, who, at the time of data collection, were engaging in activities to support practices to meet government targets whilst making efforts to remain focused on populations and individual patient care.

The longevity of my findings is also evident. Although I have worked on this thesis for six years, the findings are still topical and relevant, reflecting, perhaps, the endurance of responsiveness as a value in general practice. I believe that my findings will retain relevance for years to come.

Some limitations must also be acknowledged. It became clear that an additional set of interviews with national and regional staff at NHS England would have been beneficial, as this organisation (or rather its regional offices) held the contracts with general practices, whereas CCGs lacked the authority to apply a carrot and stick approach. Due to the disjointed nature of data collection and analysis of the strategic staff interviews whilst working full-time (part-time in a non-research role and part-time in a research role not related to this thesis), the benefits of including NHS England staff only became apparent during the analysis phase, a considerable time after the interviews were completed. After discussion with my supervisors, we concluded that this would be acknowledged as a significant limitation in the thesis. Ideally, it would have been helpful to include another set of interviews to build a fuller picture – to interview just
one or two people from NHS England would not have provided adequate data from which conclusions could be drawn.

There are potential implications of combining primary (elite and strategic-level staff interviews) and secondary (frontline staff interviews) data analysis. As suggested in the Methods chapter (Section 3.2.4) this can be termed assorted analysis (Heaton 2008). However, many of the pitfalls of assorted analysis were allayed in this study. First, alignment between the purpose of the interviews for the NIHR study (Tarrant et al. 2014) and for this thesis were closely related. The interview schedule asked staff to describe what responsiveness meant to them and to give examples of how their GP practice was responsive. This question was included as the ultimate aim of the NIHR study was to develop a patient-report measure, and in order to do that successfully we needed to understand staff views about responsiveness. Thus, even if I had conducted the interviews purely for the purposes of this thesis, the interview questions would look very similar. Indeed, it was specified on the participant information leaflet that data would be used as part of my PhD study as well as for the NIHR study. In addition to a closely-related topic guide, a further strength of the secondary data was that I conducted half of the interviews myself and a close colleague conducted the other half, thus I had an appreciation of the context in which the interviews were conducted and could be assured of a coherent standpoint. Janet Willars, the other interviewer, and I met regularly to discuss the progress of the interviews, and I had access our reflexive diaries. These strengths meant that combining the primary and secondary analyses was relatively unproblematic.

Declaring up front to the interviewees that I was interested in responsiveness may have impacted on some of my findings. In terms of the frontline staff interviews, it could be argued that this potential for impact is another consequence of secondary analysis, in that had I had conducted primary data collection, I could have reframed the topic guide to ask about the values of general practice or about how staff enacted their values in their day-to-day work. The resultant data may or may not have included responsiveness, and thus may look quite different. Alternatively, I could have asked interviewees to consider ‘patient-centred care’, ‘accessible care’, or similar, which, due to the overlapping meaning may have generated similar data. However, if I had chosen
a patient-centred care, for instance, I still would have used policy definitions to introduce the interviews, which are different to the policy definitions of responsiveness. This is because the aim of this thesis is to explore how responsiveness is understood by staff in light of policy definitions, so I remain convinced that the potential impact is minimal. The likelihood of an impact on the strategic staff and elite interviews is negligible as the purpose of these interviews was to understand how staff encouraged GP practices to implement responsiveness and to explore policy-makers views, who, by definition, would already be familiar with the responsiveness policies and the definitions therein.

Empirical data collection was limited to interviews. It may have been helpful to take an ethnographic approach, observing responsiveness in practice rather than just accessing staff’s perceptions of what happens. However, I was limited by (a) time-constraints whilst working full-time, (b) family commitments with three young children, and (c) the very nature of responsiveness – it not being something that is necessarily easy to observe. As discussed in the Methods chapter (Section 3.2.2), responsiveness is multi-faceted and pervades all parts of general practice; there were unlikely to be practice meetings that included responsiveness as an agenda item, and observations of interactions between patients and practice staff would have been fraught with ethical issues related to the ways in which I might judge what constitutes responsive behaviour. I feel that the interviews, whilst acknowledging issues such as recall bias and the possibility of respondents providing publicly acceptable answers, did in fact provide important insights into the ways in which responsiveness policy was formed and implemented on the ground.

I must also acknowledge the potential effect of volunteer bias. Inevitably, I only interviewed elite participants who were interested in responsiveness because they were the people involved in forming the policies. All those I approached were interested and those who declined to take part cited reasons of no longer being involved in that area. All interviewees expressed gratitude for being asked to take part as it reminded them of the good pieces of work with which they had been involved. Had I approached other potential participants involved more at the periphery, I may
have received both more rejections, and from those who agreed to be interviewed, differing views.

For both practice and CCG staff, I believe the volunteer bias was less pronounced. Invariably I interviewed the individuals who agreed for their practices to take part in the NIHR study (Tarrant et al. 2014) but I also interviewed others in the practices, some of whom were less enthusiastic about being involved. Similarly, in the CCG where I conducted five of the 12 strategic-level interviews, access to the CCG was achieved through a prior working relationship with the chief executive and her interest in the subject area. Whilst the other interviewees were willing to take part, their views on responsiveness were not homogenous and did not necessarily ‘toe the party line’.

As well as providing insight into how this CCG encouraged practices to improve responsiveness, I was also able to discern wider issues about the ways in which the CCG operated, for instance an absence of communication between departments and a resultant lack of integration of activities, and the lack of power the CCG possessed to influence practices to do what it wanted them to do.

It could be argued that the lack of patient data limits my findings. However, patients’ views were comprehensively explored through the NIHR study (Tarrant et al. 2014), which thus provides a sister-perspective to that of this thesis. In this thesis, I set out to examine policy formation and implementation from an organisational and staff perspective, and I believe this has been achieved.

7.6 Future research

My suggestions for future research aim to address the gaps in this current study and to reflect that the organisational context has changed since my fieldwork was conducted.

The first suggestion relates to the tension between universal and targeted responsiveness in general practice. My findings indicate that frontline staff may struggle to prioritise values when applied to populations as opposed to individuals, and policies provide no guidance (Section 7.2). Woo’s (2014) values-based practice decision making protocol to help decision-making at the frontline (Section 7.4.2) may be a helpful tool. And given the organisational changes since my fieldwork was conducted,
and that responsibility for the transformation promoted in the *Five year forward view* (Care Quality Commission et al. 2014) lies with meso-level organisations such as CCGs and large providers, the primary care home model as a means for *system change* (Section 7.3.2) is also worthy of consideration. A potential research question might be: Can the primary care home model increase perceived responsiveness and help to resolve the tension between universal and targeted responsiveness? Can the values-based decision making protocol assist with the resolution of values conflict between universal and targeted responsiveness?

The second suggestion relates to targets and incentives and how these centralised actions can affect the motivations and behaviours of staff in general practice (Section 6.5.2). Underpinning values, and tactics to express these, need to be insulated in some way from the unintended consequences of these centralised actions even when these actions are considered necessary for political, economic or social reasons (Section 7.4.2). It might be asked: Using responsiveness as an example, how can targets and incentives be designed to support rather than conflict with or undermine efforts to enact core values?

The third suggestion relates to the suggestions above, and considers the use of Beauchamp & Childress’ principle based reasoning framework (2012) (which aims to nurture mutual respect for differences in the values held by staff and patients) in its guise as a policy analysis tool as a means of addressing the tension between values and targets for policies other than responsiveness (Section 7.4.2). Consideration of beneficence, non-maleficence, autonomy, and justice (Childress & Beauchamp 2009) may help to form an explicit base for staff to discuss such challenges and come to meaningful decisions. A potential research question might be: Can the principle based reasoning framework be used as an effective way for healthcare staff to balance the enactment of values with externally-imposed actions that are potentially misaligned with those values?

### 7.7 Conclusion

This thesis has demonstrated the merits of responsiveness as a tactic to achieve core values in general practice. I have demonstrated how responsiveness can be used as a
tactic for achieving goals aligned with core values, and how responsiveness can be used to respond to diversity and to provide flexibility when making difficult choices about service delivery in relation to core values. However, my findings have also highlighted how responsiveness cannot be disentangled from the wider context of primary care, and there is a need to further reflect on the interactions between policy goals that are aligned with values, and centrally-imposed targets and incentives. Lessons for healthcare are based on an understanding of the importance of value amplification and values alignment for the implementation of policy goals aligned with values.
Appendix 1: Characteristics of each rating level for responsive general practice services from the CQC handbook (Care Quality Commission 2016c)

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsive</td>
<td>By responsive, we mean that services are organised so that they meet people's needs.</td>
</tr>
<tr>
<td>Outstanding</td>
<td>Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care. People's individual needs and preferences are central to the planning and delivery of tailored services. The services are flexible, provide choice and ensure continuity of care. The involvement of other organisations and the local community is integral to how services are planned and ensures that services meet people’s needs. There are innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs. There is a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs and promotes equality. This includes people who are in vulnerable circumstances or who have complex needs. People can access appointments and services in a way and at a time that suits them. There is active review of complaints and how they are managed and responded to, and improvements are made as a result. People who use services are involved in the review.</td>
</tr>
<tr>
<td>Good</td>
<td>People's needs are met through the way services are organised and delivered. Services are planned and delivered in a way that meets the needs of the local population. The importance of flexibility, choice and continuity of care is reflected in the services. The needs of different people are taken into account when planning and delivering services (for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation).</td>
</tr>
</tbody>
</table>

How CQC regulates: NHS GP practices and GP out-of-hours services appendices to the provider handbook
Care and treatment is coordinated with other services and other providers.

Reasonable adjustments are made and action is taken to remove barriers when people find it hard to use or access services.

Facilities and premises are appropriate for the services being delivered.

People can access the right care at the right time. Access to appointments and services is managed to take account of people’s needs, including those with urgent needs.

The appointments system is easy to use and supports people to make appointments.

Waiting times, delays and cancellations are minimal and managed appropriately. Services run on time. People are kept informed of any disruption to their care or treatment.

It is easy for people to complain or raise a concern and they are treated compassionately when they do so. There is openness and transparency in how complaints are dealt with. Complaints and concerns are always taken seriously, responded to in a timely way and listened to. Improvements are made to the quality of care as a result of complaints and concerns.

Requires improvement

Services do not always meet people’s needs.

The needs of the local population are not fully identified or understood or taken into account when planning services, or there are shortfalls in doing this. There are shortfalls in how the needs of different people are taken into account, for example on the grounds of age, disability, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.

Services are not always planned in conjunction with other local services. Services are not delivered in a way that focuses on people’s holistic needs. Services are delivered in a way that is inconvenient and disruptive to people’s lives.

People find the appointments system difficult to use, including appointments not being available unless they are made at particular times of the day (for example, immediately after a GP practice opens for bookings).

People find it hard to access services because the facilities and premises used are not appropriate for the services being provided, and action is not taken to address this.

How CQC regulates: NHS GP practices and GP out-of-hours services appendices to the provider handbook
Some people are not able to access services for assessment, diagnosis or treatment when they need to. There are long waiting times, delays or cancellations. Action to address this is not timely or effective.

People do not find it easy to, or are worried about, raising concerns or complaints. When they do, they receive a slow or unsatisfactory response. Complaints are not used as an opportunity to learn.

<table>
<thead>
<tr>
<th>Inadequate</th>
<th>Responsive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services are not planned or delivered in a way that meets people's needs.</td>
<td></td>
</tr>
<tr>
<td>Minimal effort is made to understand the needs of the local population. Services are planned without consideration of people's needs.</td>
<td></td>
</tr>
<tr>
<td>The facilities and premises used do not meet people's needs or are inappropriate.</td>
<td></td>
</tr>
<tr>
<td>People are unable to access the care they need. Services are not set up to support people with complex needs or people in vulnerable circumstances.</td>
<td></td>
</tr>
<tr>
<td>People are frequently and consistently not able to access appointments and services in a timely way. People experience unacceptable waits for some appointments and services.</td>
<td></td>
</tr>
<tr>
<td>People who raise concerns and complaints are not taken seriously and feel ignored. Complaints and concerns are handled inappropriately. There is a defensive attitude to complaints and a lack of transparency in how they are handled. People's concerns and complaints do not lead to improvements in the quality of care.</td>
<td></td>
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</tbody>
</table>

How CQC regulates: NHS GP practices and GP out-of-hours services appendices to the provider handbook
### Appendix 2: Policy documents and summaries of their purpose and responsiveness messages

<table>
<thead>
<tr>
<th>Year-month</th>
<th>Author</th>
<th>Document type</th>
<th>Policy document</th>
<th>Summary of document purpose *</th>
<th>Summary of examples of responsiveness messages o</th>
<th>Specific policy initiatives to explicitly improve responsiveness?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996-01</td>
<td>DH</td>
<td>White paper</td>
<td>Primary care delivering the future~ (Department of Health 1996c)</td>
<td>Aiming to change primary care to encourage: partnership working and linked practices; fairer funding; improved workforce planning, premises, management, and IT.</td>
<td>Responsiveness is implied through partnership working, premises and fairness.</td>
<td>No</td>
</tr>
<tr>
<td>1996-10</td>
<td>DH</td>
<td>White paper</td>
<td>Choice and opportunity # (Department of Health 1996a)</td>
<td>Aiming to encourage primary care to experiment, and improve both sides of the cost-effectiveness equation</td>
<td>Responsiveness is implied through innovation, evolution and diversity.</td>
<td>No</td>
</tr>
<tr>
<td>1996-11</td>
<td>DH</td>
<td>White paper</td>
<td>The National Health Service: a service with ambitions (Department of Health 1996b)</td>
<td>Aiming for high-quality, integrated, safe, personalised and cost-effective care, delivered at the patient’s convenience</td>
<td>Responsiveness should be part of the NHS service which is sensitive to needs and wishes of patients and carers.</td>
<td>No</td>
</tr>
<tr>
<td>1997-12</td>
<td>DH</td>
<td>White paper</td>
<td>The new NHS: modern, dependable (Department of Health 1997)</td>
<td>Aiming to bring the NHS up to date, offering prompt, high-quality, efficient care when and where patients need it. The NHS should improve health and health inequalities as well as treating illnesses, and should base reforms on the needs of patients through integration across health and social care.</td>
<td>Responsiveness is an important part of the NHS, ensuring that public expectations are met in providing for their needs and preferences.</td>
<td>No</td>
</tr>
<tr>
<td>Year-month</td>
<td>Author</td>
<td>Document type</td>
<td>Policy document</td>
<td>Summary of document purpose</td>
<td>Summary of examples of responsiveness messages</td>
<td>Specific policy initiatives to explicitly improve responsiveness?</td>
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<tr>
<td>1999-07</td>
<td>DH</td>
<td>White paper</td>
<td>Saving lives: our healthier nation (Department of Health 1999)</td>
<td>Aiming to improve the health of everyone, particularly the worst off.</td>
<td>Responsiveness is implied through fairness and partnership working with patients.</td>
<td>No</td>
</tr>
<tr>
<td>2000-07</td>
<td>DH</td>
<td>White paper</td>
<td>The NHS plan: a plan for investment, a plan for reform (Department of Health 2000)</td>
<td>Aiming to design the NHS around patient needs, integrating health and social services, changing the relationship between the NHS and the private sector.</td>
<td>Responsiveness is a way of shaping services around the needs and preferences of individual patients, and responding to the different needs of different populations.</td>
<td>No</td>
</tr>
<tr>
<td>2001-01</td>
<td>Oldham, J.</td>
<td>DH (or DH-sanctioned) guidance</td>
<td>Advanced access in primary care (Oldham 2001)</td>
<td>Aiming to guide GP practices on ways to improve access by not putting work off.</td>
<td>Responsiveness is implied through improving access.</td>
<td>No</td>
</tr>
<tr>
<td>2001-07</td>
<td>DH</td>
<td>DH policy consultation</td>
<td>Shifting the balance of power within the NHS: securing delivery (Department of Health 2001)</td>
<td>Aiming to shift the balance of power in the NHS towards clinical staff, empowering staff and local communities.</td>
<td>Responsiveness is a way to provide a fast service of consistently high-quality. The service should listen to patients and be patient-centred, allowing patients and the NHS to operate on a more equal footing. Innovative care pathways will break down traditional professional barriers to better meet patients’ needs.</td>
<td>No</td>
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<tr>
<td>Year-month</td>
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<td>Document type</td>
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<tr>
<td>2002-01</td>
<td>DH</td>
<td>DH policy for information</td>
<td>Shifting the balance of power: the next steps (Department of Health 2002c)</td>
<td>Aiming to implement organisational changes so as to meet the goals of <em>Shifting the balance of power</em>.</td>
<td>Responsiveness is part of the reform to design services around patients, services that are high quality, fast and convenient. Patients will be offered choices and be involved in planning, and localities will enact local change, developing partnerships between staff and patients, and delivering services geared towards the needs and concerns of local communities.</td>
<td>No</td>
</tr>
<tr>
<td>2002-02</td>
<td>DH</td>
<td>DH (or DH-sanctioned) guidance</td>
<td>Achieving and sustaining improved access to primary care (Department of Health 2002a)</td>
<td>Aiming to help PCTs to meet access targets set out in <em>The NHS plan</em>, increase capacity, extend primary care services and develop demand management across primary and secondary care.</td>
<td>Responsiveness is implied through improving access.</td>
<td>No</td>
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<td>Year-month</td>
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<tr>
<td>2002-04</td>
<td>DH</td>
<td>DH (or DH-sanctioned) guidance</td>
<td>Delivering the NHS plan: next steps on investment, next steps on reform (Department of Health 2002b)</td>
<td>Aiming to report progress on The NHS Plan and changes to the programme.</td>
<td>Responsiveness is about giving patients more information and more say in service delivery, patient choice, and judging the success of PCOs based on what patients say about the services they receive.</td>
<td>No</td>
</tr>
<tr>
<td>2003-12</td>
<td>DH</td>
<td>White paper</td>
<td>Building on the best: choice, equity and responsiveness in the NHS (Department of Health 2003)</td>
<td>Aiming to set out how offering choice will enable the NHS to be more responsive. It will improve patient experience, and build relationships between staff and users in health and social care.</td>
<td>Responsiveness is about meeting patients’ needs, treating them as whole persons, and decentralisation. Patient information, power and choice will make this happen.</td>
<td>No</td>
</tr>
<tr>
<td>2004-04</td>
<td>DH</td>
<td>DH policy for information</td>
<td>A responsive and high-quality local NHS: the primary care progress report 2004 (Department of Health 2004c)</td>
<td>Aiming to reflect on progress in primary care over the past four years, and how to keep it moving forward.</td>
<td>Responsiveness is a way to provide a convenient service of consistently high-quality. Patients should be able to choose to access primary care in a variety of ways.</td>
<td>No</td>
</tr>
<tr>
<td>Year-month</td>
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<td>Policy document</td>
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<tr>
<td>2004-06</td>
<td>DH</td>
<td>DH policy for action</td>
<td>The NHS improvement plan: putting people at the heart of public services (Department of Health 2004b)</td>
<td>Aiming to set out priorities for the next four years, building on <em>The NHS Plan.</em></td>
<td>Responsiveness is delivering a high-quality service that meets the needs of patients and their expectations. Quality will be performance managed.</td>
<td>No</td>
</tr>
<tr>
<td>2004-11</td>
<td>DH</td>
<td>White paper</td>
<td>Choosing health: making healthy choices easier (Department of Health 2004a)</td>
<td>Aiming to set out principles for supporting the public to make healthier and informed choices, providing information and practical support to motivate and improve emotional wellbeing and access to services.</td>
<td>Responsiveness is providing support for patients and consumers to make healthy choices, particularly those who need help in developing these skills.</td>
<td>No</td>
</tr>
<tr>
<td>2004-11</td>
<td>NPDT &amp; DH (or DH-sanctioned) guidance</td>
<td>DH (or DH-sanctioned) guidance</td>
<td>When do you want to be seen? Who do you want to see? (National Primary Care Development Team 2004)</td>
<td>Aiming to educate healthcare professionals in ways to improve access for patients, thus making it easier for staff as well.</td>
<td>Responsiveness is implied through improving access.</td>
<td>No</td>
</tr>
<tr>
<td>Year-month</td>
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<td>2005-03</td>
<td>DH</td>
<td>DH report for management</td>
<td>Creating a patient-led NHS: delivering the NHS improvement plan (Department of Health 2005a)</td>
<td>Aiming to set out how the NHS and DH will deliver The NHS improvement plan, and the changes needed to make a service that patient-led.</td>
<td>Responsiveness is part of a service that is patient-led and includes fast, convenient and integrated services delivered locally and shaped around people’s needs and preferences.</td>
<td>No</td>
</tr>
<tr>
<td>2005-12</td>
<td>DH</td>
<td>DH policy for information</td>
<td>Health reform in England: update and next steps (Department of Health 2005b)</td>
<td>Aiming to provide an update on NHS reforms, how they interact and the benefits for patients and the tax-payer. It sets out a framework for continuing the work.</td>
<td>Responsiveness is incentivised and includes providing a personalised service to meet needs and wishes, including access.</td>
<td>No</td>
</tr>
<tr>
<td>2006-01</td>
<td>DH</td>
<td>White paper</td>
<td>Our health, our care, our say: a new direction for community services (Department of Health 2006)</td>
<td>Aiming to set out a new direction for health and social care reform, ensuring personalised and convenient care, and giving people a stronger voice to improve services.</td>
<td>Responsiveness helps to provide flexible and integrated health and social care services in local settings, meeting the needs of all patients.</td>
<td>No</td>
</tr>
<tr>
<td>Year-month</td>
<td>Author</td>
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<tr>
<td>2008-02</td>
<td>DH</td>
<td>DH policy for information</td>
<td>Report of the National Improvement Team for primary care for access and responsiveness (Department of Health 2008c)</td>
<td>Aiming to present findings from a review into access and responsiveness following the results of the first GP Patient Survey, focusing on variations in patient satisfaction between practices.</td>
<td>Responsiveness is listening to patients and acting on it, meeting needs and wishes of different patient groups including those who are vulnerable.</td>
<td>Yes. “Being responsive to patients and the public: listening to what patients say and then acting on it and backing action with evidence” was found to the first of “10 common factors and behaviours displayed by the best GP practices and their PCTs” (p6). Practices were expected to “Use examples of good practice identified in the report to consider how to make the services they provide more accessible and responsive” (p.7).</td>
</tr>
<tr>
<td>2008-05</td>
<td>DH</td>
<td>DH policy for information</td>
<td>No patient left behind: how can we ensure world class primary care for black and minority ethnic people? (Lakhani 2008)</td>
<td>Aiming to present findings from a review into access and responsiveness following the results of the first GP Patient Survey, focusing on reasons for lower patient satisfactions in BME communities.</td>
<td>Responsiveness is about providing personalised care within mainstream primary care to meet the needs of patients, whatever their race, culture or religion.</td>
<td>Yes. “The report recommends a series of actions by the DH, PCTs and individual practices to embed good practice and ensure equity of access and responsiveness in primary care for BME patients. These recommendations should be regarded as good professional and managerial practice.” (p.7)</td>
</tr>
<tr>
<td>Year-month</td>
<td>Author</td>
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</tr>
<tr>
<td>2008-06</td>
<td>DH</td>
<td>DH policy for information</td>
<td>High quality care for all: NHS next stage review final report (Department of Health 2008a)</td>
<td>Aiming to set out ways to move from building capacity to delivering high quality care that is effective, personal and safe, including improving patient experience.</td>
<td>Responsiveness is about giving patients more information and choice.</td>
<td>No.</td>
</tr>
<tr>
<td>2008-07</td>
<td>DH</td>
<td>DH policy for information</td>
<td>NHS next stage review: our vision for primary and community care (Department of Health 2008b)</td>
<td>Aiming to set out a vision for primary care meeting people’s needs when they need it most, allowing services to grow and evolve, continuously improving, meeting standards and rewarding excellence.</td>
<td>Responsiveness is listening to patients, providing fast and convenient access, and improving patient experiences. Staff groups should work together to improve services available locally and to improve choice. Funding should be fairer and provide incentives.</td>
<td>No.</td>
</tr>
<tr>
<td>2008-10</td>
<td>NAPP</td>
<td>DH commissioned charity report</td>
<td>Access and responsiveness: what matters to patients? (Box 2008)</td>
<td>Aiming to present a lay view on access and responsiveness, what patients value, and what practices do well.</td>
<td>Responsiveness is an important part of PPGs’ remits. Models of access should be discussed with PPGs, and this helps practices to listen to patients.</td>
<td>Yes. “PPGs should be able to discuss access and responsiveness with their practices and to identify solutions together” (p.4).</td>
</tr>
<tr>
<td>Year-month</td>
<td>Author</td>
<td>Document type</td>
<td>Policy document</td>
<td>Summary of document purpose *</td>
<td>Summary of examples of responsiveness messages *</td>
<td>Specific policy initiatives to explicitly improve responsiveness?</td>
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<tr>
<td>2009-05</td>
<td>NHS PCC</td>
<td>PCC Incentive framework</td>
<td>Primary care service framework: Gypsy and Traveller communities (NHS Primary Care Contracting 2009)</td>
<td>Aiming to assist commissioners to ensure Romani and Traveller communities can access mainstream primary care.</td>
<td>Responsiveness is a way to meet the needs of Romani and Traveller groups through partnership working across boundaries, effective engagement with communities, convenient access to mainstream care but fast-tracked.</td>
<td>No</td>
</tr>
<tr>
<td>2009-06</td>
<td>NHS PCC</td>
<td>PCC Incentive framework</td>
<td>Primary care service framework: accessible and responsive general practice (NHS Primary Care Contracting 2008a)</td>
<td>Aiming to support improvements in accessibility and responsiveness of GP practices.</td>
<td>Responsiveness is helped by patient and public involvement, listening to patients. Staff should be trained to be culturally sensitive.</td>
<td>Yes. “This PCSF is for enhancements to existing primary medical services that will improve access and responsiveness for all patients. The funds will enable practices to tackle the specific issues relating to their own practice and their patients” (p.2).</td>
</tr>
<tr>
<td>Year-month</td>
<td>Author</td>
<td>Document type</td>
<td>Policy document</td>
<td>Summary of document purpose *</td>
<td>Summary of examples of responsiveness messages *</td>
<td>Specific policy initiatives to explicitly improve responsiveness?</td>
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<tr>
<td>2009-07</td>
<td>DH</td>
<td>DH (or DH-sanctioned) guidance</td>
<td>World class commissioning for GP services: improving GP access and responsiveness (Department of Health 2009)</td>
<td>Aiming to provide practical guidance to support PCTs in improving accessibility and responsiveness if local GP practices.</td>
<td>Responsiveness is good communication and engagement, providing access, providing customer service and decent premises, meeting the needs of vulnerable groups. Responsiveness should be measured.</td>
<td>Yes. “Practice responsiveness can have a large impact on patients’ perception of the access at their local practice. Practice responsiveness is the responsibility of all practice staff. There is no ‘one size fits all’ model, it is for practices to personalise their services to meet their patients’ preferences” (p.27)</td>
</tr>
<tr>
<td>Year-month</td>
<td>Author</td>
<td>Document type</td>
<td>Policy document</td>
<td>Summary of document purpose *</td>
<td>Summary of examples of responsiveness messages o</td>
<td>Specific policy initiatives to explicitly improve responsiveness?</td>
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<tr>
<td>2009-08</td>
<td>Practice Management Network</td>
<td>DH (or DH-sanctioned) guidance</td>
<td>Improving access, responding to patients: a ‘how-to’ guide for GP practices (NHS Practice Management Network 2009)</td>
<td>Aiming to equip practice managers with a full range of systems, tools and resources to deliver high quality, responsive and receptive services.</td>
<td>Responsiveness is achieved through measuring demand and then shaping through consideration of GP triage, skill mix, internet booking, patient education and group sessions.</td>
<td>Yes. “People come into practice management from all walks of life, and our roles can differ significantly. However, we all strive to achieve the same goals – to deliver high quality, responsive and receptive services, reaching out to local communities to make a difference to patients’ lives. Society is changing and we now live in a consumer-led world with an emphasis on a more responsive culture from those providing primary care services, which necessitates the need for a cultural change. [...] This guide is a celebration of some of this good practice, sharing the successes and signposting to real examples of things that have proven to work, things that make a real difference for patients, and the working lives of our staff” (p.i).</td>
</tr>
<tr>
<td>Year-month</td>
<td>Author</td>
<td>Document type</td>
<td>Policy document</td>
<td>Summary of document purpose *</td>
<td>Summary of examples of responsiveness messages *</td>
<td>Specific policy initiatives to explicitly improve responsiveness?</td>
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</tr>
<tr>
<td>2010-03</td>
<td>Cabinet Office</td>
<td>DH policy for information</td>
<td>Inclusion health: improving the way we meet the primary health care needs of the socially excluded (Cabinet Office 2010)</td>
<td>Aiming to improve access to and quality of services for socially excluded groups.</td>
<td>Responsiveness is especially important for socially excluded groups through building trusting relationships, tailoring care for complex needs, enabling patients to have a say in how care is delivered, allowing mainstream practices to provide better care, providing good access and continuity of care, ensuring accountability and supporting innovation.</td>
<td>No.</td>
</tr>
<tr>
<td>2010-03</td>
<td>DH</td>
<td>DH policy consultation</td>
<td>Your choice of GP practice: a consultation on how to enable people to register with the GP practice of their choice (Department of Health 2010c)</td>
<td>Aiming to seek views from patients and staff about the implications of removing practice boundaries.</td>
<td>Responsiveness is a way for staff work with patients to provide individualised care and to improve patient experience of access and customer care, especially BME groups and people with a disability.</td>
<td>No</td>
</tr>
<tr>
<td>Year-month</td>
<td>Author</td>
<td>Document type</td>
<td>Policy document</td>
<td>Summary of document purpose *</td>
<td>Summary of examples of responsiveness messages o</td>
<td>Specific policy initiatives to explicitly improve responsiveness?</td>
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<tr>
<td>2010-07</td>
<td>DH</td>
<td>White paper</td>
<td>Equity and excellence: liberating the NHS (Department of Health 2010a)</td>
<td>Aiming to set a long-term vision to provide comprehensive service to all, through putting patients at the centre, improving things that matter to patients (health outcomes), and empowering clinicians to innovate.</td>
<td>Responsiveness is the responsibility of government, commissioners, healthcare providers and GP practices to ensure efficiency and best possible outcomes for patients. Patients should be listened to and their needs and wishes should be met; they should have choice and take responsibility for the choices they make.</td>
<td>No</td>
</tr>
<tr>
<td>2010-10</td>
<td>Practice Management Network</td>
<td>DH (or DH-sanctioned) guidance</td>
<td>A best practice guide to using real-time patient feedback (Practice Management Network 2016)</td>
<td>Aiming to provide guidance for practices to gather, listen and respond to patient feedback quickly and effectively when designing new services, changing existing ones, or evaluating practice performance.</td>
<td>Responsiveness is part of the patient experience and can be measured by asking patients for their feedback in real-time. Changes should be implemented and feedback sought again.</td>
<td>No</td>
</tr>
<tr>
<td>Year-month</td>
<td>Author</td>
<td>Document type</td>
<td>Policy document</td>
<td>Summary of document purpose *</td>
<td>Summary of examples of responsiveness messages *</td>
<td>Specific policy initiatives to explicitly improve responsiveness?</td>
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<tr>
<td>2010-11</td>
<td>DH</td>
<td>White paper</td>
<td>Healthy lives, healthy people: our strategy for public health in England (Department of Health 2010b)</td>
<td>Aiming to place local communities at the heart of public health, ending central control and giving local government freedom, responsibility and funding to innovate, with financial incentives to improve health and reduce inequalities with greater transparency.</td>
<td>Responsiveness is providing a service that is owned by communities and shaped to meet their needs.</td>
<td>No.</td>
</tr>
<tr>
<td>2011-07</td>
<td>DH</td>
<td>DH policy for information</td>
<td>Healthy lives, healthy people: update and way forward (Department of Health 2011a)</td>
<td>Aiming to report on progress since Health lives, healthy people and a timeline to operationalise and develop the work.</td>
<td>Responsiveness is meeting local needs, tackling the wider determinants of health and providing access.</td>
<td>No.</td>
</tr>
<tr>
<td>2011-11</td>
<td>DH</td>
<td>DH targets</td>
<td>The operating framework for the NHS in England 2012/13 (Department of Health 2011b)</td>
<td>Aiming to set out national priorities, system levers and enablers to improve quality whilst delivering change and maintaining financial stability.</td>
<td>Responsiveness is meeting local needs, integrating services, and providing choice.</td>
<td>No.</td>
</tr>
<tr>
<td>Year-month</td>
<td>Author</td>
<td>Document type</td>
<td>Policy document</td>
<td>Summary of document purpose *</td>
<td>Summary of examples of responsiveness messages o</td>
<td>Specific policy initiatives to explicitly improve responsiveness?</td>
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</tr>
<tr>
<td>2012-02</td>
<td>NICE</td>
<td>NICE guideline</td>
<td>Patient experience in adult NHS services: improving the experience of care for people using adult NHS services (National Institute for Health and Clinical Excellence 2012)</td>
<td>Aiming to provide guidance for a good patient experience for adults using NHS services, providing evidence and direction for a ‘cultural shift’ towards a patient-centred service.</td>
<td>Responsiveness is about tailoring care for the needs of individual patients, including appropriate access.</td>
<td>No.</td>
</tr>
<tr>
<td>2014-03</td>
<td>Ben Dyson, NHS England commissioning development</td>
<td>Improving general practice: a call to action, phase 1 report (Dyson 2014)</td>
<td>Aiming to report emerging findings from the consultation <em>Improving general practice - a call to action</em>, focusing on what NHS England wants general practice to do, including collaboration with CCGs and transformational locally-led change, and national support.</td>
<td>Responsiveness is providing fast access and meets the needs of all, thus reducing inequalities and providing for different populations and localities through person-centred care for vulnerable groups.</td>
<td>Yes. One of the ambitions outlined was “fast, responsive access to care: giving you the confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations” with the overall aim of being “responsive to the needs of all – and reducing inequalities” (p.6).</td>
<td></td>
</tr>
<tr>
<td>Year-month</td>
<td>Author</td>
<td>Document type</td>
<td>Policy document</td>
<td>Summary of document purpose *</td>
<td>Summary of examples of responsiveness messages °</td>
<td>Specific policy initiatives to explicitly improve responsiveness?</td>
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<tr>
<td>2014-10</td>
<td>NHS England</td>
<td>NHS England policy for information</td>
<td>The NHS five year forward view (Care Quality Commission et al. 2014)</td>
<td>Aiming to set out a five-year plan on how the NHS needs to change: reducing gaps in population health, quality and funding. It explains why change is needed, what change might look like and how it could be achieved and covers areas such as tailoring care for local populations, service integration and leadership across health and care systems.</td>
<td>Responsiveness is providing for the changing needs of patients through new care models and local solutions.</td>
<td>No.</td>
</tr>
</tbody>
</table>

Table 14: Document details and summaries of their purpose and responsiveness messages

~ abstract only, full text not available
# abstract and full text not available, purpose based on a BMJ commentary ([http://www.bmj.com/content/313/7064/1026](http://www.bmj.com/content/313/7064/1026))
* based on the DH information box on the website or in the document if available, otherwise within the introductory chapters to the document
° examples of responsiveness messages based introductory chapters in full-text documents, otherwise as ~ and # above
### Appendix 3: Full coding frame for document analysis

<table>
<thead>
<tr>
<th>What responsiveness means</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meeting needs</strong></td>
</tr>
<tr>
<td>Allowing patients to choose NOT to choose</td>
</tr>
<tr>
<td>Communicating effectively</td>
</tr>
<tr>
<td>Coordination of care</td>
</tr>
<tr>
<td>Cultural awareness and sensitivity</td>
</tr>
<tr>
<td>Electronic systems</td>
</tr>
<tr>
<td>Further research or evaluation</td>
</tr>
<tr>
<td>Good customer service</td>
</tr>
<tr>
<td>Improving the physical environment</td>
</tr>
<tr>
<td>Information systems, sharing data</td>
</tr>
<tr>
<td>Listening and acting</td>
</tr>
<tr>
<td>Listening and acting (backed by evidence)</td>
</tr>
<tr>
<td>Meeting emotional needs</td>
</tr>
<tr>
<td>Meeting expectations</td>
</tr>
<tr>
<td>Meeting local needs</td>
</tr>
<tr>
<td>Meeting needs and wishes</td>
</tr>
<tr>
<td>Outreach services</td>
</tr>
<tr>
<td>Owned and shaped by communities’ needs</td>
</tr>
<tr>
<td>Patients having rights</td>
</tr>
<tr>
<td>Phone systems</td>
</tr>
<tr>
<td>Providing a personal patient-centred service</td>
</tr>
<tr>
<td>Providing access</td>
</tr>
<tr>
<td>Providing continuity of care</td>
</tr>
<tr>
<td>Providing or having access to information (also helping people to manage themselves)</td>
</tr>
<tr>
<td>Taking demography into account</td>
</tr>
<tr>
<td><strong>Helping patients manage themselves</strong></td>
</tr>
<tr>
<td>Patients keeping themselves healthy, managing their condition</td>
</tr>
<tr>
<td>Providing choice</td>
</tr>
<tr>
<td>Providing or having access to information (also responsiveness domains)</td>
</tr>
<tr>
<td>Using services responsibly</td>
</tr>
<tr>
<td><strong>Invoked</strong></td>
</tr>
<tr>
<td>To be fair and equitable</td>
</tr>
<tr>
<td>To meet the needs of vulnerable and marginalised groups</td>
</tr>
<tr>
<td>To respond to consumer or customer demand and expectations</td>
</tr>
<tr>
<td>To save or give value for money, be more efficient</td>
</tr>
<tr>
<td>To work with patients, local communities</td>
</tr>
<tr>
<td><strong>Working with patients and stakeholders</strong></td>
</tr>
<tr>
<td>Making responsiveness happen</td>
</tr>
</tbody>
</table>
**Accountability**
- Cost effectively and efficiently
- Measurement, audit, target
  - Incentives and sanctions
  - Outcomes framework and other frameworks
- Performance management
- Removing or changing targets or not setting new ones
- Self-monitoring
- Setting targets and milestones
  - Transparently

**Cross-boundary working**
- Through CCGs, PCTs, PCGs or SHAs
- Through DH
- Through ministers and central government
- Through NHS England
- Through pharmacy
- Through public health and health promotion
- Working with other agencies

**Localism**
- Bottom-up
- Local leadership
- Population mapping, needs assessment
- Providing different services for different people

**Staff and teams**
- Advocacy
- Aspiring to (more than) a minimum
- Attitudes
  - Being proactive
  - Being realistic
  - Peer pressure
- Changing culture
- Diverse workforce
- Enough staff
- Expertise
- Good staff
- Increasing or having investment and capacity
- Involving staff in making changes
- Local leadership (and also in localism)
- Pay and conditions
- Sharing and using best practice
- Sharing staff
| Supporting, training, valuing staff |
| Teamwork |
| Workforce planning |

**Systems**

| Consider areas outside healthcare |
| Encouraging other providers or models of care, integration |
| Increasing competition |
| Innovation |
| Legislation and compliance with the law |
| Reducing bureaucracy |
| Reducing competition |
| Shifting focus (e.g. quantity (access) to quality) |
| Thinking long term |

Table 15: Full coding frame for document analysis
Appendix 4: NVivo text query to focus text for analysis

To ensure only relevant data were included, NVivo query ‘text searches’ were conducted to find relevant text that included the terms responsive or responsiveness in the context of general practice or primary care.

Query 1: text search for (responsive OR responsiveness) AND ((general practice OR primary care) NEAR (within 50 words) to (responsive OR responsiveness)) spread to 100 words across all text

Query 2: text search for (responsive OR responsiveness) within the text coded to the node for ‘NHS (as a whole system)’) spread to 100 words

Query 3: Query 1 merged with Query 2

The results from Query 3 reduced the number of coded references to 168.

The text generated from Query 3 was read and irrelevant text was removed (if preceding or subsequent text near the mention of responsiveness was not relevant to responsiveness). Also removed were irrelevant references (text including ‘responsive’ but with no associated relevant text, e.g. a header or footer of a document, table of contents, a reference, signposting to elsewhere in the document, text exclusively about providers other than primary care, responsiveness to providers and commissioners rather than patient groups, etc).

Extra text was included if relevant text went beyond the 100-word spread.

The final text is referred to as ‘focused text’ within the thesis and included 130 text references.
## Appendix 5: Coding frame for focused policy text

<table>
<thead>
<tr>
<th>Invoked</th>
<th></th>
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<tbody>
<tr>
<td>To be fair and equitable</td>
<td></td>
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<tr>
<td>To meet the needs of vulnerable and marginalised groups</td>
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<tr>
<td>To respond to consumer or customer demands and expectations</td>
<td></td>
</tr>
<tr>
<td>To save or give value for money, be more efficient</td>
<td></td>
</tr>
<tr>
<td>To work with patients, local communities</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsibility</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CCGs, PCTs, SHAs, commissioners, NHS England, etc</td>
<td></td>
</tr>
<tr>
<td>DH, NHS Exec, government</td>
<td></td>
</tr>
<tr>
<td>GP practices, providers</td>
<td></td>
</tr>
<tr>
<td>GPs, frontline staff, other individuals</td>
<td></td>
</tr>
<tr>
<td>NHS as a whole</td>
<td></td>
</tr>
<tr>
<td>Partnership working</td>
<td></td>
</tr>
<tr>
<td>Patients, local communities</td>
<td></td>
</tr>
<tr>
<td>Practice managers</td>
<td></td>
</tr>
</tbody>
</table>

Table 16: Coding frame for focused policy text
Appendix 6: Policy document timeline
Appendix 7: Elite participants invitation email template

Dear [Name],

I would like to invite you to take part in an interview study about responsiveness in primary care.

I am a PhD student in the SAPPHIRE group in the Department of Health Sciences at the University of Leicester. My PhD looks at responsiveness: how it came to be prominent in policy and how it has been implemented in practice. This PhD sits alongside a NIHR HS&DR-funded project to develop a patient-report measure of responsiveness in primary care (http://www.netscc.ac.uk/hsgdr/projdetails.php?ref=09-1801-1029).

My PhD study involves interviewing policy-makers and members of primary care staff, and a review the policy and academic literature. I would very much like to interview you, because of your involvement with [named document(s)]. Might you be willing to spare me an hour of your time? The interview can be shorter than this, as your time commitments dictate.

The interview can be conducted over the phone or face to face, as you prefer, at a time and place to suit you. I would like to record the interview, with your permission. The transcript of your interview will be anonymised to remove any identifying information and will be kept confidential within my PhD team (i.e. my supervisors: Carolyn Tarrant, Richard Baker and Graham Martin). The findings will be presented in my thesis and potentially at academic conferences or in journals. With your permission, I would like to use anonymised quotes.

Please let me know if you would be willing to talk to me, and if so, let me know the best way to contact you to arrange an interview.

I appreciate that you are busy, so thank you for taking the time to read this, and I look forward to hearing from you.

With kind regards,

Emma

[Email signature]
Appendix 8: Elite interviewees email consent form

Dear [Name],

Thank you for agreeing to take part in my interview study. I will phone you on [phone number] at [time] on [date], as arranged.

If you have any questions before the interview please feel most welcome to get in touch. Otherwise please would you reply to this email and confirm that you agree with the statements on the consent form, pasted below?

Best wishes
Emma
[Email signature]

EMAIL CONSENT FORM
Version 1, May 2012

Once you have had a chance to ask questions please email Emma (elj1@le.ac.uk) to confirm that you agree with the following statements.

**Responsiveness in primary care: interview study**

- I confirm that I have read and understand the email (dated [date]) inviting me to take part in for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

- I agree to the interview being digitally recorded.

- I agree that excerpts from the interview may be used in academic papers or conferences and that I will not be identifiable in any way.

- I understand that relevant sections of the data collected during the study (such as this consent form) may be looked at by responsible individuals from the research team, from regulatory authorities or from the University, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

- I agree to take part in the above study.
Appendix 9: Elite participants interview guide

1. Preamble
   - Thanks for your time, have you read the information sheet?
   - Description of study (incl. focus on primary care)
   - Thanks for taking part, will talk about how policy developed and your involvement
   - Length of interview, can stop at any time
   - Can withdraw at any time prior to analysis
   - Transcription, confidentiality and anonymity
   - Confirmation of consent, digital recording

2. Description of participant’s involvement in responsiveness policy
   Could you tell me a bit about how you were involved in the development or writing of [policy document]?

3. The meaning and value of responsiveness
   What does responsiveness mean to you?
   Where did this focus on responsiveness come from: why ‘responsiveness’? (probe for how it reflected/was influenced by wider political priorities, or particular individuals’ agendas)
   How did the policy document relate to or build on previous policy? (perhaps prompt for patient centredness, patient empowerment)

4. Implementation
   What was the intention of the policy?
   What measures were taken to translate or implement it into practice?
   What did you expect to be the impact of the policy on practice – what changes would you have expected to see ‘on the ground’?
   What impact do you think it actually had? (perhaps ask how it was audited/monitored/evaluated)
Why? (probe for priorities of those on the ground, and competing priorities)

5. Relationship with later policy
How does responsiveness feature in primary care policy now? (probe: where does it fit / what role does it play in relation to the current political situation, e.g. ‘putting patients at the heart of everything’)
What’s changed since the policy was written?
Given the context of current changes to the organisation and delivery of primary care, what do you think is the place/role of responsiveness ‘on the ground’ in primary care, going forward from now?

6. End
[If time] So how would you define responsiveness in primary care?
Anything else of importance
Questions
Thank you, final report?
Appendix 10: Elite participants shortened interview guide for those who requested it prior to interview

1. Description of participant’s involvement in responsiveness policy

Could you tell me a bit about how you were involved in the development or writing of [policy/guidance document]?

How did it come about?

2. The meaning and value of responsiveness

What does responsiveness mean to you?

Where did this focus on responsiveness come from: why ‘responsiveness’? why was [policy/guidance document] the right tool to solve the problem?

How did the policy/guidance document relate to or build on previous policy/guidance?

3. Implementation

For you, what was the main intention?

Were there any measures taken to translate or implement it into practice?

What did you expect to be the impact of the policy/guidance on practice – what changes would you have expected to see ‘on the ground’?

What impact do you think it actually had?

Why?

4. Relationship with later policy

How does responsiveness feature in primary care policy/guidance now?

Do you think this is the kind of document that would be written now? (What’s changed since the policy/guidance was written?)

Given the context of current changes to the organisation and delivery of primary care, what do you think is the place/role of responsiveness ‘on the ground’ in primary care, going forward from now?
Appendix 11: Coding frame for elite interviews

<table>
<thead>
<tr>
<th>1. Participant’s involvement</th>
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</thead>
<tbody>
<tr>
<td><em>Elites’ roles in the documents</em></td>
</tr>
<tr>
<td>Delivery and supporting implementation</td>
</tr>
<tr>
<td>Development</td>
</tr>
<tr>
<td>Dissemination</td>
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<tr>
<td>Origins of document or department</td>
</tr>
<tr>
<td>Publishing the document</td>
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<tr>
<td>Writing</td>
</tr>
<tr>
<td><strong>Involvement</strong></td>
</tr>
<tr>
<td>Elite’s non-involvement</td>
</tr>
<tr>
<td>Promoting elite’s cause</td>
</tr>
<tr>
<td>Stakeholder involvement</td>
</tr>
<tr>
<td>Team involvement</td>
</tr>
<tr>
<td><strong>Tensions and problems</strong></td>
</tr>
<tr>
<td>Commissioners’ dissatisfaction</td>
</tr>
<tr>
<td>Lack of control about measures</td>
</tr>
<tr>
<td>Lack of time</td>
</tr>
<tr>
<td>Negotiated payment loop-hole</td>
</tr>
<tr>
<td>Political (with a small p or a big P) disagreements</td>
</tr>
<tr>
<td>Reactions to content</td>
</tr>
<tr>
<td>Reduction of content</td>
</tr>
<tr>
<td>Responding to public consultations</td>
</tr>
<tr>
<td>Stakeholder or co-author power struggles, reluctance, stalling</td>
</tr>
<tr>
<td>zNo tensions</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Meaning and value of responsiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Origins of responsiveness</strong></td>
</tr>
<tr>
<td>Business needs, societal and consumer demands</td>
</tr>
<tr>
<td>DH policy, not a grounded concept</td>
</tr>
<tr>
<td>Previous work on patient experience</td>
</tr>
<tr>
<td>Sub-set of quality - responsiveness AND access</td>
</tr>
<tr>
<td>Wanting more than access, looking at things differently</td>
</tr>
<tr>
<td>WHO responsiveness</td>
</tr>
<tr>
<td><strong>2 Building on earlier policy or reports</strong></td>
</tr>
<tr>
<td>Building on specific work</td>
</tr>
<tr>
<td><em>Building on Advanced Access Programme</em></td>
</tr>
<tr>
<td><em>Building on Darzi</em></td>
</tr>
<tr>
<td><em>Building on Keeping it Personal</em></td>
</tr>
<tr>
<td><em>Building on NIT and No Patient Left Behind</em></td>
</tr>
<tr>
<td><em>Building on previous NAPP work</em></td>
</tr>
<tr>
<td><em>Building on previous NICE Standards</em></td>
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</tbody>
</table>

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## Building on the NHS Plan

- Building on the Working in Partnership programme
- Not building on specific work
  - *First one to be practice manager-led rather than company-driven*
  - *Providing evidence for a concept that was previously plucked out of the air*
  - *Re-hashing of old Acts and slogans*
  - *Responding to first GP patient survey*
  - *Responding to inequalities*

### 3 Working with concurrent policy

- Current DH and KCL report (What matters to patients)
- NAPP report and other PPG work
- NICE standard and KCL What matters to patients
- NICE standard and other (undefined) research
- NICE standard and other DH work on patient experience
- NIT report and Yellow Peril
- No Patient Left Behind and Advanced Access Programme
- No Patient Left Behind fed into Darzi review

### 4 Meaning

- Don’t know
- Bigger picture
  - *Helping people stay healthy*
  - *Joined up care, smooth experience*
  - *Looking at wider environment, social, housing needs, non-clinical pathways*
  - *Outcomes, not hygiene factors*
- Continuity
- Local provision
- Measure of quality
- More than access
- Opposite of choice
- Providing for needs
  - *Access to what is required (services, information)*
  - *Personalisation, flexibility - understand patient’s needs and preferences, and delivering them, not one size fits all*
  - *Providing for legitimate expectations*
  - *Understanding population needs and providing services*
- Responding to patient feedback, surveys, listening, communication
- Responsive service mirrors responsive organisation

### 5 Influences

- Influenced by changes in society
- Influenced by personal beliefs and passions
- Influenced by political priorities

### 6 Right tool to solve the problem
Tool effective because
- Dissemination to practices
- Incentives and sanctions
- Involving stakeholders to influence policy
- Partnership with patients

Tool not effective in isolation
- Implementation more important than the report or policy
- More about changing culture
- Need a radical rethink
- Not all implemented but had influential ideas and transformed patient experience
- Process of development more effective than the finished product

3. Implementation

1 Main intention
- To change structure, systems
  - To become locally-led
  - To become patient-led
  - To focus on outcomes not process
  - To instigate locally-led system-wide change
- To change the way staff do things on the ground
  - To become as responsive as John Lewis
  - To change mind-set of primary care
  - To provide a toolkit to dip in and out of
  - To raise standards of service, to improve quality
  - To set out priorities and tools
  - To set standards
  - To share good practice
- To improve things for patients
  - To build capacity
  - To improve access
  - To improve patient experience
  - To reduce health inequalities

2 Impact
- Actual impact
  - Don’t know
- Changed systems
  - Improved access
  - Provided choice of hospital
  - Transformed patient experience
- Changed the way people think
  - Engaged with practices that were difficult to engage with
  - Responsiveness became an accepted concept
**Shared good practice**

- Some ideas have become currency
- Thinking of the patient as a customer

**Changed what people do**

- Changed GPs’ behaviour
- Enabled practices to make quicker decisions
- GP surgeries made changes to their practices
- GPs actively looking for early stages of ill-health

**Created a tool**

- Created a template for a DES or LES
- Created NHS Choices website
- Provided a toolkit for people to dip into

**Success and failure**

**Failure**

- *Acute care more successful than primary care*
- *Competing priorities*
- *Patients’ views not taken into consideration*
- *Perverse consequences (risk of)*
- *Resistance*

**Success**

- *Influenced later work and priorities*
- *Longevity*
- *QOF has reduced inequities*

**Expected impact on practice**

- *Didn’t expect much of an impact*
- *Don’t know*

**To affect funding**

- To create financial penalties and incentives to improve performance
- To make efficiency gains

To make the application of contract terms between commissioners and providers more consistent

- To re-prioritise investment
- *To be used by commissioners, providers and patients*

**To develop measures**

- To inform development of QOF indicators or other measures
- To introduce metrics and measures
- To promote the development of high quality measures

**To encourage practices to change**

- For practices to take responsibility for themselves
- For practices to use the document to address their specific needs
- To encourage GPs to actively look for early stages of ill-health
To get recognition for the good work done in primary care

To improve patient experience
To get more than just improved access
To improve responsiveness
To improve service provision
To reduce variation

To improve patient involvement
To find flexible ways for practices and patients to work together
To improve interaction with patients

To promote responsiveness
To get patient experience and responsiveness on Board agendas
To reduce culture
To shift opinion about responsiveness

Wanted there to be choice of GP

3 Translation or implementation in practice

Change management

Ensuring good practice manager and good leadership
Using the NHS Change Model
Working alongside other policies’ implementation

Encouraging partnership working

Allowing patients to opt out of being involved
Developing a shared vision
Educating patients

Practices, PCTs and SHAs working together

Ensuring a target doesn’t miss the point

Implementing specific initiatives

Changing small procedures to save money (organisational change)
Encouraging effective commissioning
Implementing Choice agenda
Implementing individual policy initiatives
Stratifying patient needs

Introducing new methods of communicating in the practice

Improving clinician-patient relationships in acute care
Introducing touch-screens to book in on arrival

Introducing new ways to access services and information

Changing appointment and phone systems
Granting patients’ access to medical records
Introducing electronic prescribing
Introducing online systems
Introducing scrolling messages in the surgery

Introducing structural change
Encouraging effective commissioning

Introducing targets, measures, incentives
- DES for patient participation
- Nudging and mandating
- Offering out of hours in 80% of practices
- Opening a GP-led health centre in every PCT
- Promoting as a way to answer to the PCT’s monitoring
- Reducing elective waiting lists

Promoting and communicating
- Asking if practices have made changes in response to the toolkit
- Embedding responsiveness into discussions
- Promoting the toolkit through conferences and exhibitions

4 Targets culture

Changing hearts and minds
- Behavioural change
  - But does it change behaviour
  - QOF had positive effect on GPs’ culture and behaviour
  - Talking and acting now, not putting it off
- Encouraging engagement
  - Changing attitudes
  - Communicating
  - Encouraging active PPGs
  - Encouraging GPs and patients to treat each other as equals
- Getting people on board
  - Getting professional bodies on board
  - Not winning hearts and minds
  - Shifting opinion, encouraging discussion, changing perceptions
- Reducing tick box culture

PCT or DH targets, measures, rules, incentives
1. Carrots and sticks (incentives and penalties)
   - Carrots don’t work, need sticks
   - Interplay between sanctions and incentives
2. Making targets
   - Contract negotiations should be between patient and provider, not provider and PCT
   - DH encouraging LESs to be set up locally
   - DH introducing competition through GP-led health centres
   - DH introducing targets and initiatives which contribute to positive change
   - DH making targets harder to reach
   - National DES to encourage longer opening hours
   - Targets should be set locally
3. Description of targets
CQUIN - financial incentives in acute care (DH)
DH (unspecified) incentives
DH creating a template for a LES (to improve responsiveness)
DH using DES to incentivise
DH using QOF incentives (extended opening, access within 48 hours, PPG, screening, etc)
Differences between QOF and DES
PCT initiative funding (reward)
PCTs using LESSs to incentivise (PPG, phone system)

4. Techniques to implement targets
   (Consistent) change only possible through contractual means
   DH using GP patient survey to measure (keep an eye on) targets
   DH using inpatient survey to translate into performance metric

5. Application of targets
   DH national data collections - providers and populations
   DH structured review of practices’ performance
   DH using targets to identify under-performers
   DH using the Operating Framework to highlight problems
   Evaluations
   Foundation trusts - a way to measure acute care
   NICE standards may be measured using existing surveys
   Tensions can help keep standards up
   Using NICE standards to audit
   Using NICE standards to ensure aspirations are comparable and transparent
   Using NICE standards to inform QOF

6. Problems with targets
   Dodgy behaviour
     Gaming
     PCTs over-egg the QOF
     PCT’s underhand tactics
   Measures
     Lack of measures
     Measuring activity not outcomes
     Practices don’t trust or like PCT measures
     Responsiveness not really measurable
     The trouble with surveys
   Motivation
     GPs motivated by money
     Practices only react to PCT demands
   One size does not fit all
     DH treating all PCTs the same
     PCTs treating all practices the same
QOF rewards standard behaviour, doesn’t reward patient experience

**Side effects**

- *Perverse effects*
- Targets and measures inadvertently encourage tick-box mentality

### 4. Relationship with later policy

#### 1 Responsiveness in policy now

- CCGs the antithesis to responsiveness
- **Choice**
  - *Choice of GP pilots*
  - *Social care has improved (direct payments, etc)*
- Clinically-led commissioning

#### Economics

- *GP practices market themselves more*
- *Increase in private sector*
- *More responsiveness means less litigation*
- *The Richmond Group - From vision to reality*

#### Patient experience and engagement

- *CQUIN rewards for patients being engaged in their care*
- *More real-time feedback now*
- *Patients involved in their health*
- *Patients’ views are very important now*
- *PROMs as a record of the patient journey*
- *Putting patients at the heart of everything*
- *QOF on patient experience not changed*
- *Satisfaction and experience are different ways to express the same thing*

To reduce variation in the locality

#### 2 What’s changed since the document

**Negative changes**

- *A lot of focus on new structures*
- *Access figures have gone down*
- *Different Secretaries of State have different ideas*
- *Fragmentation of services*
- *Less ambitious now*
- *Less focus on patients, more on clinicians*
- *Responsiveness has been diluted*

**Positive changes**

- *Improved access, reduced variation*
- *McDonaldisation*
- *More emphasis (hype) on patient involvement*
- *Moving from paying and incentivising for outputs rather than inputs*
- *Removal of some targets, introduction of new incentives*
3 Would this document be written now

1. Yes
   - Yes, but the difficulty is engaging with practice managers
   - Yes, but the difficulty is funding
   - Yes, still relevant
   - Yes, would like to do it again

2. No
   - No, Commissioning Board more interested in relationships than reports
   - No, GPs as commissioners now influence GPs as providers
   - No, less ambitious now
   - No, outdated, more interested in whole system improvement now (local commissioning)

3. Don’t know

4. Other
   - If it were written, it would have a different baseline

4 Changes in primary care, how this affects responsiveness

Colour of politics

Agenda
   - Colour of politics does (adversely) affect the responsiveness agenda
   - Colour of politics not affecting responsiveness agenda (still a focus)

System changes
   - Change in government and new structures is the way forward
   - National Commissioning Board will create measures to NICE standard
   - New performance monitoring processes will go to a different place
   - Primary care divorced from public health
   - Responsiveness more important now as services become more fragmented
   - System upheaval takes precedence over responsiveness agenda

PPI
   - PPI working with CCGs
   - Rhetoric about PPI but not evident on the ground - clinically-led

Societal changes

Co-production of health

New generation of doctors brought up on shift work, have different views of primary care

The need for responsiveness
   - ‘Responsiveness’ (as a word) has gone out of fashion
   - The need for responsiveness is still very real (inequities exist)

Thinking of patients as customers

5 Current or future measures

Peer pressure and support
   - CCG peer challenge and support
   - Not performance management
   - Referral numbers (population based, not individuals)
### Performance management

- **CQUIN (acute care)**
- *Desire for sensitive measures, but there aren’t any*
- *Emergency admissions and readmissions*
- *Friends and Family Test (FFT), Net Promoter Score (NPS)*
- *Future yet-to-be-developed measures*
- *GP patient survey*
- *Outcome measures*
- *Performance management measures (population based, not individual)*
- *Primary care likely to move towards sanctions rather than incentives*
- *Unspecified patient surveys*

### Anything else of importance

**Elite’s roles and motivations**

- Elite’s roles since
- Motivation
- Not my problem
- Shaping report around personal philosophy
- Staying ahead of the game
- Sticking your neck out

**How elites refer to patients, customers, consumers, etc**

**Interview conduct and value**

- Aggression
- Avoiding the question, being careful with words
- Can’t remember or don’t know things
- Choosing to answer a different question
- Concerns about confidentiality and anonymity
- Concerns about wrong emphasis in interviews
- Helicopter vs personal perspective
- Horror story
- Humour
- Story telling
- Value of interview

**Leadership and teams**

- Aspiration
- Innovative solutions
- Old boys’ network, hand-picked team
- Open and transparent
- Strong leadership, influence
- Turf wars
- Vision

**Politics**
Different approaches

- Moving towards a bottom-up approach
- Top down vs bottom-up
- Top providing data, bottom deciding what to do about it

Health reforms

- Health reforms are impenetrable
- Process not outcomes

Politicians

- Controlling in the times of Blair
- Lansley the technocrat
- Political sloganeering
- Politicians love initiatives but not implementation
- Secretary of State in charge

Ways of implementing policy

- Deadlines
- DH not trusting practices to be honest
- Policy not leading to legislation
- Pushing or leading
- Sheepdog yapping at heels

Ways of making policy

- Accidental policy making
- Evidence based policy and politics
- Realpolitik
- Resources, funding to do a good job
- Short policy cycles
- Sudden announcement followed by consultation to back it up

Times change

- Changing workforce
- Living in different times
- More risk averse now
- Shift from acute care to primary care

Table 17: Coding frame for elite interviews
Appendix 12: Frontline staff interview guide (NIHR study)

Introduction

Thank you for seeing me today. Have you had a chance to read the information sheet?

The study

If I could just explain very briefly what our study is about... we are hoping to develop a patient-report measure of primary care responsiveness that can be completed a diverse group of patients (so for instance, we would like to include those with sensory or learning disability or who may not read or write English or who are from a BME background). It may take the form of a paper questionnaire but we will look at other formats, so as to ensure that it is accessible to all patients. It is hoped that the questionnaire will be suitable to be used by a range of different primary care organisations (PCOs) including GP practices, walk-in centres and pharmacies. So what I’m hoping to discuss with you today and get your views and feelings on is what do you feel is important when we talk about responsiveness.

What is responsiveness?

So just to explain what we mean by responsiveness, we are not talking about what happens in the consultation with the doctor or nurse, or about how good the medical treatment is at this GP practice. But we are interested in everything else that goes around this, like: how easy or hard it is to make an appointment, or to get into the practice, the welcome and the customer service. There may be other issues that you feel are important to patients and we are interested in these too.

So I’ll be asking you questions around what responsiveness means to you, what are the things that you are currently doing, how you might be measuring this, what things would you like to do and possibly what are the barriers or facilitators to being as responsive as you would like to be.

Does that sound okay to you?

Recording and data
So before we take each of these points individually, I just want to make sure that you are okay with me digitally recording the interview. As I mentioned in the information sheet, we transcribe each interview verbatim and then anonymise the data prior to analysis. This ensures that everything that you say is confidential and nothing can be traced back to you. Is this okay? Also just to re-emphasise that this is voluntary and we are very grateful that you are willing to take part, but if you wish to withdraw at any time then that is fine. Do you have any questions at all about the study that you would like me to answer?

Please could you sign the consent form to confirm this (Check that they have signed and dated the consent form).

[Switch on the digital recorder]

Get verbal consent for the recording again.

General

[Only if the About The Practice questionnaire hasn’t been completed]: So maybe to start with I wonder if you could give me a picture of what your practice is like?

[probe specifically types of services they provide, patient population]

Could you tell me what responsiveness means to you?

Would you say that responsiveness is something that is important to you as a PCO?

Responsiveness in their own experience

Could you give me a picture of what your practice is like in terms of responsiveness?

Can you tell me about any specific examples of ways in which you feel that your PCO is successful at being responsive to patients?

You mentioned xxxxxx as an area that you have been successful in. Why do you believe that you have been successful in this area? Has anything been particularly helpful in bringing about these changes?

Did you face any difficulties in trying to implement these changes?
Do you have any other examples of you being successful in terms of improving the responsiveness of your practice?

[When interviewee gives ‘reactive’ examples, ask when you ask them about responsiveness] Have you done anything or are you doing anything proactively to help meet the needs of your patients, such as thinking about your appointment systems, flagging up carers, redesigning their waiting room for people with a disability?

On the flip side, can you think of any examples of ways in which you feel your PCO is not particularly responsive to your patients? [probe specifically if they feel that they may not be particularly responsive to a particular group of patients]

What do you think are the reasons for this? [probe actions of staff, systems, policies of the service etc.]

What do you think would need to happen to improve in this area?

Are you doing anything currently to improve your responsiveness? Why?

If we were to ask the patients that visit this practice, what do you think they would say at this moment in time if we asked them how responsive the practice is?

Bearing in mind the characteristics of your patient population, are there any particular needs or wants that you are aware of, for example, in particular subgroups of the population (e.g. mothers want urgent appointments)?

Some groups of patients find it harder to use primary care services e.g. disabled people, people who don’t speak English, people from other minority groups like LGBT, travellers. Is there anything you do as a practice to try to make it easier for potentially disadvantaged groups of people?

What are the difficulties?

What would you say makes it easier for you to be responsive to the needs of your specific patient population (i.e. what are the facilitators)?
On the other hand what would you say are the barriers to being responsive to your specific patient population?

**Development of a measure**

As I mentioned we are trying to develop a measure that practices are can use to measure responsiveness.

Do you have any measurements or indicators to let you know how responsive you are as a practice? [probe survey data, actions of staff, systems, policies of the service etc.]

What do you think of these indicators/measurements? [probe are they useful or not]

What do you think a measure should look like? What would it be like to work for you? Or maybe not be like?

**Conclusion**

Thank you for your time is there anything else that you would like to add that you feel is possibly important but hasn’t been covered in today’s discussion?

Any questions that you would like to ask?

Thanks again, would you be interested in a copy of the results?
Appendix 13: Strategic level GP practice staff invitation email

Dear [Gatekeeper],

My apologies for the delay in getting this report to you. Thank you for taking part in the Responsiveness study. Your help with distributing the questionnaires is very much appreciated. Of the [number] that you handed out to your registered population, we have received [number] completed questionnaires back. Please find attached a summary of your patients’ responses.

As part of the study, we would be really interested to learn more about how useful these findings are to your practice. We would be grateful if you would **complete the attached short (1 page!) questionnaire** about the responsiveness questionnaire: any challenges you faced when handing it out, and how useful you found the data.

**I would also like to invite you to take part in an interview about your views of responsiveness in policy and practice.** This is purely for the purposes of my PhD and participation is entirely voluntary. If you do not wish to take part, that’s absolutely fine. I would also like to interview a senior GP, if at all possible, if you wouldn’t mind please passing on my request to someone you feel might be interested? I am aiming this request at practice managers and senior GPs with strategic input into the practice, as I will be asking questions about policies, incentives, targets, patient mapping, CCGs, etc., and how these impact on how responsive your practice is.

If you do decide to take part, we can compensate you for your time at standard PCRN rates.

Please do return the electronic questionnaire to me, and also let me know if you would be interested in being interviewed, and we can arrange a convenient time to speak over the telephone. I would anticipate the interview lasting no longer than half an hour, and with your permission, I would like to record our conversation. This will help with data analysis. The recording and transcript will be kept confidential within my supervision team, and you will not be identifiable from any quotes I use in the thesis or subsequent papers.

Many thanks again for participating in the study so far. I hope you will find the data useful.

With best wishes

Emma

[Email signature]
Appendix 14: Strategic general practice staff interview guide

Motivation to be responsive

1. Do you think there are currently pressures and incentives for PCOs to be more responsive* to the needs of diverse patient groups? What are they (e.g. policy, patient choice, cost)?

2. Are there other priorities, targets and pressures which conflict or are in tension with being responsive?

3. What sorts of priorities, targets, pressures, incentives and so on have the most impact on the way you organise and deliver your services as a PCO? (i.e. what drives what they do – prompt – patient voice and choice / demand too)

Implementing responsiveness

4. Have you tried to improve your responsiveness (e.g. by setting up a PPG, by mapping needs, by working through the PM network resources on improving the patient experience, doing work with specific disadvantaged groups e.g. travellers...).
   a. Why did you decide to do this?
   b. How have patients / the PCO benefitted from this?

5. How are your efforts to be responsive been affected by government-led initiatives to change the organisation and delivery of primary care, e.g. federations – consortia – CCGs, reduction in overall budgets, no funding to meet CQC registration criteria, subsequent reduction in staff numbers, moving services from secondary to primary care?

6. What about the effects of changes at a local level, e.g. the rise of large private companies, such as The Practice Plc?

7. Do you feel that you, as a practice, have ‘bought into’ the need to be responsive, or if you see it as something you are under pressure to do?

* “Practice responsiveness is the way in which a practice communicates and engages with its patients and their carers and responds to their non-clinical needs and preferences, reflecting the different ways in which they might prefer to access the service and an appropriate clinician, book, or indeed cancel an appointment. It includes the practice’s attitude to customer service and friendliness of staff, the environment in which patients wait to be seen and the way in which they interact and support patients from particular groups, such as those with hearing or sight loss or people from a black or minority ethnic background.”
Appendix 15: Questionnaire for GP, based on the strategic GP practice staff interview guide

Motivation to be responsive

1. Do you think there are currently pressures and incentives for GP practices to be more responsive* to the needs of diverse patient groups? What are they (e.g. policy, patient choice, cost)?

2. Are there other priorities, targets and pressures which conflict or are in tension with being responsive?

3. What sorts of priorities, targets, pressures, incentives and so on have the most impact on the way you organise and deliver your services as a practice? (ie what drives what they do – prompt – patient voice and choice / demand too)

* “Practice responsiveness is the way in which a practice communicates and engages with its patients and their carers and responds to their non-clinical needs and preferences, reflecting the different ways in which they might prefer to access the service and an appropriate clinician, book, or indeed cancel an appointment. It includes the practice’s attitude to customer service and friendliness of staff, the environment in which patients wait to be seen and the way in which they interact and support patients from particular groups, such as those with hearing or sight loss or people from a black or minority ethnic background.”

Implementing responsiveness

4. Have you tried to improve your responsiveness (e.g. by setting up a PPG, by mapping needs, by working through the PM network resources on improving the patient experience, doing work with specific disadvantaged groups e.g. travellers...).
   a. Why did you decide to do this?
   b. How have patients / the practice benefitted from this?

5. How are your efforts to be responsive been affected by government-led initiatives to change the organisation and delivery of primary care, e.g. federations – consortia – CCGs, reduction in overall budgets, no funding to meet CQC registration criteria, subsequent reduction in staff numbers, moving services from secondary to primary care?

6. What about the effects of changes at a local level, e.g. the rise of large private companies, such as The Practice Plc?

7. Do you feel that you, as a practice, have ‘bought into’ the need to be responsive, or if you see it as something you are under pressure to do?
Appendix 16: Public health and CCG staff interview guide

Responsibility to be responsive
1. Whose responsibility do you feel it is to improve responsiveness* to diverse groups (e.g. DH, CCGs, PCOs, etc)?
2. To what extent do you feel it is a priority within your CCG?

Motivation to be responsive
3. Do you think there are currently pressures and incentives for PCOs to be more responsive to the needs of diverse patient groups? What are they (e.g. policy, patient choice, cost)?
4. Are there other priorities, targets and pressures which conflict or are in tension with being responsive?
5. What sorts of priorities, targets, pressures, incentives and so on have the most impact on the way you organise and deliver your services as a CCG? (i.e. what drives what they do – prompt – patient voice and choice / demand)

Implementing responsiveness
6. Have you tried to improve responsiveness across practices within the CCG (e.g. by setting up a PPG, by mapping needs, by working through the PM network resources on improving the patient experience, doing work with specific disadvantaged groups e.g. travellers...)?
   a. Why did you decide to do this?
   b. How have patients / the PCO / the CCG benefitted from this?
7. Are there any barriers to improving responsiveness?
   a. How does responsiveness fit with other pressures or agenda?
8. How are your efforts to be responsive been affected by government-led initiatives to change the organisation and delivery of primary care, e.g. federations – consortia – CCGs, reduction in overall budgets, no funding to meet CQC registration criteria, subsequent reduction in staff numbers, moving services from secondary to primary care?
9. What about the effects of changes at a local level, e.g. the rise of large private companies, such as The Practice Plc?
10. Do you feel that you, as a CCG, have ‘bought into’ the need to be responsive, or if you see it as something you are under pressure to do?

* “Practice responsiveness is the way in which a practice communicates and engages with its patients and their carers and responds to their non-clinical needs and preferences, reflecting the different ways in which they might prefer to access the service and an appropriate clinician, book, or indeed cancel an appointment. It includes the practice’s attitude to customer service and friendliness of staff, the environment in which patients wait to be seen and the way in which they interact and support patients from particular groups, such as those with hearing or sight loss or people from a black or minority ethnic background.”
Appendix 17: Coding frame for general practice staff interviews

<table>
<thead>
<tr>
<th>Responsiveness domains</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accessing services</strong></td>
<td></td>
</tr>
<tr>
<td>Accessing or signposting to other services</td>
<td></td>
</tr>
<tr>
<td>Appointment system</td>
<td></td>
</tr>
<tr>
<td><strong>Customer service</strong></td>
<td></td>
</tr>
<tr>
<td>Answering queries, giving advice, dealing with complaints</td>
<td></td>
</tr>
<tr>
<td>People skills including flexibility and treating people as individuals</td>
<td></td>
</tr>
<tr>
<td><strong>Don’t believe in responsiveness</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Environment</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Information and engagement</strong></td>
<td></td>
</tr>
<tr>
<td>Communication from practice to patients</td>
<td></td>
</tr>
<tr>
<td>Educating patients</td>
<td></td>
</tr>
<tr>
<td>Ensuring staff are good communicators</td>
<td></td>
</tr>
<tr>
<td>Language provision and appropriate formats</td>
<td></td>
</tr>
<tr>
<td>Telling patients about changes</td>
<td></td>
</tr>
<tr>
<td><strong>Engagement with patients</strong></td>
<td></td>
</tr>
<tr>
<td>Actively monitoring and seeking feedback</td>
<td></td>
</tr>
<tr>
<td>Being available</td>
<td></td>
</tr>
<tr>
<td>Engaging with the community</td>
<td></td>
</tr>
<tr>
<td>Having a PPG</td>
<td></td>
</tr>
<tr>
<td>An obstacle</td>
<td></td>
</tr>
<tr>
<td>Conduit for dealing with patient suggestions and complaints</td>
<td></td>
</tr>
<tr>
<td>Desiring a representative membership</td>
<td></td>
</tr>
<tr>
<td>Do surveys for the practice</td>
<td></td>
</tr>
<tr>
<td>Encouraging the seldom-heard to get involved</td>
<td></td>
</tr>
<tr>
<td>Focus group-like, arms-length listening</td>
<td></td>
</tr>
<tr>
<td>Moanfest</td>
<td></td>
</tr>
<tr>
<td>Negotiation</td>
<td></td>
</tr>
<tr>
<td>Patient education (clinical)</td>
<td></td>
</tr>
<tr>
<td>Patient education (non-clinical)</td>
<td></td>
</tr>
<tr>
<td>Provide practice with feedback and suggestions</td>
<td></td>
</tr>
<tr>
<td>Two-way communication</td>
<td></td>
</tr>
<tr>
<td><strong>No opinions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Managing needs, wants and expectations</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Changing policies, procedures and services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Managing expectations</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Meeting the needs of the local population and different groups</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Responding to needs, perceived needs and wants incl. alternative solutions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Meeting needs of different groups</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Characteristics</strong></td>
<td></td>
</tr>
<tr>
<td><strong>BME, cultural issues</strong></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td></td>
</tr>
<tr>
<td>Elderly or older people</td>
<td></td>
</tr>
<tr>
<td>LGBT</td>
<td></td>
</tr>
<tr>
<td>Low literacy</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td></td>
</tr>
<tr>
<td>Mothers with young children or pregnant mothers</td>
<td></td>
</tr>
<tr>
<td>Non-English speakers</td>
<td></td>
</tr>
<tr>
<td>Vulnerable - poor memory, social skills</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td></td>
</tr>
<tr>
<td>Young people and children</td>
<td></td>
</tr>
</tbody>
</table>

**Different groups, generally**

**Illnesses, conditions and disabilities**

- Blind or partially sighted
- Deaf or hard of hearing
- Disability
- Drug users and alcoholics
- Learning disability
- Mental illness
- Specific diseases
  - Cancer
  - Chronic illness
  - Diabetes
  - Epilepsy
  - HIV positive
  - Very sick

**Situation, location and lifestyle**

- Busy or working people
- Carer
- Deprived area
- Ex-prisoners
- Homeless
- Immigrants
- Sex workers
- Smokers
- Travellers

**Proactive and reactive (examples of)**

**Proactive**

- Making changes proactively
- Modes of preparation, mind-set
  - Ensuring reception staff
    - are dedicated to meet and greet or telephone duties
    - are friendly, welcoming, helpful
are incentivised or have the right motivations

| can market services |
| understand and implement policies and procedures |
| understand enough medicine |

*Ensuring that the practice*

- caters for disadvantaged groups
- communicates and works as a team
- has a good practice manager
- is prepared for the worst
- is proactively creative and innovative
- knows patients’ needs

*Table 18: Coding frame for general practice staff interviews*
## Appendix 18: Coding frame for strategic staff interviews

<table>
<thead>
<tr>
<th>Doing responsiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Federating, networks, etc</em></td>
</tr>
<tr>
<td><em>Forward planning</em></td>
</tr>
<tr>
<td><strong>Innovation</strong></td>
</tr>
<tr>
<td><em>Meeting minimum standards</em></td>
</tr>
<tr>
<td><em>Population mapping, demand modelling</em></td>
</tr>
<tr>
<td><em>Responding to local needs, community engagement</em></td>
</tr>
<tr>
<td><em>Shifting secondary to primary care</em></td>
</tr>
<tr>
<td><em>Staff training, education, guidance</em></td>
</tr>
<tr>
<td><strong>Meaning</strong></td>
</tr>
<tr>
<td><strong>Domains</strong></td>
</tr>
<tr>
<td><em>Access</em></td>
</tr>
<tr>
<td><em>Continuity</em></td>
</tr>
<tr>
<td><em>Coordination with secondary care</em></td>
</tr>
<tr>
<td><em>Customer service</em></td>
</tr>
<tr>
<td><em>Environment</em></td>
</tr>
<tr>
<td><em>Responding to feedback, complaints, surveys</em></td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
</tr>
<tr>
<td><em>Good patient care, meeting their needs</em></td>
</tr>
<tr>
<td><em>Patient-centredness, experience</em></td>
</tr>
<tr>
<td><strong>Measures</strong></td>
</tr>
<tr>
<td><strong>Responsibility</strong></td>
</tr>
<tr>
<td><em>CCG</em></td>
</tr>
<tr>
<td><em>CQC</em></td>
</tr>
<tr>
<td><em>DH</em></td>
</tr>
<tr>
<td><em>GP practices</em></td>
</tr>
<tr>
<td><em>NHS England or area team</em></td>
</tr>
<tr>
<td><em>Patient</em></td>
</tr>
<tr>
<td><em>Voluntary sector</em></td>
</tr>
<tr>
<td><strong>Structure, finances</strong></td>
</tr>
<tr>
<td><em>Finance, resource, demand, capacity</em></td>
</tr>
<tr>
<td><em>Practices and CCGs working together, federating, localities</em></td>
</tr>
<tr>
<td><em>Targets or rules in conflict with being responsive (other things)</em></td>
</tr>
<tr>
<td><strong>Thesis themes</strong></td>
</tr>
<tr>
<td><em>Implementation, improvement, embedded - culture, guideline implementation</em></td>
</tr>
<tr>
<td><em>Patient positioning, involvement</em></td>
</tr>
<tr>
<td><em>Professional values</em></td>
</tr>
<tr>
<td><em>Targets, top down vs groundswell, doing and sharing best practice</em></td>
</tr>
<tr>
<td>Bottom-up and across</td>
</tr>
<tr>
<td><em>Everyone’s responsibility</em></td>
</tr>
<tr>
<td>Ideas start at the bottom</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>Sharing good practice</td>
</tr>
<tr>
<td>Targets, incentives</td>
</tr>
<tr>
<td><em>Targets are bad and ineffective</em></td>
</tr>
<tr>
<td><em>Targets are good and effective</em></td>
</tr>
</tbody>
</table>

**Universal vs individualised**

Table 19: Coding frame for strategic staff interviews
Appendix 19: Sample terms of reference for PPGs
(from the NAPP website, now login only)

This PPG can support patients and the practice in many ways which include:

1. seeking feedback from patients on service development and provision to inform and influence practice decision making, ensuring services are responsive and continuously improve
2. being a ‘critical friend’ to the practice by providing feedback on patients’ needs, concerns and interests and challenging the practice constructively whenever necessary
3. supporting the practice to communicate with the patient population
4. assisting the practice and its patients by providing information about local groups and support services
5. communicating information about the community which may affect healthcare;
6. supporting the practice in helping patients to become more informed about their health care options
7. promoting good health and higher levels of health literacy amongst patients by encouraging and supporting activities within the practice, promoting self-care and providing information about health and wellbeing issues
8. supporting locality Clinical Commissioning Groups (CCGs) to gain feedback on healthcare and social care services to inform local commissioning decisions and planning
9. supporting Local Area Teams of the NHS Commissioning Board to gain feedback on the provision of and priorities for primary medical care services
10. building relationships with other PPGs and user-led groups in the area, e.g., Local Healthwatch, community and user-led groups
11. giving feedback to and getting involved in local and national consultations;
References


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National Primary Care Development Team., 2004. When do you want to be seen? Who do you want to see? London: Department of Health.


