TO WHAT EXTENT ARE TWENTY FIRST CENTURY GENERAL PRACTITIONERS ENTREPRENEURIAL WHEN DELIVERING PRIMARY CARE SERVICES IN NEW WAYS?

A thesis submitted to The University of Manchester for the degree of Master of Philosophy in the Faculty of Humanities

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Michael Spence

Manchester Business School
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ABSTRACT

Traditionally, General Practitioners (GPs) in England are self-employed contractors, who work in combination with other GPs as profit sharing partners (Lester, Campbell, & McDonald, 2009). The introduction of The Health and Social Care Act (The Department of Health, 2012) and a move towards ‘any willing provider’, creates opportunities for GPs and an increasing necessity to focus on their business interests. However, the NHS is facing extreme financial and capacity pressures, largely due to the expanding and ageing English population (Addicott & Ham, 2014). Hence, this study focusses on the provision of ‘new services’ within primary care, whilst exploring the extent to which GPs are required to be entrepreneurial, to provide such services.

A review of the literature revealed a substantial amount of empirical work around economic entrepreneurship theory; however, identifying a universal definition of entrepreneurship was difficult to decipher. Due to the contextual and political influences present within the primary care NHS market place, and identification that entrepreneurial working can create ‘new value’, this study has utilised the work of Rae (2007b) and his model of entrepreneurial management. However, the literature review revealed that there was minimal empirical work on entrepreneurial working within the primary care NHS context. Although two key papers focussing on GP Fundholding and entrepreneurial working were identified, namely Boyett & Finlay (1995) and Ennew, Whynnes, Jolleys, & Robinson (1998).

A case study approach was taken, relying largely on face to face interviews with practitioners involved in the delivery of new services within primary care. A purposive sampling method was used, with data collected from four different localities. Data analysis was performed using a paper based approach akin to Smith & Osborn (2003), with themes and sub-themes developed from the data.

The results of this study identify that on the whole, participants were entrepreneurial in the delivery of new services. The data express that differences exist within the extent to which participants were entrepreneurial. In terms of the motivations to deliver new services, ‘improved patient care’ was seen by all participants as being a key motivator; however a number of others such as ‘financial gain’, ‘career development’ and ‘clinical expertise’ were identified by participants. The results of this study also outline the importance of being ‘alert’ to opportunities that present themselves, with participants expressing that both formal and informal relationships with the local commissioning group were advantageous.
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My mother Janet for her dedicated proof reading and Emily, my devoted fiancée and soon to be wife, for her support throughout.

Finally, I am also very grateful to all of the participants who were kind enough to take part in this research.
Chapter 1: Introduction

1.1 Introduction

This chapter introduces the focus of the research and my motivations (1.2) for carrying out this study. The chapter also includes a brief description of the National Health Service (NHS) primary care context where the research is based (1.3); furthermore it outlines the scope of the research questions (1.6) and concludes with a brief overview of the structure of this thesis (1.9).

1.2 Motivation for the research

I was employed by The National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester as a Knowledge Transfer Associate (KTA)\(^1\), largely working with primary care practitioners, clinical and management academics to design, develop and facilitate the implementation of evidence based research into primary care practice, during the period of this research.

As part of my role, I had close proximity to a number of primary care interventions which involved the moving and provision of services closer to home i.e. away from the hospital and back into primary care. The particular interest for this research derives from the piloting of a specialist cardiology clinic that was managed within primary care, led by a General Practitioner (GP) with a specialist interest in cardiology. The service was designed to reduce the number of inappropriate referrals to secondary care cardiology. The GP involved with the service seemed to be ‘entrepreneurial’ and to develop his/her practice, challenge the traditional model of primary care delivery and keen to ensure that his/her patients received optimal care. From this working relationship, I began to question whether the GP saw him/herself as an entrepreneur. Whether or not this GP was standalone in his/her approach? How it was possible to develop a service like the GP had?

My educational background is within the field of international business and management and I have previously worked in a fast moving private sector business environment, specialising in sales and business development. As part of this role, I was involved in interactions with ‘one man band’ start-ups, small medium enterprises (SMEs) and a number of larger national and international

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\(^1\) Based on the Knowledge Transfer Partnership model, more information about the KTA role and CLAHRC Greater Manchester is available from Harvey, Fitzgerald, Fielden, McBride, Waterman, Bamford, Kislov and Boaden “The NIHR CLAHRC for GM: combing empirical practice, theoretical and experiential evidence to design and evaluate a large scale implementation strategy” Implementation Science 2011, 6:96
business, which often meant that I encountered many ‘enterprising’ and ‘entrepreneurial’ individuals.

Whilst working for the NIHR CLAHRC Greater Manchester, I was also actively working with primary care practitioners within a rapidly changing political climate. The introduction of the Health Social Care Act (The Department of Health, 2012) and the preceding White Paper appeared to create a new marketplace where GPs were actively involved in the commissioning of services and I was keen to explore what this meant for the provision of existing and new primary care services.

The motivation for this research and its focus on entrepreneurs within the NHS is bound from the anecdotal similarities I found in interactions with the GP delivering the cardiology service and those from the private sector.

1.3 The English NHS context: The changing make up of primary care
Since its inception on the 5th July 1948, The NHS has been responsible for bringing together hospitals, GPs, dentists and numerous other services in an integrated system to provide health care for the population of England (Department of Health, 2007). According to Smith, Holder, & Edwards (2013), primary care, with GPs sitting at the forefront, has long been considered as the bedrock of care provision for the NHS, acting as the gatekeeper for access, offering “entry into the system for all new needs and problems, [it] provides person focussed care over time, provides for all but very uncommon or unusual conditions and co-ordinates or integrates care provided elsewhere by others” (Starfield, 1998: 8-9). However with the legislative changes of the Health and Social Care Act 2012, the ‘gatekeeping’ role of the GP extends beyond the health care of individual patients to now include the commissioning of healthcare services.

Walshe (2012) argues that over the last 30 years the NHS has become an ever increasing political tool, with political agendas and propaganda resulting in a number of large scale re-organisations. There have been at least 15 identifiable major NHS structural changes made within the last 30 years, and there is little evidence to suggest that any of these structural re-organisations have improved, or made any positive impact (Oxman, Sackett, Chalmers, & Prescott, 2005). Although Grand, May, & Mulligan (1998) suggest that the governments mid 1990’s flirtation with primary care commissioning policy, via a) GP fundholding, b) total purchasing and c) locality based commissioning, produced some benefit to primary care provision. Thorlby, Smith, Barnett, & Mays (2012) note that such policies were particularly successful in fostering new approaches to improving quality in primary care, along with the creation of additional services at primary and...
community levels. Ennew, Whynnes, Jolley, & Robinson (1998) believe that it is the development of the quasi-market, with GPs being responsible for the provision of primary care and secondary care services, which allows for comparisons to be drawn with the Clinical Commissioning Group (CCG) structures that currently exist.

Smith, Mays, Dixon, & Goodwin (2004) state that until comparatively recently there have not been any key changes to the provision of primary care NHS services. According to Smith et al. (2004) a number of these key recent changes include:

- The diversification of a range of public, private and third sector healthcare providers that are commissioned by the NHS (Addicott & Ham, 2014).
- The development of new forms of service provision such as primary care walk-in centres, one-stop centres, and private and NHS owned diagnostic and treatment centres for elective surgery (Smith, Holder, Edwards et al., 2013).
- The introduction of ‘payment by results’ to reimburse and commission providers of healthcare services i.e. the Quality Outcome Framework (Grant et al., 2009).
- The renewed interest in creating a competitive mixed market place, to include the provision of care by Foundation Trusts and independent service providers.

For the purpose of this research, the most pertinent developments of the NHS structure relate to GP fundholding and the current CCG model, rather than the whole historical development of the NHS structure.

1.3.1 The development of a quasi-market
Boyett & Finlay (1995) identified that the publication of the Griffiths report in 1983 highlighted the need for a ‘business approach’ to management, with policy makers general approach centred around the development of ‘quasi-markets’. These were artificial internal markets which encompassed both the purchasers and providers of healthcare services. Exworthy, Powell, & Mohan (1999) note that it is often claimed that the Conservative governments of 1979 – 1997 ‘marketised’ the NHS. This has been described in a number of ways with Walsh (1995); Flynn (1997); Salter (1998) believing that market mechanisms were injected; Ranade (1998) notes the rise of markets; Powell (1997) outlines a greater market orientation, and Mohan (1995) stresses the move towards a more entrepreneurial NHS.

Propper (1995) believes that one of the key aspects of the development of the quasi-market was that public sector health service providers changed from simply being ‘departmental
administration’ arms of the wider public sector enterprise, to be free standing entities with their own borrowing rights from central government. Le Grand (1991) outlined that the key features of the quasi-market involved the development of agents who were responsible for purchasing on behalf of end users and a supply side which largely comprised of non-for-profit organisations and government owned enterprises. According to Propper (1995), Le Grand (1991) believed that a number of market conditions needed to exist in order for quasi-markets to meet the governmental goals of increased efficiency, equity and a consumer responsive NHS. These included:

a) A competitive or contestable market
b) Sufficient information should be available for purchases, in order to make informed choices
c) Transaction costs should be low
d) The motivation of providers should have some financial aspect to them
e) Purchasers should be motivated to take into account the ideas of consumers
f) Opportunities for selection by both purchases and providers i.e. cream-skimming or dumping, should be limited.

Consequently as highlighted by Boyett & Finlay (1995), the quasi-market involved a new system of contracting for healthcare, which introduced an ‘intermediate customer’ and created an artificial ‘internal market’ between providers and purchasers of services. The development of the quasi-market reflected the government’s belief in the power of competition. As part of the marketplace the NHS was split into two distinct ‘provider’ and ‘purchaser’ arms. The providers supplied health care services i.e. hospitals, whereas the purchasers were usually a) district health authorities, b) fundholding GPs, and/or c) private individuals.

1.3.2 GP fundholding
Ham & Shapiro (1995) note that GP fundholding was introduced as part of the Conservative governments NHS Reforms in 1991, with ministers claiming that it was a voluntary scheme. There was a rapid uptake in fundholding with 7% of England’s population covered by the scheme in 1991-1992, increasing to 40% in 1995-1996. Kay (2002) reported that when the Labour government abolished fundholding in 1997-1998, 57% of the GPs in England were fundholders.

Kay (2002) goes on to explain that fundholders were privy to a different set of ‘property rights’ to non-fundholders, they were empowered to negotiate their own secondary care hospital contracts.
and to decide which patients, services and providers would benefit from their funds. Non-fundholders had to rely on the local Health Authority for these decisions.

The introduction of GP fundholding is a landmark moment within primary care, because it was the first scheme to involve GPs in key leadership and decision making roles related to the provision and commissioning of NHS services. It was the first step towards primary care commissioning, which Smith, Mays, Dixon, & Goodwin (2004) define as being:

‘Commissioning led by primary health care clinicians, particularly GPs, using their accumulated knowledge of their patients’ needs and of the performance of services, together with their experience as agents for their patients and control over resources, to direct the health needs assessment, service specification and quality standard setting stages in the commissioning process in order to improve the quality and efficiency of health services used by their patients.’ (Smith et al, 2004: 5)

The creation of a ‘purchaser, provider’ resulted in two models of purchasing, the first concerned Health Authorities and involved the purchasing of services in relation to the health needs of the population; the second concerned general practices and it involved the purchasing of services to improve patient care by allocating a budget to each general practice (Smith et al., 2004). As part of this process groups of fundholding general practices started to create organisations or GP consortia, that could pool resources, avoid competition and share in the financial risks (Mays & Dixon, 1996).

The development GP fundholding is important for this investigation as comparisons have been made to today’s CCG structure (Klein, 2013; Walshe, 2012), where for the first time, GP fundholders were able to purchase NHS services which they believed to be of patient benefit.

1.3.3 Primary care groups to primary care trusts
As the new Labour government came into power in 1997, they announced their ten year vision, in the White Paper document The New NHS – Modern and Dependable (The Department of Health, 1997). According to Klein (2013), this was a move to co-operation rather than competition, with the internal market to be abolished, but with some of its characteristics remaining and the introduction of a top down performance and management system. According to Smith et al. (2004) the purchaser-provider split remained, but the overall responsibility for commissioning health services fell within the remit of the Health Authorities. Certain elements of health care commissioning, such as community health was devolved to the 481 newly created Primary Care Groups (PCGs), with membership being made compulsory for all GPs and primary care health professionals. According to NHS Executive (1994) PCGs had three main functions:
1. To improve the health of the population in the PCG
2. To develop primary and community health services within the PCG
3. To commission secondary and tertiary services for the population in the PCG.

However, as Klein (2013) notes, five years later, the barriers to an internal market were once again removed with commissioning services being devolved on a local level to Primary Care Trusts (PCTs)², who were responsible for 75% of NHS budget to commission services from not only NHS institutions, but from both private and overseas firms.

According to Smith et al. (2004) criticisms of the PCTs largely centred around their increasing management and corporate culture, and their lack of clinical engagement and support (Lewis, 2004; NHS Alliance, 2004; Smith & Walshe, 2004). This was perhaps a pre-cursor for the current system and the changes made by the Coalition government (2010-2015).

1.3.4 The White Paper Equity and Excellence 2010
Despite the pre-election promises from Andrew Lansley (Secretary of State for Health at the time) to “stop the top-down re-organisations of the NHS that have got in the way of patient care” (HM Government, 2010), new plans outlined in The White Paper Equity and Excellence: Liberating the NHS (Department of Health, 2010), showed a shift from such pre-election ideals. According to Walshe (2012) The White Paper document planned to abolish PCTs and Strategic Health Authorities (SHAs); with around 500 newly created GP commissioning consortia groups to control healthcare commissioning, public health responsibilities and a number of previously managed local authority commitments. The Department of Health would be stripped of many of its primary functions; these would be undertaken by a new independent NHS board. NHS hospital providers would be forced to become Foundation Trusts rather than the mixed model that existed and the arrangements for healthcare regulation would be restructured. Rowlands (2010) states that the plans accounted to around 80% of the NHS budget being placed under the control of the GP commissioning consortia³. The key changes outlined by Equity and Excellence: Liberating the NHS are displayed in figure 1.1.

Poole, Dixon, Goodwin, & Raleigh (2011) note that the decision to dissolve PCTs and bring GPs to the forefront of commissioning decisions was an attempt to provide a more transparent and systematic approach to how quality was measured, monitored, managed and reported on; in a

---
² Primary Care Trusts were introduced to replace Primary Care Groups.
³ Since the enactment of the Health and Social Care Act, ‘GP consortia’ have been called by a different name; this being Clinical Commissioning Groups (CCGs).
way which went much further than the current Quality Outcomes Framework (QOF). As figure 1.1 illustrates, there was also direct reference to ‘promoting competition’ and patients having the choice of ‘any provider’; the White Paper suggested a movement towards a quasi-market where public and private sector organisations would compete to provide health services.

**Figure 1.1 Key elements of Equity and Excellence: Liberating the NHS**

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<th>Putting Patients and Public First</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Shared decision making will become the norm ‘no decision without me’</td>
</tr>
<tr>
<td>B) Patients will have the choice of any provider</td>
</tr>
<tr>
<td>C) Health Watch England will be created to express the views of local patients and the public</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improving Health Care Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) NHS will be held accountable against clinically credible evidence based outcome measures rather than process targets</td>
</tr>
<tr>
<td>B) Quality standards developed by NICE will inform commissioning decisions</td>
</tr>
<tr>
<td>C) Drug companies will be paid on the basis of the value of new medicines</td>
</tr>
<tr>
<td>D) Payments will be made to providers according to performance, reflecting outcomes not just activity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Autonomy, Accountability and Democratic Legitimacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Power and the responsibility for commissioning services will be devolved to the healthcare professionals working closest to patients i.e. GPs and their practice teams through ‘Consortia’</td>
</tr>
<tr>
<td>B) NHS services will be joined, combining social care and health improvement</td>
</tr>
<tr>
<td>C) An independent and accountable NHS Commissioning Board will be created, taking the lead on the achievement of health outcomes</td>
</tr>
<tr>
<td>D) Monitor will become an economic regulator, promoting competition, regulating prices and safeguarding the continuity of services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cutting bureaucracy and improving efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) £20bn of efficiency savings by 2014, which will be reinvested into the NHS</td>
</tr>
<tr>
<td>B) NHS Management costs will be reduced by 45% over the next 4 years</td>
</tr>
<tr>
<td>C) Radically de-layer and simplify the number of NHS bodies</td>
</tr>
</tbody>
</table>

Adapted from (Department of Health, 2010)

1.3.5 Clinical Commissioning Groups

There was wide spread criticism and opposition to many of the proposals outlined in Equity and Excellence: Liberating the NHS (Department of Health, 2010), Klein (2013) states that after the introduction of the White Paper, there was the usual public consultation exercise, however this had little effect and there was unrelenting press, professional and political opposition to the proposed changes, which resulted in the government taking the unusual step of ‘pausing’ and setting up the NHS future forum to review the proposal. Professor Steven Field (Head of the NHS Future Forum) explains the reasons why further consultation was necessary,
‘There is no doubt that the NHS needs to change. The principles underlying The Bill – devolving control to clinicians, giving patients real choices and control, and focusing on outcomes – are well supported. However, during our listening we heard genuine and deep-seated concerns from NHS staff, patients and the public that must be addressed if the reforms are to be progressed. If the substantial changes we propose are accepted by government, then I think the resulting framework will place the NHS in a strong position to meet this objective and tackle the pressing challenges in the years ahead.’ (NHS Executive, 2011)

The recommendations made by the NHS future forum, were largely listened to and amendments were made to the original Bill. Figure 1.2 below highlights the main elements of the Health and Social Care Act 2012 (The Department of Health, 2012).

**Figure 1.2: Key elements of The Health and Social Care Act 2012**

<table>
<thead>
<tr>
<th>The Health and Social Care Act 2012 – Main elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>The majority of NHS healthcare will be purchased by consortia of GPs, which are to be known as CCGs. These will replace PCTs and CCGs will continue to receive central funding on the basis of the size and composition of their populations</td>
</tr>
<tr>
<td>CCGs will be funded by and be accountable to the newly created NHS Commissioning Board—itself answerable to the Department of Health. The Department of Health will no longer have any direct, day-to-day control over the NHS, to ensure the service is protected from direct political intervention</td>
</tr>
<tr>
<td>All NHS providers of hospital and community services must become Foundation Trusts (FTs). These are independent legal entities—public-benefit corporations—which consist of an elected board of governors and an obligation to balance the books. FTs are to be allowed to generate up to 49 percent of their income from private patients</td>
</tr>
<tr>
<td>Monitor, is to become the competition regulator for the health care sector. Monitor will license providers and be responsible for identifying potentially anti-competitive behaviour. Along with NHS Commissioning Board, Monitor will regulate prices through a national tariff. The Care Quality Commission (CQC) will continue to be regulatory body for quality.</td>
</tr>
<tr>
<td>Local authorities will take over the responsibilities for public health commissioning. New Health and Wellbeing Boards will bring together local authority representatives and NHS commissioners to agree on integrated ways of improving local health.</td>
</tr>
<tr>
<td>Existing local level patient involvement groups such as LINK, are to be replaced by a new organisation, called Health Watch</td>
</tr>
<tr>
<td>Top-down performance management targets are to be scrapped in favour of more outcome focussed indicators</td>
</tr>
<tr>
<td>Changes in the managerial structure of the NHS will include a cull of agencies in the health care arena and the abolition of the Department of Health’s regional offices. The overall aim is to cut management costs by 45 percent.</td>
</tr>
</tbody>
</table>

Klein (2013: 852)
The creation of a quasi-market which involves competition for the provision of services from not just the NHS but from alternative providers of medical services (APMS), means that within this current climate it is possible for GPs, general practices, or groups of general practices to be able to offer services that were previously offered by secondary care providers. This is perhaps even more pertinent, due to the current backdrop of financial crises and the requirements of efficiency savings of £20bn by the end of 2014 (National Audit Office, 2011).

1.3.6 Innovative models in primary care
According to Thorlby et al. (2012) perhaps the biggest challenge for general practices is to ensure that they pay attention to the health of all of the population who are on their practice list, rather than focussing on those patients who seek the most advice and support. General practices and GPs must develop proactive models of healthcare to anticipate the needs of their practice before they present and arise, thereby enabling earlier and more effective interventions. Addicott & Ham (2014) outline that England’s population is expanding and ageing, which is causing increasing pressure on the NHS in general and on primary care in particular. Such pressures are also compounded by the increasing prevalence of long-term conditions and multi-morbidity due to the impact of risk factors i.e. smoking, alcohol misuse and obesity; which tend to cluster in certain communities (Buck and Frosini, 2012).

As part of this process, CCGs are looking to commission services in different ways and due to the structural changes of primary care, GPs and general practices may be in a position to provide a range of these. This research will focus on the provision of new or ‘non-traditional’ services, through the lens of entrepreneurial theory, to investigate the extent to which GPs are required to be entrepreneurial when delivering such services.

1.4 Review of the literature
An initial literature review found a wealth of academic research on the development of economic theory of the entrepreneur within the private sector, along with considerable academic literature around whether entrepreneurial behaviour can be taught within academic institutions, and entrepreneurs in the public sector, but a lesser amount of literature focussing on entrepreneurs in the NHS, particularly with relevance to primary care and GPs.

The initial literature review showed that there has been widespread academic debate over the past century regarding a universal definition of what an entrepreneur is (Casson, 2003; Chell, Howarth, & Brearley, 1991; Eisenmann, 2013; Rae, 2007b), with there still being no unified definition. The literature also illustrated that over the past twenty years it has been widely
accepted that entrepreneurial activity is not simply bound to the classical economic profit making model; with a greater focus on activity (Bolton & Thompson, 2004; Rae, 2007b), with increasing relevance to the public sector through the work on ‘policy entrepreneurship’, ‘public entrepreneurship’ and ‘institutional entrepreneurs’ (Tuohy, 2012). The English NHS primary care context is neither a public nor private sector market, but consideration of the more ‘modern’ day academic work around entrepreneurial behaviours and actions around innovation, creation, motivation (Bolton & Thompson, 2004; Kirzner, 1982; Leibenstein, 1966) are explored and have relevance.

The literature review also showed that there has been little academic work around entrepreneurship in healthcare, particularly within the English NHS. Literature tended to focus on international private healthcare systems and have little relevance within the English NHS (Baines, Bull, & Woolrych, 2010; Currie, Humphreys, Ucbasaran, & McManus, 2008; Exton, 2008; Lockett, Currie, Waring, Finn, & Martin, 2012). However, as part of the review two key papers looking at entrepreneurial working within GP fundholding structure were identified (Boyett & Finlay, 1995; Ennew et al., 1998) and these have been explored further in sub-sections 2.8.1 and 2.8.2.

1.5 Pilot study
As previously outlined, the literature review revealed limited empirical work focussed on entrepreneurship in primary care. Consequently, I was keen to further understanding this area and keen to establish if this was a valid area to research. Two pilot interviews were conducted with key informants from primary care, and these are described in more detail in sub-section 3.5.2 (b). In summary, the findings of the pilot study are:

- The term entrepreneur was understood by GPs
- The political context and developing CCGs appeared to possess similar characteristics to GP fundholding
- GPs need to be entrepreneurial to compete and to keep their practices financially viable.

The findings of the pilot investigation, along with the literature review, were used to develop the research questions below.

1.6 Research questions
Drawing on my professional experience, specific interactions with GPs and member of CCGs, the review of the literature and the result of the pilot study, a number or key areas of interest were identified to investigate further. The first and primary area that I was keen to explore involved the
notion of whether GPs are entrepreneurial when delivering non-traditional or new services. The pilot study and the literature review identified that this was an area that had not been particularly researched. However, it seemed like there was an ever increasing number of new services being delivered in primary care, which required GPs to work in new ways. Hence, I was keen to establish the extent to which this was led by GPs, and whether this involved entrepreneurial working.

The second area of focus arose from my professional experience and the literature review as I was keen to understand the roles individuals within the GP practice/service played in the delivery of new services. With the development of GP practice teams to include administration staff, nurse prescribers, health care assistant and practice managers amongst others, I was keen to establish the roles that people played in the delivery of new services.

The third and fourth areas of focus centred on the NHS primary care context and the rapidly changing nature of primary care. The literature review revealed the numerous organisational restructures that primary care had been through. At the time of developing this research, the development of CCGs was very topical and the changes were being introduced at a rapid pace. I was keen to investigate the relationships and the influences that CCGs had on the delivery of new services.

These areas of interest were developed into four research questions, with the primary question being focussed on the entrepreneurship literature and its resonance within GPs providing new services. The three secondary questions are very much related to the NHS primary care context and their influences:

<table>
<thead>
<tr>
<th>Primary research question</th>
<th>1) To what extent does a GP have to be entrepreneurial to deliver a service in a new way?</th>
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</thead>
<tbody>
<tr>
<td>Secondary research question</td>
<td>2) How does the inner practice relationship result in a service being delivered in a new way?</td>
</tr>
<tr>
<td></td>
<td>3) What influence does the practice relationship with the commissioning group have in delivering a service in a new way?</td>
</tr>
<tr>
<td></td>
<td>4) To what extent do the priorities of the commissioning groups have an effect on the practice delivering a service in a new way?</td>
</tr>
</tbody>
</table>

1.7 Research methodology
As the review of the literature and pilot study identified, there was little understanding or data focussing on the entrepreneurial behaviour of GPs, an instrumental case study approach
(Scapens, 1990; Stake, 2000) has been adopted for this research. Data will be collected from four different geographical sites, but a single case study method (Yin, 2009) will be adopted, as Yin (2003) states that a case study strategy is justified in studies that involve complex multivariate or contextual conditions. The GPs will be the case rather than focussing on the individual data collections sites.

Data will be collected from four different sites using semi-structured interviews. Each interview will be digitally recorded and transcribed. A flexible inductive approach to the interview analysis will be taken utilising an approach akin to Smith & Osborn (2003) which is a paper method of data analysis involving the grouping of themes and linkages to develop ‘superordinate themes’.

1.8 Scope of the research
All of the 4 data collection sites are based within Greater Manchester as this research was conducted on a part-time basis whilst I was in full time employment and further travel was not possible due to my time constraints. Greater Manchester is comprised of 12 CCG localities, within which there 538 GP practices servicing approximately 2.9m people (North West CCG and HWB Boundaries, n.d.). The CCGs in Greater Manchester vary in size and in their population demographics. All of the data collection sites provide a ‘new’ primary care service.

1.9 Thesis structure
This thesis is structured as follows:

Chapter 2 provides a critique of the historical development of the entrepreneurship literature from its economic theory routes to the more modern day approach of entrepreneurial activity and behaviour. The chapter also outlines the model of entrepreneurial management and concludes by outlining the key literature relating entrepreneurship theory to that of GP fundholding.

Chapter 3 provides justification for adopting a single case study approach. The chapter also details the research design and describes how the data was collected and analysed.

Chapter 4 presents the findings of this research; the data is displayed in sections associated to answering the four research questions.

Chapter 5 discusses the results presented in chapter 4, in relation to the literature identified in chapter 2 to discuss the findings in relation to a) the individual (5.2), b) the GP practice/service (5.3), and c) the external context (5.4).
Chapter 6 provides a summary of the research, along with the contributions, limitations and implications of this research. The chapter concludes with providing future research topics.

1.10 Research question
This study focusses on the following research question:

‘To what extent are twenty first century general practitioners entrepreneurial when delivering primary care services in new ways?’
Chapter 2: Literature Review

2.1 Review methodology

Easterby-Smith, Thorpe, & Lowe (2002) outline that there are a number of ways in which a literature search can be performed; the most obvious beginning with the use of the library. As Collis & Hussey, (2003); Easterby-Smith et al. (2002); Ghauri & Gronhaug, (2005) outline, the use of electronic journal resources and articles specific to the field of study, coupled with books, should be used when conducting a literature review. As table 2.1 shows, for this study a number of search terms focussing around ‘entrepreneurship’, ‘GPs’ and the ‘primary care nhs’ were used across library, e-journals, health care specific journals and ‘trade’ magazines.

<table>
<thead>
<tr>
<th>Search terms</th>
<th>Databases</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘entrepreneur’</td>
<td>John Ryland Library</td>
</tr>
<tr>
<td>‘entrepreneurship’</td>
<td>ProQuest</td>
</tr>
<tr>
<td>‘public sector entrepreneurship’</td>
<td>Springer</td>
</tr>
<tr>
<td>‘non-profit entrepreneurship’</td>
<td>EBSCO</td>
</tr>
<tr>
<td>‘policy entrepreneurship’</td>
<td>Science Direct</td>
</tr>
<tr>
<td>‘social entrepreneurship’</td>
<td>ABI Inform</td>
</tr>
<tr>
<td>‘healthcare and entrepreneurship’</td>
<td>Medline</td>
</tr>
<tr>
<td>‘nhs and entrepreneurship’</td>
<td>Kings Fund</td>
</tr>
<tr>
<td>‘GPs and entrepreneurship’</td>
<td>Nuffield Trust</td>
</tr>
<tr>
<td>‘doctors and entrepreneurship’</td>
<td>British Medical Journal</td>
</tr>
<tr>
<td>‘fundholding and entrepreneurship’</td>
<td>Health Foundation</td>
</tr>
<tr>
<td>‘CCGs and entrepreneurship’</td>
<td>NICE – Eyes on Evidence</td>
</tr>
<tr>
<td>‘quasi-market and entrepreneurship’</td>
<td>Department of Health</td>
</tr>
<tr>
<td>‘fundholding’</td>
<td>NHS England</td>
</tr>
<tr>
<td>‘nhs primary care’</td>
<td>NHS Information Centre</td>
</tr>
<tr>
<td>‘quasi-market and nhs’</td>
<td>Google Scholar</td>
</tr>
<tr>
<td>‘GPs and innovation’</td>
<td></td>
</tr>
<tr>
<td>‘hybrid organisations’</td>
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</table>

This produced over a thousand references, the majority of which were irrelevant to this study; sub-section 2.8 describes in more detail the irrelevant nature of the literature relating to entrepreneurship in the NHS. Consequently, a snowballing approach was taken, using the key references from relevant sources of literature and key authors from the field.

4 Snowballing is the practice of using the reference list of a piece of literature, to inform and guide other literature related to the subject (Collis & Hussey, 2003)
2.2 Introduction to entrepreneurship

Over the last 20 years, the business sector has increasingly become concerned with the concept and idea of entrepreneurship, with entrepreneurs evolving into ‘super heroes’ who fight to maximise the most of business opportunities (Burns, 2007). Alvarez (1996: 192) stated that love for entrepreneurship is universal and worldwide ‘entrepreneurship fervour in the 1980’s became a worldwide movement, spreading across countries regardless of development or even the basic mentality of value creation towards business activities’. Gibb (1996) puts the increasing contemporary interest in entrepreneurship down to three main factors:

- Economic development and the creation of jobs
- Strategic adjustment and/or realignment
- National deregulation of services and privatisation of public utilities and government owned enterprises.

However it is important to recognise that while there is an increasing contemporary focus on entrepreneurship, the origins relate back to the early economic theories of capitalist markets (Tuohy, 2012).

As far back as the eighteenth century, scholars have debated and deliberated entrepreneurship and the role of the entrepreneur within economy and society (Kirby, 2003). The ‘traditional’ concept developed by seminal work of Richard Cantillon (1755) and Jean-Baptiste Say (1803) identified that an entrepreneur’s social identity was formed predominantly through economic history (Chell et al. 1991; Hebert & Link, 1988), with the entrepreneur being an agent of economic change and activity (Rae, 2007). The work of Schumpeter (1934), Kirzner (1973) and Leibenstein (1957) introduced that facet of uncertainty and dynamism within the role of the entrepreneur. Rae (2007) outlines in ‘modern entrepreneurship’ theory, where uncertainty is assumed to exist, entrepreneurs are given a chance to create or exploit innovations and profit making opportunities.

Over more recent times, political scientists have developed the concept of entrepreneurship to evolve from the profit income model of the economic theorists, to focus on ‘innovation’ and ‘value creation’ rather than profit, which are inherent of public sector and service sector organisations. Tuohy (2012) outlines that different types of entrepreneurs have evolved, with ‘economic entrepreneurs’, ‘policy entrepreneurs’, ‘public entrepreneurs’, and ‘institutional entrepreneurs’ playing key roles within organisations.
This literature review will describe and critique the historical development of entrepreneurship theory, whilst looking at the roles, processes and influences that entrepreneurs play within organisations.

2.3 Complexities in defining entrepreneurship

Richard Branson (founder of Virgin Management Limited), who many would describe as an entrepreneur, admits that defining exactly what an entrepreneur is, is not easy.

‘There is no simple answer. It is clear that successful entrepreneurs are vital for a healthy, vibrant and competitive economy. If you look around you, most of the largest companies have their foundations in one or two individuals who have the determination to turn a vision into reality.’ (Anderson, 1995: 3)

Defining what entrepreneurship is and what entrepreneurs do, is something of considerable academic debate. Chell et al. (1991: 1) state that ‘the problem of identification of an entrepreneur has been confounded by the fact that there is still no standard, universally accepted definition of entrepreneurship’. Eisenmann (2013) emphasizes that the meaning of entrepreneurship is ‘elastic’ depending on the viewpoint of the expresser. Casson (1982: 22) states that the ‘definition of the entrepreneur is one of the most crucial aspects of the theory’, identifying that there are two main approaches: a) the functional approach, and b) the indicative approach. However, Casson (1982) laments that the problem with defining the theory of entrepreneurship is that these two approaches have never been integrated, leading Chell et al. (1991: 2) to come to the conclusion that continuing to ask the question ‘what is entrepreneurship and who are entrepreneurs?’ is perhaps futile. However, Rae (2007b: 24) has a slightly different viewpoint and asks ‘is entrepreneurship a form of behaviour which is practised by people we can readily identify and label with a fixed identity as entrepreneurs, or is it instead a way of the working which is flexible and contingent, depending on personal, social, economic and organisational factors?’

To be able to answer the question posed by Rae (2007b) and to attempt to define entrepreneurship and understand what entrepreneurs do, it is necessary to review the historical development of the theory of entrepreneurship from its eighteenth century origins, through to the modern day.

2.4 The classical economy and the entrepreneur

The classic economy refers to the economic contribution made by the entrepreneur, before the later part of the nineteenth century; this is often referred to as the ‘political economy’. There are a number of developments to the theory of the entrepreneur during this period of time, with the most cited being the work of Cantillon (1755), Say (1803), and Menger (1871). Kirby (2003)
categorises the different classical contributions to the entrepreneurs into their country of origin, these being a) the French school, b) the American school, c) the Austrian school, d) the British school, and e) the German school. However, it is important to note that Casson, Yeung, Basu, & Wadeson (2008) outline that the writings of the classical economics theorists are open to wide interpretation.

2.4.1 The French school
The ‘traditional’ concept developed by the seminal work of Cantillon (1755) and Say (1803), identified that an entrepreneur’s social identity was formed predominantly through economic history (Chell et al. 1991; Hebert & Link, 1988). Cantillon (1755) and Say (1803) developed the notion that an entrepreneur was a person who would make buying and selling decisions within changing market conditions to find profit opportunities. The entrepreneur would buy from one place at a known and fixed price and sell elsewhere at an unknown future price (Rae, 2007b). For Cantillon (1755), there was a clear distinction between the capitalist and the entrepreneur. Cantillon (1755) was the first person to introduce the term entrepreneur (Casson et al., 2008), he established that the entrepreneur was a risk-taker, who was unable to calculate the extent of the risks involved with making decisions (Kirby, 2003).

Say (1803) popularised Cantillon’s (1755) theory; however there was one key difference in his view of the entrepreneur. Unlike Cantillon (1755), Say (1803) did not believe that risk or uncertainty was a function of the entrepreneur, he believed that an entrepreneur was a manager who was required to estimate and forecast demand (Kirby, 2003).

The French school of thought has been key to the development of entrepreneurial theory, with Chell (2008) arguing that the analysis of Cantillon’s (1755) theory raises a number of issues, the resolution of which is vital to a contemporary understanding of the role of entrepreneurs, these issues are:

- The nature of risk and uncertainty facing the entrepreneur, as a decision maker
- The clear definition between the role of entrepreneurs and the capitalists within an economy
- The innovative function of the entrepreneur.

2.4.2 The British School
The work of Smith (1776) and Ricardo (1817) conflated the role of the entrepreneur with that of the capitalist (Casson et al., 2008; Kirby, 2003). Ricardo (1817) held the view that three factors of land, labour and capital were rewarded through rent, wages and profits accordingly (Casson et al.,
2008). Kirby (2003) argues that profits were realised as a reward for risking capital, they were not achieved through anticipating the future and directing the business appropriately. Entrepreneurs invested in their own businesses in line with demand for their products, from which they were rewarded. Casson et al. (2008) argue that the conflation of the role of the entrepreneur and the capitalist is actually an example of the entrepreneur being excluded from the classical economic theory within Britain. Hebert & Link (1988: 37) identify that Smith (1776) viewed the entrepreneur as a ‘menace or boon’, which leads the theory of the entrepreneur to be ‘rather muddled’ (Chell, 2008: 22).

2.4.3 The American School
The notion of the entrepreneur emerged through the work of Amasa Walker (1799-1875), who believed the role to be one involving the creation of wealth (Kirby, 2003). According to Chell (2008), Walker disassociated from the British school of thought, by suggesting that the entrepreneur was a creator of wealth, and should therefore be distinguished from the role of the capitalist. Subsequently, Amasa Walker’s son, Francis Walker (1840-1897), suggested that successful business conduct required exceptional abilities and opportunities (Chell, 2008). Kirby (2003) outlines that Francis Walker believed that successful entrepreneurs had a) foresight, b) energy, c) leadership skills, d) a faculty for organisation, and e) administration, from which they realised profit as a reward for their skill, ability and talent (Chell, 2008; Kirby, 2003).

2.4.4 The Austrian School
The origins of this school of thought are based on the work of Menger (1871), who theorised that entrepreneurial activity involved obtaining information to make decisions that lead to economic change (Kirby, 2003). Menger (1871) believed that it was the individual’s (entrepreneur’s) awareness and understanding of situations that gave rise to economic change (Chell, 2008). According to Kirzner (1973), Menger (1871) specified a number of specific functions which he believed to represent entrepreneurial activity, these being:

- Information about the economic situation
- Economic calculation in relation to developing an efficient production process
- The act of will by which goods of a higher order are assigned to a particular process i.e. wheat is turned into flour (Chell, 2008)
- The supervision of the execution of the production plan.

As part of the entrepreneurial process (the systematisation of the activities above), Menger (1871) stressed that the entrepreneur faces uncertainty in regards to the quantity and quality of the final
goods that the entrepreneur produces. Despite Menger (1871) clearly acknowledging the role of uncertainty, he did not believe that risk-bearing to be an essential function of the entrepreneur (Chell, 2008; Kirby, 2003).

2.4.5 The German School
The classical German school of thought focused on how the entrepreneur was rewarded for the entrepreneur's activity (Kirby, 2003). One of the key theorists was Von Thunen (1785-1850), who distinguished between the return, or reward, that was given to the entrepreneur and that of the capitalist, by emphasising the residual, which is in return for entrepreneurial risk: this is a risk which is uninsurable (Chell, 2008; Kirby, 2003). Von Thunen further distinguished between the entrepreneur and the manager, by suggesting that it is the entrepreneur who takes the problems associated with the firm home, not the manager. For Von Thunen the entrepreneur was both a risk taker and an innovator within the firm. The entrepreneur would receive a return for the gain or loss associated with the uninsurable risk taking and entrepreneurial ingenuity as the innovator and problem solver (Chell, 2008; Kirby, 2003).

According to Chell (2008) the notion of risk was further developed and defined by Mandoldt (1824-1858) who put forward the contemporary familiar distinction between a) producing goods to order and b) producing goods for the market. Hence where goods are produced to order the level of associated risk is reduced, whereas producing goods for the open market was much more speculative and involved a higher degree of risk propensity due to the dual market conditions of uncertainty of demand and unknown future price. Kirby (2003) highlights that Mandoldt believed that time affected the level of uncertainty, with the longer the time to final sale, the greater the risk, and by definition entrepreneurialism. Chell (2008) argues that such a distinction could serve to suggest different types of entrepreneur:

- The innovator or inventor - whose product requires a relatively long time scale to get to market.
- The opportunistic entrepreneur – who identifies a change in taste and opinion and capitalises on the foreseen opportunity.

2.4.6 Contribution to the theory of the entrepreneur
As outlined in this section, the views of the classical theorists from different schools of thought are essential in outlining the building blocks of the modern contemporary understanding of the theory of the entrepreneur. The distinction between a) the capitalist, or manager, and the entrepreneur, b) the contrasting views regarding uncertainty and risk, c) the inference of market
knowledge, d) the differing views around reward and payment, and e) the early acknowledgement of innovation, are key themes that were developed and added to throughout the neo-classical period of the nineteenth century and a prelude to contemporary thinking.

2.5 Dynamic entrepreneurship
In the previous sections of this chapter key contributions to the academic literature from the classical economic period has been discussed. This section aims to build on these economic underpinnings by focussing on the distinction between static and dynamic approaches to entrepreneurial theory and how the key contributions that selected theorists made to the development of defining entrepreneurial theory.

2.5.1 A taxonomy of entrepreneurial theory
Hebert & Link (1988) developed a taxonomy of approaches, from which they deduce two categories, these being either static or dynamic, arguing that only dynamic characterisations can have any operational meaning (Batstone & Pheby, 1996).

- **Static theories** – relate to traditional definitions where neither creativity, change nor uncertainty is present. The entrepreneur is described as having a fixed, or static, role in economic exchanges.

- **Dynamic theories** – relate to theories where uncertainty is assumed to exist and the entrepreneur has the opportunity to create or take advantage of innovations and profit making opportunities (Rae, 2007b)

As table 2.2 illustrates, within the two economic approaches, Hebert & Link (1988) identify 12 definitions or characteristics of entrepreneurs. It is important to note that these include characteristics from both the classical and neo-classical economic periods.
Table 2.2: Static and dynamic definitions of the entrepreneur

<table>
<thead>
<tr>
<th>Static definition of the entrepreneur</th>
<th>Author(s)</th>
<th>Dynamic definitions of the entrepreneur</th>
<th>Author(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person who supplies financial capital</td>
<td>Smith; Turgot; Pigou; Mises</td>
<td>Risk-taking</td>
<td>Cantillon; Thunen; Mangoldt; Mill; Hawley; Knight; Mises; Cole; Shackle</td>
</tr>
<tr>
<td>A manager or superintendent</td>
<td>Say; Mill; Marshall; Menger</td>
<td>Innovating</td>
<td>Baudeau; Bentham; Thunen; Schumpeter</td>
</tr>
<tr>
<td>The owner of an enterprise</td>
<td>Quesnay; Pigou; Hawley</td>
<td>Decision-making</td>
<td>Cantillon; Menger; Marshall; Amasa Walker; Francis Walker; Keynes; Mises; Shackle; Cole; Schultz; Hayek; Casson</td>
</tr>
<tr>
<td>An employer of factors of production</td>
<td>Amasa Walker; Francis Walker; Keynes</td>
<td>Leading an industry</td>
<td>Say; Saint-Simon; Amasa Walker; Francis Walker; Marshall; Schumpeter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Organising and co-ordinating economic resources</td>
<td>Say; Walrus; Clark; Davenport; Schumpeter; Coarse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contracting</td>
<td>Bentham</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Arbitrage (market – maker)</td>
<td>Cantillon; Kirzner; Walrus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allocating resources among alternative uses</td>
<td>Cantillon; Kirzner; Shultz</td>
</tr>
</tbody>
</table>

Adapted from Chell (2008: 47) and (Rae, 2007b)

From these 12 characteristics of the entrepreneur, Hebert & Link (1988) categorised three main theories of dynamic entrepreneurship, which are rooted from the work of Cantillon (1755), these are a) the Chicago tradition, b) the German tradition, and c) the Austrian tradition (Kirby, 2003; Rae, 2007b). Binks & Vale (1990) also summarised the historical development of entrepreneurial theory into three distinct categories, these being a) the reactive entrepreneur, b) the innovate entrepreneur, and c) the entrepreneur causing incremental and gradual change (Rae, 2007b). Table 2.3 displays how Hebert & Link (1988) and Binks & Vale (1990) relate to each other and the key associated authors from each.
Table 2.3: Three main categories of dynamic entrepreneurship

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicago tradition</td>
<td>The reactive entrepreneur as an agent of adjustment in the market economy.</td>
<td>Knight - Shultz</td>
</tr>
<tr>
<td>German tradition</td>
<td>The innovative entrepreneur causing economic change.</td>
<td>Thunen - Schumpeter</td>
</tr>
<tr>
<td>Austrian tradition</td>
<td>The entrepreneur causing incremental, gradual change through management of the enterprise.</td>
<td>Mises – Kirzner - Shackle</td>
</tr>
</tbody>
</table>

Adapted from Chell (2008: 46)

2.5.2 Chicago tradition

Knight (1921) is regularly defined as the pioneer of the Chicago tradition. Kirby (2003) states that Knight (1921) was the first neo-classical economist to identify a specific function for the entrepreneur within the general equilibrium market, other than the role of superintendence. According to Casson et al. (2008), it was Knight (1921) who deconstructed the Marshallian business manager to highlight the entrepreneurial elements that Marshall (1920) referred to. According to Chell et al. (1991), Knight (1921) believed that if change was predictable then neither profit nor loss could be achieved, only if change and the consequences of change were unforeseen was there any possibility that profit or loss could be made from such a change. Knight (1921) concluded that it was not the change itself that caused profit; it was in-fact uncertainty.

‘Without change of some sort there would, it is true, be no profits, for if everything moved along in an absolutely uniform way, the future would be completely foreknown in the present and competition would certainly adjust things to the ideal state where all prices would equal costs’ (Knight, 1921: 37)

According to Chell et al. (1991), Knight’s (1921) theory helps to distinguish between the boundaries of the manager and the entrepreneur, with a manager only becoming an entrepreneur when the exercise of his/her judgement is liable to error and he/she assumes the responsibility for its correctness. Knight (1921) suggests that there are four key characteristics of entrepreneurs who operate in conditions of uncertainty:

1. Knowledge
2. Foresight
3. Superior management ability
4. Confidence.
Knight (1921) argued that entrepreneurial income was generated in two ways: a wage or rent for the entrepreneur’s ability, and a payment for the bearing of uncertainty (Chell et al., 1991; Kirby, 2003). Knight’s (1921) work was important for the development of the theory of entrepreneurship through his distinction between risk and uncertainty, whilst starting to develop key characteristics that entrepreneur’s require.

In more recent times Schultz (1980), who was the pioneer of human capital theory, has attempted to broaden the concept of entrepreneurship through his belief that in a dynamic economy entrepreneurial behaviour and activity can be manifested by people who are not necessarily involved with the business (Chell et al., 1991). Schultz (1980: 441) states that entrepreneurial ability is the ‘ability to reallocate their services in response to changes in the value of the work they do’. From this, Schultz (1980) argues that educational activities can be considered to be entrepreneurial, he argues that people from all walks of life may face disequilibria and the essence of entrepreneurship is to possess the ability to react and deal with such conditions. Shultz (1980) links this to educational enhancement and he illustrates this using a farming example, where an entrepreneur can, through education, improve his/her knowledge and understanding of new farming techniques to gain a competitive advantage. The decision to re-allocate resources is based on the entrepreneur’s knowledge base and expectations. The success of the entrepreneur is their ability to acquire and act upon knowledge (Chell, 2008).

Schultz’s (1980) work on human capital was a key development in the theory of the entrepreneur, through his recognition that entrepreneurial ability is not confined solely to the business world and his belief that entrepreneurial ability is influenced by their entrepreneur’s education, knowledge base and experience.

2.5.3 German tradition
According to Rae (2007b), Schumpeter (1934) was one of the key originators of modern entrepreneurship theory, through his description of the entrepreneur as an innovator who engaged in the process of creative destruction by disrupting the market equilibrium. Glancey & McQuaid (2000) outline that Schumpeter (1934) saw the entrepreneur as a person who implements ‘new combinations of means of production’ and an innovator (Kirby, 2003). According to Swedberg (2000), Schumpeter (1934) developed five ways in which innovation could take place:

1. The introduction or creation of a new good or a new quality of good – one which consumers are not familiar with
2. The introduction of a new production method – one which has not yet been tested by the organisation
3. The opening up of a new market – one which the organisation has not previously been associated with
4. The capturing of a new source of supply for raw materials
5. The development of a new organisation.

As Rae (2007b) notes, Schumpeter (1934) not only described the entrepreneur as an innovator, he also characterised the entrepreneur as a leader requiring qualities of:

- Intellect
- Will
- Initiative
- Foresight
- Intuition.

In terms of payment for entrepreneurs, Kirby (2003) outlines that Schumpeter (1934) argued that entrepreneurship is the source of change, under such circumstances the reward for entrepreneurs was the profit as a residual arising due to an innovative act that results from lower costs or higher prices. According to Chell (2008), Schumpeter (1934) believed that entrepreneurial profit could be separated out from the earnings of the management, with the size of the surplus of residual profit being directly correlated with the entrepreneur’s productivity.

Schumpeter’s (1934) work was a key development in the theory of the entrepreneur; not only did it move away from the general market equilibrium concept of Walrus, but it introduces the notion of innovation in relation to the entrepreneur. Schumpeter (1934) started to develop a set of traits which have been linked to modern entrepreneurs.

2.5.4 Austrian tradition
Chell et al. (1991) note that Mises (1949) is identified as being important to the ‘Austrian revival’; he defined economic theory in relation to human action. Mises (1949) outlined that human action influences, and is influenced by, the future. According to Mises (1949) the entrepreneur was the decision maker whose behaviour influenced the future, which in itself was influenced by his/her own vision of the future (Kirby, 2003). Mises (1949) viewed the role of the entrepreneur as being a decision maker, that was all encompassing; he argued that Schumpeter (1934) had confused entrepreneurial activity with that of technological innovation. Mises (1949) argued that making
decisions about innovation was only one element of the decision making role of the entrepreneur (Chell, 2008). Furthermore, Mises (1949) stressed that the profitability of the enterprise was a direct consequence of the entrepreneurial acts, he did not believe that profitability has anything to do with the capitalist (Chell et al., 1991).

The work of Mises (1949) had a strong influence on the work of Kirzner (1973), who characterised the entrepreneurship as ‘alertness to profit opportunist’. Kirzner (1973) argued that the entrepreneur was required to be constantly watchful for short-term profit opportunities arising from market disequilibrium, where shrewd decision making and acting quickly were essential (Rae, 2007b). Chell et al. (1991) note that Kirzner (1973) distinguished between the arbitrator and the entrepreneur, by establishing that only the entrepreneur was required to act creatively and with imagination in the case of uncertainty; with the arbitrator responsible for adjusting prices and costs in light of experience. Kirzner (1982) argued that the value of entrepreneurship is to be ‘corrective’ by exploiting profit opportunities that have been unexploited. Such opportunities arise from the misallocation of resources which results in social waste. Kirzner (1982) argued that this misallocation arose from imperfect knowledge; however, it is important to note that the imperfect knowledge identified by Kirzner (1982) was concerned with awareness, rather than the gathering of knowledge; this is a different view to that taken by Schultz (1980) (Chell et al., 1991).

‘Entrepreneurial profit opportunities exist where people do not know what they do not know, and do not know that they do not know it. The entrepreneurial function is to notice what people have overlooked.’ (Kirzner, 1982: 273)

Rae (2007b) suggests that Kirzner (1973) viewed the entrepreneur as being motivated by profit within the market place, with the entrepreneur needing to search unceasingly for new opportunities. Kirzner (1973) identified that the entrepreneur outperforms others operating in the market because of his/her superior ability to perceive and act on opportunities, the difference being the entrepreneurs ability to learn from experience faster and more effectively than his/her competitors.

Kirzner’s (1973) view that entrepreneurs pursued existing opportunities is in contrast to that of Shackle (1943), who believed that opportunities existed in the imagination of the entrepreneurs, and successful entrepreneurship is the ability to create and realise this imagination. The academic debate between whether opportunities are discovered or created is one that has been rife through contemporary times and it will be further discussed during sub-section 2.6.5 of this chapter.
According to Chell (2008), Shackle (1943) identified that an entrepreneur required imagination to make decisions, with ‘enterprise’ being the choice of a course of action, the commitment to resources and the system that is devised in its pursuits. However, at the point of decision making, knowledge of the future is unknown and the entrepreneur is required to take a gamble based on his/her imagination of what is possible in the future. Shackle (1943) outlined that when deciding which possible action or decision was the best one, the entrepreneur must either draw on information or their own personal experience (Chell, 2008).

2.5.5 Antecedents to modern entrepreneurship
The contribution of economic theorists to the development of the theory of entrepreneurship cannot be denied, they have been highly influential and dominant in defining the principle of entrepreneurship. Table 2.4 expresses the key theories and the contributions that a number of economic theorist have made to the modern understanding of entrepreneurship.

However, as Rae (2007b) demonstrates, there are limitations to basing entrepreneurship theory solely on economics because economists provide theories that are associated to economic phenomena rather than entrepreneurial behaviour. Rae (2007b) believes that rather than seeing the entrepreneur as a fixed role within the economic marketplace, it is more helpful to focus on the processes and behaviours of entrepreneurship as a flexible way of working. Bolton & Thompson (2000) summarise the main conclusions from the literature around entrepreneurs and entrepreneurship into three key areas of interest:

1. What entrepreneurs are like – the personality or trait factors
2. Where entrepreneurs come from – the environmental factors
3. What entrepreneurs do – the action factors
### Table 2.4: The antecedence of modern entrepreneurship

<table>
<thead>
<tr>
<th>Date</th>
<th>Author</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>1755</td>
<td>Cantillon</td>
<td>Introduced the concept of entrepreneur from ‘entreprendre’ (ability to take charge)</td>
</tr>
<tr>
<td>1803, 1817</td>
<td>Say</td>
<td>Emphasised the ability of the entrepreneur to ‘marshal’ resources in order to respond to unfulfilled opportunities</td>
</tr>
<tr>
<td>1872</td>
<td>Menger</td>
<td>Noted the ability of entrepreneurs to distinguish between ‘economic goods’ i.e. those with a market or exchange value, and all others.</td>
</tr>
<tr>
<td>1893</td>
<td>Ely and Hess</td>
<td>Attributed entrepreneurs with the ability to take integrated action in the enterprise as a whole, combining the roles in capital, labour, enterprise and entrepreneur.</td>
</tr>
<tr>
<td>1911, 1928</td>
<td>Schumpeter</td>
<td>Envisioned that entrepreneurs proactively ‘created’ opportunity using ‘innovative combinations’ which often included ‘creative destruction’ of passive lethargic economic markets.</td>
</tr>
<tr>
<td>1921</td>
<td>Knight</td>
<td>Suggested that entrepreneurs were concerned with the ‘efficiency’ in economic factors by continually reducing waste, increasing savings and thereby creating value, implicitly understanding the opportunity-risk-reward relationship.</td>
</tr>
<tr>
<td>1948, 1952, 1967</td>
<td>Hayek</td>
<td>Continued the Austrian tradition of analytical entrepreneurs giving them capabilities of ‘discovery’ and ‘action’, recognising the existence of information asymmetry which they could exploit.</td>
</tr>
<tr>
<td>1975, 1984, 1985</td>
<td>Shapero</td>
<td>Attributed a ‘judgement’ ability to entrepreneurs to identify ‘credible opportunities’ depending on two critical antecedents – perceptions of ‘desirability’ and ‘feasibility’ from both personal and social viewpoints.</td>
</tr>
<tr>
<td>1974</td>
<td>Drucker</td>
<td>Attributed entrepreneurs to sense or ‘foresee’ market trends and make timely responses.</td>
</tr>
<tr>
<td>1972, 1979, 1997, 1999</td>
<td>Kirzner</td>
<td>Attributed to entrepreneurs a sense of ‘alertness’ to identify opportunities and exploit them accordingly.</td>
</tr>
</tbody>
</table>

(Burns, 2007: 12)

### 2.6 Modern day entrepreneurship

According to Kruger (2004), much of the modern academic debate on entrepreneurship has been largely concerned with entrepreneurial behaviour and personality traits (Frabroni & Saltsone, 1990; McClelland & Winter, 1969; McClelland, 1961). However, since the 1980s there has been a much greater focus on activity based research. In this context, entrepreneurial activity places an
emphasis on the opportunity and the task of acquiring resources to pursue the opportunity (Kao, 1991). This section of the literature review will focus on the current line of entrepreneurial understanding, the traits, characteristics, behaviours, environmental learning and the role within the organisation.

2.6.1 A clearer definition of entrepreneurship?
The work of the antecedents of modern entrepreneurship and the current academic work around the theory of the entrepreneur have enabled a greater understanding of the facets of modern day entrepreneurship. However, there is still a lack of clarity and consistency around the definition of the term entrepreneurship. Anderson, Dodd, & Jack, (2012) argue that theory of entrepreneurship is actually becoming obscured by the increasing fragmentation of the conceptual prisms that it is viewed from. As Gartner (2001) notes, every discipline has their own way of viewing entrepreneurship and this is relatively unaffected by how other disciplines perceive entrepreneurship. Here are a number of different definitions for entrepreneurship:

‘[An entrepreneur is someone who] takes initiative, assumes considerable autonomy in the organisation and management of resources, shares in the asset risk, shares in an uncertain monetary profit, and innovates in more than a marginal way.’ (Harwood, 1982: 98)

‘[an entrepreneur is] A person who habitually creates and innovates to build something of recognised value around perceived opportunities.’ (Bolton & Thompson, 2000: 16)

‘Entrepreneurs use innovation to exploit or create change and opportunity for the purpose of making profit. They do this by shifting economic resources from an area of lower productivity into an area of higher productivity and greater yield, accepting a high degree of risk and uncertainty in doing so.’ (Burns, 2007: 11)

‘[an entrepreneur] is a person who acts in an enterprising way, and who identifies or creates and acts on an opportunity’ (Rae, 2007b: 3)

The definition by Rae (2007b) introduces the notion of enterprise, Anderson et al. (2012) believe that beauty, completeness and simplicity of the white light of enterprise that shines through a conceptual prism, breaks down into a bright clear component of colours, allowing universal understanding. However, as previously discussed Chell et al. (1991: 2) comes to the conclusion that to continue to ask the question ‘what is entrepreneurship and who are entrepreneurs?’ is perhaps futile, due to there being no precise definition. However, what is clear is that there is an increasing evidence base to suggest what the essential elements of entrepreneurship are and what roles entrepreneurs play.

5 Definition of enterprise ‘if people display enterprise, it means they are using skills, knowledge and personal attributes which are needed to apply creative ideas and innovations to practical situations. These include initiative, creativity, problem solving, identifying and working on opportunities, leadership, and acting resourcefully to effect change.’ (Rae, 2007b: 3)
2.6.2 Personality and trait factors
Schumpeter (1934) was one of the first entrepreneurial theorists to suggest specific personality traits to uniquely identify characteristics of the entrepreneur. For a number years after, identifying traits was occasionally a topic for academic research, albeit one with moderate success (Brandstätter, 2011). However during the 1970s and 1980s adopting a personality approach to understanding entrepreneurial behaviour was largely discredited (Gartner, 1989).

‘At the heart of the matter of whether the psychological and social traits are either necessary or sufficient for the development of entrepreneurship. Character traits are at best modalities and not universalities, since many successful and unsuccessful entrepreneurs do not share the characteristics identified. Further, historical studies do not show the same character traits in earlier entrepreneurs. Also, studies of life paths of entrepreneurs often show decreasing ‘entrepreneurship’ following success. Such evidence at least raises the question whether the nature of entrepreneurship is innately embedded in the personality from early stages of childhood. Finally, while many authors have purported to find statistically significant common characteristics of entrepreneurs, the ability to attribute causality to these factors is seriously in doubt.’ (Stevenson & Sahlman, 1989: 103-4)

It is also important to note that Deakins (1996) identified a number of methodological problems associated with attempts to measure personality traits:

- They are not stable and can often change over time
- They require subjective judgements based on personal understanding
- Measures of personality often tend to ignore cultural and environmental influences
- The roles of education, learning and training are often overlooked
- Contextual issues such as age, race, social class and education are regularly ignored.

However, Zhao & Seibert (2006) argue that over more recent times there has been an increasing amount of research surrounding personality traits, largely due to the increasing acceptance of the five factor model (FFM) of personality.

As Kirby (2003) suggests, one of the problems with entrepreneurship is that there is no standard definition and no stereotypical model. However, it is frequently contended that entrepreneurs often display similar characteristics and traits. The work of Timmons, Smollen, & Dingee (1985) expressed in table 2.5 identified 19 traits of the entrepreneur.
From a UK perspective Gibb (1987) reviewed the literature and developed a list of 12 common entrepreneurial attributes, these are displayed in table 2.6

| (1) Initiative | (7) Problem solving |
| (2) Strong persuasive powers | (8) Need for achievement |
| (3) Moderate rather than high risk-taking ability | (9) Imagination |
| (4) Flexibility | (10) High belief |
| (5) Creativity | (11) Leadership |
| (6) Independence/autonomy | (12) Hard work |

Gibb (1996) built on McClelland’s (1961) influential work on the notion of ‘need for achievement’, which is often referred to as ‘nAch,’ and Rotter’s (1966) work around ‘locus of control’. According to Rae (2007), McClelland (1961) believed that ‘nAch’ was the key motivator for entrepreneurial performance, it divided people into two categories: a) achiever, and b) non-achievers. Similarly, Rotter (1966) believed in the ‘loss of control’ which centred around the notion of people believing that they were either in control of the world around them, or their destinies were determined by
external factors. It is important to note that there are limitations with the attributes Gibb (1987) identifies, in relation to their measurement and their evidence base,

‘Not all the attributes mentioned in [table 2.6] are measureable at present, and many are controversial, in that the evidence associating them with particularly forms of behaviour is as yet weak.’ (Gibb, 1987: 7)

McClelland (1987), as outlined in Kirby (2003), attempted to define a set of key competencies involved with successful entrepreneurship. This involved researching 12 successful, and 12 average entrepreneurs using a behavioural event interview method, to identify critical successful incidents in the life of the business operations. Table 2.7 demonstrates the nine key competencies which have been divided into three categories a) proactivity, b) achievement orientation, and c) commitment to others.

Table 2.7: The nine competences of successful entrepreneurs

<table>
<thead>
<tr>
<th>Proactivity</th>
<th>Achievement orientation</th>
<th>Commitment to others</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Initiative</td>
<td>(3) Ability to see and act on opportunities</td>
<td>(8) Commitment to the work contract</td>
</tr>
<tr>
<td>(2) Assertiveness</td>
<td>(4) Efficiency orientation</td>
<td>(9) Importance of business relationships</td>
</tr>
<tr>
<td></td>
<td>(5) High quality work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(6) Systematic planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(7) Monitoring</td>
<td></td>
</tr>
</tbody>
</table>

(Chell, 2001: 85)

McClelland’s (1987) work is an excellent example of the subjectivity associated with significantly defining traits associated with successful entrepreneurs, in respect to how the researcher defines success and views its various nuisances.

Chell (2001) outlines that the idea of a trait which distinguishes an entrepreneur from a manager, has been widely criticised; however more recent research has suggested that a profile of entrepreneurial characteristics is perhaps more pertinent. Table 2.8 displays ten characteristics which Chell (1991) attributes to the ‘prototypical’ entrepreneur. This supports the view of Gartner (1989), who not only criticises a trait based approach due to the lack of clarity attached to specific traits, and the validity of such studies due to their subjectivity, but believed that researchers should be studying what people do and the behaviours, skills and knowledge that is involved in the entrepreneurial process, rather than specific traits (Rae, 2007b).
Table 2.8: Characteristics of the prototypical entrepreneur

<table>
<thead>
<tr>
<th>Chell et al (1991) 10 characteristics of the prototypical entrepreneur</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Alert to business opportunities</td>
</tr>
<tr>
<td>(2) Pursues opportunities regardless of resources currently</td>
</tr>
<tr>
<td>controlled</td>
</tr>
<tr>
<td>(3) Adventurous</td>
</tr>
<tr>
<td>(4) An ‘ideas person’</td>
</tr>
<tr>
<td>(5) Restless/easily bored</td>
</tr>
<tr>
<td>(6) High profile image maker</td>
</tr>
<tr>
<td>(7) Proactive</td>
</tr>
<tr>
<td>(8) Innovative</td>
</tr>
<tr>
<td>(9) Thrives on change</td>
</tr>
<tr>
<td>(10) Adopts a broad financial strategy</td>
</tr>
</tbody>
</table>

(Chell, 2001: 86)

Even though the validity of trait based approaches has been widely criticised (Amit, Glosten, & Muller, 1993; Chell et al., 1991; Gartner, 1989; Gray, 1998; Kauffman & Dant, 1998), there is a large amount of consistency in the traits identified by authors. But, adopting a solely trait focussed understanding of the entrepreneur would be naïve, as there are a number of intervening variables that affect the propensity for people to behave entrepreneurially.

‘Personal attributes are important but not all pervading determinants of behaviour’ (Cromie, 2000: 25)

2.6.3 Entrepreneurial behaviour

Gray (1998) states that in order to understand entrepreneurial behaviour, there are a number of essential elements to focus on:

- Culture
- Family
- Social class.

This is supported by Timmons (1989), who highlighted that external factors are influential in shaping the entrepreneurial concern and the ability of an entrepreneur to be successful (Chell et al., 1991). Bolton & Thompson (2004), outline that environmental factors play a key role in understanding and explaining entrepreneurial behaviour, notably:

- Family background
- Education and age
- Work experience.
A number of these environmental factors, such as, whether entrepreneurship can be taught and learned, or whether entrepreneurs are born or made will be discussed in more detail in section 2.6.4.

Kirby (2003) outlines that cognitive theories are perhaps more appropriate in explaining the complexity inherent in entrepreneurial behaviour. They assume that the entrepreneur does not possess perfect knowledge of the market nor of the world, and that entrepreneurs are required to select and interpret information appropriately. As entrepreneurs have different experiences, they will view the world differently. An opportunity for one entrepreneur may be problematic for another.

Kirby (2003) goes on to identify that more recent academic research has focussed on “situations that lead to entrepreneurial behaviour” (2003: 14) rather than traits, believing that entrepreneurs will only activate their entrepreneurial potential if they have:

- A specific ability – a sensitivity
- Environmental possibilities
- Social support.

Kirby (2003) argues that all three of these must exist in order for entrepreneurship to take place. Guo (2006) agrees that situations are important, whilst also suggesting that innovation and the factors surrounding innovation are key elements of entrepreneurship, with Morris, Kuratko, & Schindenhutte (2001) and Thompson (1999) identifying that these factors involve a multidimensional process, these include: a) the environment, b) organisations, and c) individuals.

2.6.4 Are entrepreneurs born or made (including environmental factors)?
The debate around whether entrepreneurs are born or made has been one of interest within the literature for a number of years. This historically relates back to a trait approach and whether or not entrepreneurs are born with a predefined set of personality traits which typify successful entrepreneurs. However, with limitations to the strength of the literature around successful personality traits (Amit et al., 1993; Chell et al., 1991; Gartner, 1989; Gray, 1998; Kauffman & Dant, 1998), and the credible view that external environmental factors influence entrepreneurial behaviour, it would be naïve to believe that entrepreneurs are born. Both Burns & Dewhurst (1989), and Kent (1984) believe that this debate is over and that entrepreneurs are made, not born. This is supported by Kuratko & Hodgetts (1998) who argue that it is a myth that entrepreneurs are born and not made; they outline that the techniques of entrepreneurship can
be taught and mastered, like other academic disciplines. Burns (2007), cited in Bolton & Thompson (2004: 18) focusses on education and believes that ‘anyone who applies four key principles can become an entrepreneur and develop a successful business’; these four principles of behaviour are:

1. **Belief** – in one’s personal ability to succeed
2. **Focused knowledge** – prioritised relevant learning
3. **Proactive approach** – evaluating information deliberately and acting on conclusions
4. **Perseverance** – working through the rough periods.

However, Bolton & Thompson (2004) refute the claim that a set formula for successful entrepreneurs exists, they agree that 1) belief, 2) focussed knowledge, 3) a proactive approach, and 4) perseverance are important, but they do not accept that these are all encompassing and explain entrepreneurial working. They highlight that people who may wish to be entrepreneurs may not possess the essential elements of talent or temperament, which are required for success. It is important to note that talent and temperament are characteristics that are more likely to be born, than taught.

This view that there may be a mix of behaviours and approaches that can be taught and a number that cannot is supported by the work of Timmons et al. (1985). Table 2.5 explains 19 traits and behaviours of entrepreneurs, however Timmons et al. (1985) believe that 15 of these can be taught and learned, with four of them being behaviours that are difficult to learn, these being:

1. High energy, health and emotional stability
2. Creativity and innovativeness
3. High intelligence i.e. being streetwise and having a nose for business
4. Vision and the capacity to inspire.

Bolton & Thompson (2004) argue that educational programmes for entrepreneurs have their place and are essential in nurturing and developing entrepreneurial skills, but there are boundaries to education. They state that it is undefined exactly what the ratio is between the skills that are born or made, be it 75:25 or 40:60, highlighting that the environment and context is an essential parameter of entrepreneurial working.

Rae (2007b) outlines that it can be concluded from the extensive literature around entrepreneurship education that, whilst education can assist and provide cultural and personal
support, knowledge and entrepreneurial skill development, the art of entrepreneurship practice is largely learned within the business environment through an inductive, practical, social experiences, rather than in a classroom (Gibb, 1993; Gorman, Hanlon, & King, 1997).

Hence, it is not possible to be completely in either camp for the born or made debate. It is important to consider that environmental factors, such as those developed by Bolton & Thompson (2004) and the experiential learning within the local context, are important factors to the development and honing of entrepreneurial activity.

2.6.5 Are opportunities discovered or created?
This is a debate that has its roots in the antecedent work of the classical and neo-classical theorists, however to fully understand whether opportunities are created or discovered, it is important to first explore what an opportunity is. Rae (2007b: 3) defines opportunity as being ‘the potential for change, improvement or advantage arising from our action in the circumstances’.

Casson (2003) defines how the concept of opportunity relates to the entrepreneur, stating that entrepreneurial opportunities are ‘those situations in which new goods, services, raw materials and organised methods can be introduced and sold at greater than their cost of productions’.

Casson (2003) identifies that opportunity is involved in the financial and profit making function, a view that is shared by Shane (2003: 18) ‘a situation in which a person can create a new means-end framework for recombining resources that the entrepreneur believes will yield a profit’. Kirzner (1982) supports Shane’s (2003) view that an opportunity should focus on profit-making, in his belief that entrepreneurs discover opportunities that others often may not,

‘Entrepreneurial profit opportunities exist where people do not know what they do not know, and do not know what they do not know. The entrepreneurial function is to notice what people have looked.’ (Kirzner, 1982: 273)

The inclusion of financial reward and profit making as part of entrepreneurial opportunities limits the utility and scope of the possible opportunities that do not necessarily lead to financial reward. Rae (2007b) takes a broader definition, believing that the quest for profit is important but it is not the only determinant for entrepreneurial opportunities. Rae (2007b) expresses that advancements and developments in cultural, social, environmental and health arenas are equally important. This is endorsed and expanded on by Bolton & Thompson (2000), who stress that entrepreneurial opportunities should not be confined to the business world,

‘Entrepreneurial activities can be found everywhere. Some are genuinely new; others are innovatory improvements on a theme. Some are limited growth areas; others can be used to build businesses. They only succeed if they are different in some meaningful way and executed
effectively. There is, then, an infinite set of possibilities for people with talent and temperament to become successful entrepreneurs to choose from.’ (Bolton & Thompson, 2000: 96)

For this investigation I will rely on Rae’s (2007b) definition of an opportunity, as this appears to be more holistic in nature and profit as a product is not always the reward required, especially within the health sector. In terms of whether opportunities are created or discovered Rae (2007b) concludes that as Kirzner (1982) argued, short term opportunities exist and they await to be discovered by the alert entrepreneur. However, the circumstances that give rise to ‘new’ opportunities can be identified by people with imagination, experience and judgement i.e. entrepreneurs. The effective entrepreneur needs to be able to both discover and create opportunities.

2.6.6 Action Factors (process)

During this literature review the majority of the focus has been on the skills, behaviours and traits of entrepreneurs, without a specific focus on what entrepreneurs actually do. This section looks at the process and the workings of the entrepreneur in practice.

Bolton & Thompson (2004), outline ten key action roles that are associated with entrepreneurs and entrepreneurship; these are highlighted in table 2.9.

Table 2.9: Ten key action roles associated to entrepreneurship

| (1) Entrepreneurs are individuals who make a significant difference | (6) Entrepreneurs are determined in the face of adversity |
| (2) Entrepreneurs are creative and innovative | (7) Entrepreneurs manage risk |
| (3) Entrepreneurs spot and exploit opportunities | (8) Entrepreneurs have control of the business |
| (4) Entrepreneurs find the resources required to exploit opportunities | (9) Entrepreneurs put the customer first |
| (5) Entrepreneurs are good networkers | (10) Entrepreneurs create capital. |

(Bolton & Thompson, 2004; 27)

Bolton & Thompson (2004) developed two process models which look to explain the actions of entrepreneurs as part of a wider system, to explain how ‘value’ can be created. The first model, figure 2.1 is closely connected to the ten action roles outlined in table 2.9, in this model Bolton & Thompson (2004) identify how these roles interplay to create capital. However, it is important to note that the recognition of value which is attained by the entrepreneur resonates back to their motivation to make a difference at the outset of the process.
1. Motivation to make a difference

2. Creativity & innovation

3. Spotting and exploiting opportunities

4. Finding the required resources

5. Using networks extensively

6. Showing determination in the face of adversity

7. Managing risk

8. Controlling the business

9. Putting the customer first

10. Financial, social, aesthetic, capital

Recognition of value

THAT SUCCEDS

GROWING ENTERPRISE

Figure 2.1: The entrepreneur process diagram

Bolton & Thompson (2004: 33)

The entrepreneur

The opportunity-spotter

The invention

The idea

Engaging the opportunity

Realising the opportunity

Exploiting the opportunity to build something of value

The project champion

Theenterprising person who realises the opportunity and is minded to engage it

The person who makes things happen

The direction of the project or venture is affected by the interests and values of the opportunity-spotter and his/her personal environment

Figure 2.2: The entrepreneur, the opportunity-spotter and the project champion

Bolton & Thompson (2004: 34)
The second entrepreneurial process model, figure 2.2, developed by Bolton & Thompson (2004) identifies two distinct stages, these being a) the opportunity spotter, and b) the project champion, which together make up the role of the entrepreneur.

Bolton & Thompson (2004) describe the opportunity spotter as the person who realises the potential for an idea, but he/she is not necessarily the inventor or the originator of the idea. Often the inventor or the originator does not appreciate the full potential of how it may be exploited. The ability to exploit the market is often related to the knowledge of it, the environment and personal characteristics of the opportunity spotter. The project champions are described as being the people who make things happen; they gather the necessary resources and they know where to find help and support. According to Bolton & Thompson (2004) the entrepreneur is successful because he/she is able to combine and execute the roles of both the opportunity spotter and the project champion effectively. Figure 2.3 goes on to display the strategic relationship of the roles of the opportunity spotter and the project champion, in relation to a successful business.

**Figure 2.3: The relationship between the three roles to create a successful business**

In the previous section (2.6.6), the role(s) which the entrepreneur play(s) within the organisation was discussed. However, this did not look at the division of roles between manager-owner and
that of the entrepreneur. This is something that has been debated since the early economic work of the classical and neo-classical theorists. The modern entrepreneurship view is that there are often clear divisions between the two roles. However, it is important to note that in relation to traits, there is often an overlap within literature as to the traits required for both roles (Brandstätter, 2011; Burns, 2007). Despite such overlap, Burns (2007) stresses that what most researchers believe is that collectively, owner-managers have a similar set of traits. He believes that character traits for owner-managers might be best described as being associated with survival, whereas those of the entrepreneur are more concerned with growth. In table 2.10 Burns (2007) outlines a number of character traits for owner-managers and entrepreneurs.

Table 2.10: Characteristics of owner managers vs. entrepreneurs

<table>
<thead>
<tr>
<th>Owner-Managers</th>
<th>Entrepreneurs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for independence</td>
<td>Opportunistic</td>
</tr>
<tr>
<td>Need for achievement</td>
<td>Innovative</td>
</tr>
<tr>
<td>Internal locus of control</td>
<td>Self-confident</td>
</tr>
<tr>
<td>Ability to live with uncertainty and take measured risks</td>
<td>Proactive and decisive with high energy</td>
</tr>
<tr>
<td></td>
<td>Self-motivated (intrinsic motivation)</td>
</tr>
<tr>
<td></td>
<td>Vision and flair</td>
</tr>
<tr>
<td></td>
<td>Willingness to take greater risks and live with greater uncertainty</td>
</tr>
</tbody>
</table>

Adapted from Burns (2007: 32)

As highlighted earlier, a solely trait base approach to understanding entrepreneurship has been widely criticised due to its limitations (Amit et al., 1993; Chell et al., 1991; Gartner, 1989; Gray, 1998; Kauffman & Dant, 1998). Rae (2007b) looks at the division between owner-managers and entrepreneurs from a more action focussed angle. Figure 2.4 displays a simple conceptual framework for looking at the facets of entrepreneurial working and managerial working. This demonstrates the relationship in which they both have to work in synergy within an organisation to create ‘new value’ by stimulating and meeting customer demand in new way (Carr, 2000; Stevenson & Jarillo, 1990).
According to Rae (2007b), the two facets i.e. entrepreneurial working and managerial working, become successfully integrated to develop an entrepreneurial focus on customer attractiveness and rapid innovation in response to new opportunities, whilst being able to manage direction, processes, relationships and the resources of the business. As highlighted in sub-section 1.2 my motivation for this study relate to my professional experience of NHS services moving closer to home, and sub-section 1.3 outlines the rapidly changing nature of the NHS primary care system with an increasing focus on the new provision and commissioning of services, with sub-section 1.3.1 describing a ‘business approach’ to management (Boyett & Finlay, 1995). Rae's (2007b) entrepreneurial management model includes both managerial and entrepreneurial working, to provide ‘new value’ and in light of new service delivery context within the NHS, I am keen to build and expand on this model.

### 2.7 Social Entrepreneurship

Currently, this literature review has largely focussed on the traditional economic, private sector entrepreneurship literature. However, as detailed in figure 2.4 Rae's (2007b) model of entrepreneurial management, the creation ‘value’ rather than ‘profit’ is increasingly accepted as being an output of entrepreneurial working. Chell (2007) endorses such a view and goes one step further by suggesting that more recently the leader(s) of not-for-profit (NFP) organisations have often been considered to be entrepreneurs. Austin, Stevenson, & Wei-Skillern (2006) outline that such entrepreneurial activity within an NFP, is classed as social entrepreneurship. Austin et al. (2006) identify that there a number of broad and narrow definitions of what constitutes social entrepreneurship, but common across them all is that the underlying drive is to create social value, rather than personal and/or shareholder wealth. Santos (2012) agrees and states that
social entrepreneurship is often defined as being ‘entrepreneurial activity within an embedded social purpose.’ (2012: 335)

Austin et al. (2006) expand further to explain that social entrepreneurship often refers to the phenomenon of applying business skills and market expertise in the NFP sector, especially in utilising innovative approaches to earn income (Reis, 1999; J Thompson, 2002). Chell (2007) supports this by demonstrating that social entrepreneurs need to possess a) knowledge, b) social networks/relationships, and c) the ability to spot and act on opportunities,

‘Social entrepreneurs... have the intellectual capacity, the thought processes and the imagination to recognise opportunity based on their technical/or professional experience; they have social and personal networks that add non-material, human and social capital resources; and they have personal ability to make judgements about appropriate courses of action that will result in the pursuit of an opportunity of socio-economic value based on the realisation of competitive advantage’. (Chell, 2007: 18)

These are aspects of entrepreneurial working, that have previous been outlined in this chapter as being important for traditional, profit focussed entrepreneurs. However, it is important to note that Austin et al. (2006); Chell (2007); Doherty, Haugh, & Lyon (2014) all believe that social entrepreneurship is not just bound to NFP organisations, but also spans business, government, NFP and hybrid organisations.

2.7.1 Hybrid organisations
As Doherty et al. (2014) outline, social enterprises are organisational forms that have emerged due to the increasing blurry and fluid nature of private, public and non-profit sectors; with social enterprises attempting to achieve both financial sustainability and a social purpose for their local community, which can lead to tensions when attempting to ‘craft a balance between pursuing commercial and social objectives’ (2014: 2). Doherty et al. (2014) believe that social enterprises do not sit discretely into any of the traditional private, public and non-profit markets, suggesting that they are ‘hybrid’ organisations bridging and spanning different sectors.

According to the OED (2010) by definition hybrids are the offspring of two different species, and in the organisational and management literature authors such as Brandsen & Karré (2011); Pache & Santos (2011); Reuf (2000); Jay (2013); Smith (2010) have used the term ‘hybrid’ to describe organisations that span these traditional institutional boundaries, and operate in a number of functional domains (Doherty et al., 2014).

‘Hybridity as a concept is scattered across numerous academic disciplines. It is for example used in biology to denote racial mixing; in linguistic and cultural studies to describe the effects of colonialism and globalisation on language and identity formations; and in technology to indicate
the combination of various technologies. In all of these contexts, through describing different things, hybridity always symbolizes the process and product of a mixture of essential contradictory and conflicting elements. ' (Brandsen & Karré, 2011: 828)

Rainey (1997) provides a number of examples of hybrid organisations which appear to have relevance to the current NHS primary care context described in sub-section 1.3, these being:

- Government organisations that resemble business firms
- Third sector organisations that perform functions similar to those of governmental organisations, and
- Commercial firms that engage in the production of public good and services (Brandsen & Karré, 2011)

Brandsen & Karré (2011) outline that one of the most widely employed frameworks to conceptualise hybridity involves the visualisation of society as a triangle containing different domains. As displayed in figure 2.5, in one corner is the market, co-ordinated by free exchange of goods and services; the state largely concerned with hierarchy is another; with community in the third and final corner, this being concerned with special bonds as its operating mechanism. Each of these three domains has a different response to a deterioration of quality in products and services i.e. voice in the state, exit in the market and loyalty in the community.

According to Brandsen & Karré (2011), Van de Donk (2001) expanded on the earlier work around conceptualising hybridity by adding further dimensions to the triangle (figure 2.5), describing organisations in terms of their:

- Publicness,
- Profit orientation, and
- Formality.
As figure 2.5 illustrates, in this model state (or government) organisations are defined as being public, formal and non-profit making; with market organisations being those that are private, formal and profit orientated; and community organisations those that are private, informal and non-profit making. Brandsen & Karré (2011) suggest that hybrid organisations are those that have moved from one of the three corners of the triangle towards the centre of the triangle, where the characteristics of the domains are mixed.

In table 2.11 Evers, Rauch, & Stisz (2002) identify the characteristics associated with the three traditional organisational forms. As table 2.11 identifies, the three separate traditional markets have a number of different and competing characteristics and Brandsen & Karré (2011) suggest that hybrid organisations need to combine ‘a profit and a not for profit orientation; a public and a private orientation; formality and informality’ (2011: 828), it leads them to suggest that organisations containing conflicting characteristics will inherently be unstable and this is likely to have a negative effect on service quality. Both Chell (2007) and Austin et al. (2006) appear to support Brandsen & Karré (2011), by suggesting that ‘trade-offs’ and ‘tensions’ are common within hybrid social enterprise organisations; with Austin et al. (2006) highlighting that trade-offs and tensions are often related to a) the mission of organisation, b) the mobilisation of financial resources, and c) human resource management.

As outlined in 1.3.5, the move from PCTs to CCGs as part of the Health and Social Care Act has resulted in the NHS primary care context being one that sits between the boundaries of the
traditional concepts of market boundaries, as part of a ‘quasi-market’ (described in more detail in 2.8.1). As part of this study I am keen to explore the concept of hybridity further, to understand whether the GP practice and/or new service delivery setting is one which could be described as being hybrid.

Table 2.11 Characteristics of public, private and third sector organisations

<table>
<thead>
<tr>
<th></th>
<th>Public</th>
<th>Private</th>
<th>Third sector</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resources</strong></td>
<td>General allocations</td>
<td>Earnings on market place</td>
<td>Donations, subsidies and voluntary contributions</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>Public good and welfare</td>
<td>Profit maximisation</td>
<td>Specific to groups, situation and environment, contribute to public good and welfare</td>
</tr>
<tr>
<td><strong>Co-ordination mechanisms</strong></td>
<td>Politics and public administration</td>
<td>Competition on the market place</td>
<td>Formal and informal influence of societal stakeholders</td>
</tr>
<tr>
<td><strong>Organisational culture and action logics</strong></td>
<td>Hierarchy, legality, equality</td>
<td>Entrepreneurialism, efficiency and effectiveness</td>
<td>Trust</td>
</tr>
</tbody>
</table>


2.8 Entrepreneurship in the NHS

Unlike other market places, there has been limited research within the field of entrepreneurship in the NHS, especially regarding primary care. The most well researched areas within the healthcare sector appear to focus around the entrepreneurial aspects of leadership, social entrepreneurship and policy entrepreneurship, with these often being secondary care focussed and from different international health care systems with the most notable contributions from Baines, Bull, & Woolrych (2010); Currie, Humphreys, Ucbasaran, & McManus (2008); Exton (2008); Goodwin (2000); Lockett, Currie, Waring, Finn, & Martin (2012). However, there has been a small amount of research concerning entrepreneurial working as part of GP fundholding and the development of a quasi-market. Two of the key pieces being the work of Ennew, Whynnes, Jolleyes, & Robinson (1998); and Boyett & Finlay (1995).

During the following sub-sections of this chapter, I will focus specifically on the literature which resonates with the current CCG operating structure (as previously detailed in the Introduction chapter 1) of the NHS primary care system.
2.8.1 The development of a quasi-market

Boyett & Finlay (1995) identified that the publication of the Griffiths report in 1983 highlighted the need for a ‘business approach’ to management; this resulted in the general approach of NHS policy being to create and develop quasi-markets. These were artificial internal markets which encompassed both the purchasers and providers of healthcare services. Exworthy, Powell, & Mohan (1999) note that it is often claimed that the Conservative governments of 1979 – 1997 ‘marketised’ the NHS. This has been described in a number of ways with Walsh (1995); Flynn (1997); and Salter (1998) outlining that market mechanisms were injected; Ranade (1998) notes the rise of markets; Powell (1997) outlines a greater market orientation, and Mohan (1995) stresses the move towards a more entrepreneurial NHS.

Propper (1995) argues that one the key aspects of the development of the quasi-market was that public sector health service providers changed from simply being ‘departmental administration’ arms of the wider public sector enterprise, to be free standing entities with their own borrowing rights from central government. Le Grand (1991) outlined that the key features of the quasi-market involved the development of agents who were responsible for purchasing on behalf of end users and a supply side which largely comprised of non-for-profit organisations and government owned enterprises. According to Propper (1995), Le Grand (1991) believed that a number of market conditions needed to exist in order for quasi-markets to meet the governmental goals of increased efficiency, equity and a consumer responsive NHS. These included:

- A competitive or contestable market
- Sufficient information should be available for purchases, in order to make informed choices
- Transaction costs should be low
- The motivation of providers should have some financial aspect to them
- Purchasers should be motivated to take into account the ideas of consumers
- Opportunities for selection by both purchases and providers i.e. cream-skimming or dumping, should be limited.

Consequently as highlighted by Boyett & Finlay (1995), the quasi-market involved a new system of contracting for healthcare, which introduced an ‘intermediate customer’ and created an artificial ‘internal market’ between providers and purchasers of services. The development of the quasi-market reflected the government’s belief in the power of competition. As part of the marketplace,
the NHS was split into two distinct ‘provider’ and ‘purchaser’ arms. The providers supplied health care services i.e. hospitals, whereas the purchasers were usually a) district health authorities, b) fund holding GPs, and/or c) private individuals.

Boyett & Finlay (1995) went on to outline that orthodox and neo-classical theory predicts that the introduction of competition through the quasi-market should create a marketplace where information is exchanged through the normal price mechanism with resource efficiency gains being made by those who are treated as rational, well informed and self-interested. However, it is argued that one essential omission from such a prediction is the lack of attention paid to managerial decision makers. Boyett & Finlay (1995) argue that undoubtedly managerial decision makers possess limited and unequal amounts of information, along with operating within different and uncertain environments. It is this uncertainty which provided the opportunity for health service entrepreneurship.

Boyett & Finlay (1995) argue that entrepreneurial theories associated to Leibenstein, (1966) and the work of the Austrian School of Economics (see sub-section 2.4.4) are applicable models to consider for entrepreneurs in quasi-markets. Leibenstein (1966) believed that the major role of an entrepreneur was to reduce ‘organisational slack’ or ‘X-inefficiency’; hence an entrepreneur was alert to organisational slack, and within such a view Boyett & Finlay (1995) identify that health service entrepreneurship can be defined as “a creative response to inefficiency within an organisation” (1995: 396). It is noted that Leibenstein's (1966) model was predominantly internal focussed, but as highlighted in section 2.5.4, the work of Kirzner (1973) adopted a more macro-market view about the market not functioning with entrepreneurial activity, through the re-allocation of resources when the market is in dis-equilibrium.

Table 2.12: The eight most important entrepreneurial role characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer orientated</td>
<td>1</td>
</tr>
<tr>
<td>The ability to generate or retain business</td>
<td>2</td>
</tr>
<tr>
<td>A seeker of opportunities</td>
<td>3</td>
</tr>
<tr>
<td>Identifier of resources optimisation of opportunities</td>
<td>4</td>
</tr>
<tr>
<td>Has a good knowledge of the external environment</td>
<td>5</td>
</tr>
<tr>
<td>Has the ability to operate in a non-conducive culture</td>
<td>6</td>
</tr>
<tr>
<td>Identifier if income generating opportunities</td>
<td>7</td>
</tr>
<tr>
<td>An influencer of external strategies</td>
<td>8</td>
</tr>
</tbody>
</table>

(Boyett & Finlay, 1995: 404)
One of the major elements of Boyett & Finlay's (1995) work was the development of key characteristics associated with an entrepreneurial role within a secondary care healthcare environment, as table 2.12 illustrates, these characteristics were then ranked in terms of their order of importance.

2.8.2 GP Fundholding and entrepreneurship

As noted within the introduction (sub-section 1.3.2) GP fundholding was introduced by the Conservative government, and it is the primary care bi-product of the quasi-market place described in 2.8.1, where GPs are able to become fundholders and be involved with the commissioning of healthcare services for their health economy. Ennew et al. (1998) argue that the introduction of fundholding put GPs in a position which was akin to that of an entrepreneur. As previously identified, there is no widespread universal definition of the entrepreneur within traditional economic and private sector markets, Ennew et al. (1998) believes that this lack of clarity is perhaps even more pronounced within the public sector. However, along with Gartner (2000), Ennew et al. (1998) acknowledge that there is widespread acceptance that entrepreneurship is relevant outside the private sector, but it does lead to questions about the nature of entrepreneurship within a marketplace where a) profit is not a motive, b) there is a lack of ownership, and c) a number of other private sector characteristics that elicit entrepreneurial activity exist.

Ennew et al. (1998) support Boyett & Finlay’s (1995) view that Leibenstein (1966) and the Austrian School of Economics work around the theory of the entrepreneur may have use within the healthcare setting, whilst also highlighting the importance of the work of Casson (1982) and his work around identifying a shared element amongst the various theories of the entrepreneur. Casson (1982) introduced the concept of ‘entrepreneurial judgement’ and he defined an entrepreneur as “someone who specialises in taking judgemental decisions about the coordination of scare resources” (1982: 23). Based on Casson’s (1982) wider view, Ennew et al. (1998) argue that a GP who was responsible for managing a practice budget and making decisions based on the purchasing and provision of healthcare services could potentially be classified as an entrepreneur. Profit may not necessarily be the motivator when GPs are managing a budget; decisions will be motivated by attempting to achieve increased utility by delivering an improved quality of service and better patient satisfaction. This led Ennew et al. (1998) to identify that Leibenstein’s (1966) theory of ‘X-inefficiency’; Kirzner’s (1973) work on ‘Price quality – arbitrage’; and innovation, as being key elements to GP fundholding and entrepreneurial working.
Ennew et al. (1998) interviewed 21 participants to investigate a) the nature and form of entrepreneurship, and b) to identify if there were any types or groupings of GPs that were distinctive in their behaviour and motives. Table 2.13 identifies that the GP motives for participating in fundholding fell largely within two broad categories; namely, positive and negative. Ennew et al. (1998) argued that as part of this, three main categories of GP fundholder entrepreneurs existed:

1) **True entrepreneurs** – these GPs displayed more positive motivations for being involved and demonstrated types of entrepreneurial behaviour akin to E-inefficiency, Price quality – arbitrage and innovation

2) **Partial entrepreneurs** – these GPs displayed more negative motivations and were largely concerned with keeping themselves in business rather than switching providers and shopping around for the best price and quality.

3) **Reluctant entrepreneurs** – these were a small number of GPs who were more reluctant than partial entrepreneurs and very much felt that they were pushed into fundholding and had made very few, if any changes as a result of their fundholding status.

Overall, Ennew et al. (1998) identified that GP fundholders were to varying degrees entrepreneurs; however it is important to note that although Ennew et al. (1998) outlined that entrepreneurial behaviour existed, they identified that not all fundholding GPs held or wanted to hold entrepreneurial roles. Identifying that,

‘Creating a quasi-market in the public sector may create an environment in which individuals can behave entrepreneurially, but it does not necessarily guarantee that they will.’ (Ennew et al. 1998: 64)
Table 2.13: Motives for adopting fundholding status

<table>
<thead>
<tr>
<th>Positive (with the number of mentions by participants)</th>
<th>Negative (with the number of mentions by participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve the quality of patient care, patients choice and service (nine times)</td>
<td>Neighbouring practices had become fundholders and they felt they would be disadvantaged (four times)</td>
</tr>
<tr>
<td>To reduce waiting lists and facilitate access to secondary care consultation and admissions (five times)</td>
<td>The threat of restrictions on freedom to refer and/or use staff (six times)</td>
</tr>
<tr>
<td>To maintain the existing good services they were experiencing (four times)</td>
<td>The Conservative election victory and the future pattern of health care (three times)</td>
</tr>
<tr>
<td>The practice had been innovative in the past and wanted more control (twice)</td>
<td>The FHSA(^6) exerted gentle pressure (twice)</td>
</tr>
<tr>
<td>The practice felt that they could do a better job of managing health care (twice)</td>
<td>Limitation of resources in the practice and the ability to use resources more as a team</td>
</tr>
<tr>
<td>Wanted to improve patients’ access to consultants (once)</td>
<td>Money was available to fundholders from the FHSA for computerisation and extra staff (once)</td>
</tr>
<tr>
<td>Gain quick access to NHS facilitators (once)</td>
<td>Reap the benefits of financial inducements before everyone joined fundholding (once)</td>
</tr>
<tr>
<td></td>
<td>Was seen as the only way to get some form of loyalty from a particular provider (once)</td>
</tr>
</tbody>
</table>

(Ennew et al. 1998: 62)

2.10 Research question

As outlined in sub-section 2.6.7, I have relied on Rae’s (2007b) model of entrepreneurial management (figure 2.4) and extended this to the NHS primary care setting, to include the surrounding CCG contextual environment as displayed in figure 2.6.

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\(^6\) FHSA – Family Health Service Authorities; The FHSA became responsible for: (1) Making services more responsive to the identified needs of consumers; (2) Giving patients wider range of choice in obtaining high quality primary care services; (3) Raising standards of care; (4) Promoting health and preventive illness; (5) Improving value for money; (6) Enabling clearer priorities to be set for family health services in relation to the rest of the NHS. The FHSA was to monitor and ensure GPs fulfilled the obligations of the contract. (Warwicker, 1998)
In Rae’s (2007b) model, ‘new value’ is created by synergistic entrepreneurial and managerial working. Relating this to the focus of this investigation this research aims to explore the delivery of a ‘new service’ as an element of ‘new value’. Figure 2.6, builds on Rae’s (2007b) model, by including differing levels of influence and context, through the hybrid nature of the GP practice(s), the roles and influence of the local CCG within the wider national NHS primary care quasi-market setting.

**Primary research question:**

RQ 1: To what extent does a GP have to be entrepreneurial to deliver a service in a new way?

**Secondary research questions:**

RQ 2: How does the inner practice relationship result in a service being delivered in a new way?

RQ 3: What influence does the practice relationship with the commissioning group have in delivering a service in a new way?

RQ 4: To what extent do the priorities of the commissioning groups have an effect on the practice in delivering a service in a new way?
Chapter 3: Methodology

3.1 Introduction
This chapter builds on the findings of the literature review (chapter 2) to explain and justify the methodological approach relied on. It provides an overview of the methodological philosophy (3.2), focusing on the two traditional paradigms (3.2.1), with an explanation of the dominant paradigm (3.2.2) this study adopts. Different research methods (3.3) are explored and I explain why a case study strategy (3.4) has been used. This chapter also provides a detailed description about how the research was undertaken (3.5), which includes the methods of data collection (3.5.2 and 3.5.3) and the approach taken to data analysis (3.5.4).

3.2 Methodological philosophy
According to Easterby-Smith, Thorpe, Jackson, and Lowe (2008), there are three reasons why it is essential for researchers to understand philosophical issues:

1) *Clarifying the research design is useful* – this does not simply include the consideration of what type of evidence will be required and how it will be collected and interpreted, it should also take into consideration how this will provide good answers to the basic questions of the research investigation.

2) *It can help the researcher to identify designs that will and will not work* – this should limit the researcher from spending too much time from looking at inappropriate research designs, along with highlighting the limitations of particularly approaches.

3) *It can assist the researcher to identify, or create, new designs that are outside the researchers past experience* – this can involve adapting research designs to different subjects and knowledge structures (Easterby-Smith et al., 2008).

Maylor & Blackmon (2005) state that the methodological philosophy adopted sets the ‘rules of the game’, or the logic of inquiry which governs the approach, describing methodological philosophy as being the ‘study of the study’. Maylor & Blackmon (2005), also identify that there are two overarching arms of philosophy which relate to business and management research, these being:

a) *The philosophy of science* - sets overarching rules for the ideal way to perform scientific research in the natural world.

b) *The philosophy of social science* - sets overarching rules for the ideal way to perform research on the social world (Maylor & Blackmon, 2005).
These two philosophical arms identified by Maylor and Blackmon (2005) are often referred to as being the two traditional ‘paradigms’ of research philosophy. A paradigm can be described as:

‘The progress of scientific practice based on people’s philosophies and assumptions about the world and the nature of knowledge; in this context about how research should be conducted.’ (Collis and Hussey, 2003: 46)

Collis and Hussey (2003) believe that the term paradigm means different things to different researchers, and within academia it is often used loosely. Morgan (1979) suggested that paradigms can be used at three different levels:

1. **Philosophical level** – to reflect beliefs about the world
2. **Social level** – to provide guidance about how the researcher should undertake his/her research
3. **Technical level** – to specify the appropriate methods and techniques that should be adopted. (cited in Collis and Hussey, 2003: 47)

Therefore, the way in which I view the world has been reflected in the design of this research investigation; the way that I have collected the results and analysed the data (Collis and Hussey, 2003). Jennings, Perren, & Carter (2005) endorse this further.

‘Either explicitly or implicitly, researchers base their work on a series of philosophical assumptions regarding ontology, epistemology, and human nature, which have methodological consequences.’ (2005: 145)

### 3.2.1 Two traditional paradigms

Easterby-Smith, Thorpe, and Lowe (2002) state that the two traditional paradigms are a) positivism, and b) social constructivism, which some authors refer to as phenomenologism or interpretivism (Collis and Hussey, 2003). These are the two extreme ends of the spectrum; table 3.1 identifies the main assumptions associated with the two traditional paradigms.
Table 3.1: Assumptions of the two main paradigms

<table>
<thead>
<tr>
<th>Philosophical assumption</th>
<th>Positivist</th>
<th>Phenomenological (Interpretative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontological assumption</td>
<td>Reality is objective and singular, separate from the researcher</td>
<td>Reality is subjective and multiple as seen by participants in a study</td>
</tr>
<tr>
<td>(nature of reality)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epistemological assumption</td>
<td>Researcher is independent of that being</td>
<td>Researcher interacts with that being researched</td>
</tr>
<tr>
<td>(what constitutes valid knowledge)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axiological assumption</td>
<td>Research is value-free and unbiased</td>
<td>Value-laden and biased</td>
</tr>
<tr>
<td>(the role of values)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhetorical assumption</td>
<td>Researcher writes in a formal style and uses the passive voice, accepted quantitative words and set definitions</td>
<td>Researcher writes in an informal style and uses the personal voice, accepted qualitative terms and limited definitions</td>
</tr>
<tr>
<td>(the language of research)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methodological assumption</td>
<td>Process is deductive</td>
<td>Process is inductive</td>
</tr>
<tr>
<td>(the process of research)</td>
<td>Study of cause and effect with a static design (categories are isolated beforehand)</td>
<td>Study of mutual simultaneous shaping of factors with an emerging design (categories are identified during the process)</td>
</tr>
<tr>
<td></td>
<td>Research is context free</td>
<td>Research is context bound</td>
</tr>
<tr>
<td></td>
<td>Generalisations lead to prediction, explanation and understanding</td>
<td>Patterns and/or theories are developed for understanding</td>
</tr>
<tr>
<td></td>
<td>Results are accurate and reliable through validity and reliability</td>
<td>Findings are accurate and reliable through verification</td>
</tr>
</tbody>
</table>

Collis & Hussey (2009: 58)

3.2.2 Dominant paradigm

This research study predominantly adopts the phenomenological (interpretative) paradigm, as it is concerned with understanding ‘to what extent GPs are entrepreneurial when delivering primary care services in new ways?’ To investigate this question fully I am largely taking an inductive approach with regard to interpreting the data; I am keen to obtain a rich and thorough understanding, to be able to answer the research questions appropriately. As part of this I will be a) reviewing documentation relating to the provision of primary care services, and b) interviewing participants, which means that I will have close proximity to the participants, so that I can investigate any similarities and differences that exist. I am also acutely aware of the importance and influence that both the national and local context can have when studying the NHS, and in particular the differing primary care environment, so I am keen that this piece of research is bound within the context of the participants. I have chosen to use qualitative methods of data
collection, as this allows me to gather a level of understanding and context laden detail that would be difficult to achieve if a quantitative methods of data collections were relied upon. In line with table 3.1 and with the key characteristics outlined by Maylor & Blackmon (2005) in table 3.2 it is clear that these approaches are more akin to the phenomenological paradigm, rather than those that are present in approaches that adopt are positivist.

Table 3.2: Summary of the positivist and phenomenologist approaches

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Positivist (scientific) approach</th>
<th>Phenomenologist (ethnographic) approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Archetype</td>
<td>Experimenter operating in a laboratory</td>
<td>Research present or participating in the field of interest</td>
</tr>
<tr>
<td>Questions that could be answered</td>
<td>What, how much</td>
<td>Why, how</td>
</tr>
<tr>
<td>Starting point</td>
<td>Structure for data (you know what you need to collect), theory-led</td>
<td>Unstructured (what you need to do emerges), data-led</td>
</tr>
<tr>
<td>World-view</td>
<td>Objective (the researcher is independent)</td>
<td>Subjective (the researcher is part of what is being researched)</td>
</tr>
<tr>
<td>Objective</td>
<td>To find general patterns or laws (generality)</td>
<td>To understand meaning in one specific situation (depth)</td>
</tr>
<tr>
<td>Underlying logic</td>
<td>Deduction</td>
<td>Induction</td>
</tr>
<tr>
<td>Who uses?</td>
<td>Predominant in economics, finance, operations research, management science, and marketing</td>
<td>Predominantly in human resource management, organisational behaviour, and organisational science</td>
</tr>
<tr>
<td>Role of theory</td>
<td>Testing of theory through the development of hypotheses, collection of data, and verification</td>
<td>Generation of theory through pattern analysis</td>
</tr>
<tr>
<td>Process</td>
<td>Predominantly liner, sequential, and ordered.</td>
<td>Predominantly iterative, over lapping, and messy</td>
</tr>
<tr>
<td>Associated methods</td>
<td>The scientific methods of which surveys are an example. Modelled on closed system experiments, minimising bias, but limiting the possibilities of discovery</td>
<td>Video diaries. Recognises that social systems are most likely to be open systems, and tries to recognise personal biases and keep an open mind</td>
</tr>
<tr>
<td>Data type</td>
<td>Predominantly quantitative</td>
<td>Predominantly qualitative</td>
</tr>
<tr>
<td>Finding</td>
<td>Measure</td>
<td>Meaning</td>
</tr>
</tbody>
</table>

Maylor & Blackmon (2005: 153)
Throughout the following sub-sections of this chapter, the various approaches, such as; the choice of research design, strategy and methods of data collection are all associated with this paradigm, and are described in more detail. However, it would be incorrect to suggest that the approach taken is entirely phenomenologist in nature, as when designing the interview schedule (discussed in more detail in 3.5.2) a flexible semi-structured approach was taken, which was developed from the literature review and involved set topics of discussion to investigate the research questions. I also chose to limit my association and knowledge of the local context and the new service, by omitting new services within North, Central and South Manchester CCGs due to my working knowledge of services within these localities (discussed further in sub-section 3.5.1). So it would be inaccurate to suggest that this was a truly phenomenologist approach, as it was not completely unstructured.

### 3.3 Types of research methodology

Collis & Hussey (2009) identify that a number of different types of research methodologies exist within the positivist or phenomenological paradigms. They go on to clarify that the choice of methodology should reflect the assumptions of the researchers chosen paradigm. Figure 3.1 outlines the main methodologies that are used in social science, and in particular, business research.

**Figure 3.1: Methodological assumptions of the two main paradigms**

<table>
<thead>
<tr>
<th>Positivist</th>
<th>Phenomenologist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Associated Methodologies</strong></td>
<td><strong>Associated Methodologies</strong></td>
</tr>
<tr>
<td>Experimental studies</td>
<td>Hermeneutics</td>
</tr>
<tr>
<td>Surveys</td>
<td>Ethnography</td>
</tr>
<tr>
<td>Cross-sectional studies</td>
<td>Participative enquiry</td>
</tr>
<tr>
<td>Longitudinal studies</td>
<td>Action research</td>
</tr>
<tr>
<td></td>
<td>Case studies</td>
</tr>
<tr>
<td></td>
<td>Grounded theory</td>
</tr>
<tr>
<td></td>
<td>Feminist, gender and ethnicity studies</td>
</tr>
</tbody>
</table>

Collis & Hussey (2003: 60)

Collis & Hussey (2009) note that is it important to remember that the two paradigms are the two extremes and sit at opposite ends of the continuum; with it being possible to move each of the
methodologies some way along the spectrum with regards to my own assumptions. As discussed in 3.2.2, the approach adopted is one that sits more within the phenomenologist paradigm, but it is one which sits along the continuum represented in figure 3.1.

3.4 Case study strategy
Case study research is appropriate when the researcher desires to, or is forced by the circumstances to a) define research topics broadly, rather than narrowly, b) cover complex multivariate or contextual conditions, rather than simply focussing on isolated variables, and c) rely on multiple sources of evidence, rather than single sources (Yin, 2003).

‘A case study is a history of a past or current phenomenon, drawn from multiple sources of evidence. It can include data from direct observation and systematic interviewing as well as from public and private archives. In fact, any fact relevant to the stream of events describing the phenomenon is a potential datum in a case study, since context is important.’ (Leonard-Barton, 1990: 249)

‘The basic idea is that one case (or perhaps a small number of cases) will be studied in detail, using whatever methods seem appropriate. While there may be a variety of specific purposes and research questions, the general objective is to develop as full an understanding of that case as possible.’ (Punch, 1998: 150)

A ‘case study is a unit of analysis in case research’ and ‘case research is the method that uses case studies as its basis’ (Voss, Tsikriktsis, & Frohlich, 2002: 197). Eisenhardt (1989) describes the case study as ‘a research strategy which focuses on understanding the dynamics present within single settings’ (1989: 534). The definition of a case study strategy varies and its meaning often encroaches on the approach of ethnography, participant observation and qualitative research (Gomm, Hammersley, & Foster, 2000). Yin (2009) outlines that the majority of case study definitions merely repeat the types of topics which case studies are applied to, as demonstrated by Schramm (1971)

‘The essence of a case study, the central tendency among all types of case study is that it tries to illuminate a decision, or set of decisions: why they were taken, how they were implemented, and with what result.’ (Schramm cited in Yin, 2009: 17)

Yin (2009) criticises definitions like this due to the reference to a ‘case topic’; in Schramm's (1971) definition it cites cases of ‘decisions’, when cases can involve other focusses such as individuals, processes, events and institutions. Yin (2009) has developed a two part technical definition of a case study, the first part focussing on the scope of the study,

‘An empirical inquiry that investigates a contemporary phenomenon within its real life context especially when boundaries between phenomenon and context are not clearly evident in which multiple sources of evidence are used.’ (Yin, 2009: 18)
The second part relating to the technical aspects of data collection and analysis strategies,

‘The case study inquiry copes with the technical distinctive situation in which there will be many more variables of interest, than data points and as one result relies on multiple sources of evidence, with data needing to be converged in a triangulating fashion, and as another result benefits from the prior development of theoretical propositions to guide data collection and analysis.’ (Yin, 2009: 18)

Yin (2009) outlines that adopting a case study strategy is one of several ways of performing social science research, other ways can include surveys, experiments, histories and archival analysis. Each of which has advantages and disadvantages, these are dependent on three conditions a) the type of research question, b) the control that the research investigator has over the behaviour of events, and c) the focus being on either contemporary or historical phenomenon (Yin, 2009).

For the purpose of this investigation, I have used a single case-study approach, focussing on the role of GP as the case in question. Yin (2009) states that there are both advantages and disadvantages in using a single case-study approach, rather than multiple-cases, believing that the rationale for using a single case-study is rarely satisfied when looking at multiple sites, as the unusual, rare, critical or revelatory case is normally specific to single cases. However, Herriot & Firestone (1983) believe that the evidence obtained from multiple-cases is more compelling and resultantly more robust than using a single site design. The choice to use the collective GPs as a single case-study, rather than focussing on a multiple-site design from each locality is born out of the complexities in comparative analysis between the various services, in light of their vastly different political and social environments. Relying on the GPs as a single-case allows a deep and richer understanding into the various contributing factors in understanding the ‘extent to which GPs are entrepreneurial when delivering primary care services in new ways’.

It is important to note that as Easterby-Smith et al. (2002) highlight in figure 3.2, the various research approaches sit along a continuum, in relation to how attached or detached the researcher is from the study. For the purpose of this study I have decided to rely on case study strategy, more akin to the approach of Yin (2003), where I was more detached from the study than the approach of Stake (1995).
In relation to table 3.3, I have chosen to adopt a case study strategy, because of the nature of the study. The rapidly changing national primary care NHS context i.e. contemporary events (condition (c) in table 3.3) and the differing local market environments are difficult to quantify, which resulted in me having limited control of the behavioural events (condition (b) in table 3.3). In order to develop a rich understanding about ‘the extent to which GPs are entrepreneurial when delivering primary care services in new ways’ the reasons ‘why’ and ‘how’ within different contexts must be explained (condition (a) in table 3.3). Yin (2003) states a case study strategy is justified in studies that involve complex multivariate or contextual conditions and at present, the influence of the varying contextual layers and factors must not be underplayed.
Table 3.3 Three conditions to consider when choosing the appropriate strategy

<table>
<thead>
<tr>
<th>Strategy</th>
<th>(a) Form of Research Question</th>
<th>(b) Requires Control of Behavioural Events</th>
<th>(c) Focusses on Contemporary Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiment</td>
<td>How, why?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Survey</td>
<td>Who, what, where, how many, how much?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Archival Analysis</td>
<td>Who, what, where, how many, how much?</td>
<td>No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>History</td>
<td>How, why?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Case Study</td>
<td>How, why?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Yin (2009: 8)

Stake (2000) develops the notion that there are different types of case study, believing that there are three distinct approaches:

1. **Intrinsic case study** – this is where the case study is of interest and where there is no attempt to generalise beyond the case itself.

2. **Instrumental case study** – this is where a case is studied to provide insight into a specific issue, which can mean that although the case is selected and explored in depth, the main focus for enquiry is on something else.

3. **Collective case study** – this is where multiple cases are studied in an attempt to investigate general phenomenon. (Silverman, 2005: 127)

Scapens (1990) describes four types of case studies:

1. **Descriptive case studies** – these solely involve a description of current practice.

2. **Illustrative case studies** – these are focussed on illustrating new and possibly innovative practices.

3. **Experimental cases studies** – these focus on the difficulties in implementing new procedures and techniques.

4. **Explanatory case studies** – these involve the use of existing theory to understand and explain current practice. (Collis & Hussey, 2009: 68)

Drawing on the work of both Stake (2000) and Scapens (1990), I have chosen an approach similar to what Stake (2000) describes as an ‘instrumental case study’ with the case itself being one which is ‘illustrative’ as described by Scapens (1990).
3.4.1 Validity and reliability
According to Collis & Hussey (2009), validity is the extent to which the findings of the research study actually represent the situation being investigated. Coolican (1992: 35) states that ‘an effect or test is valid if it demonstrates or measures what the researcher thinks or claims it does’. In terms of reliability Collis & Hussey (2009) identify that if the research can be repeated then it is reliable. Raimond (1993: 55) suggests that I need to ask myself ‘will the evidence and my conclusions stand up to the closet scrutiny?’

Yin (2009) outlines that four tests have been commonly used to assess the quality i.e. validity and reliability of empirical social science research, which are consequently important for assessing the quality case study designs. These are displayed in table 3.4:

Table 3.4: Four tests of quality

<table>
<thead>
<tr>
<th>Tests</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construct validity</td>
<td>Identifying the correct operational measures for the concepts being researched.</td>
</tr>
<tr>
<td>Internal validity</td>
<td>Seeking to find a causal relationship, whereby certain conditions are believed to lead to other conditions.</td>
</tr>
<tr>
<td>External validity</td>
<td>Defining the domain to which the findings of the study can be generalised.</td>
</tr>
<tr>
<td>Reliability</td>
<td>Demonstrating that the operations of the research study e.g. data collection procedures can be repeated with the same results.</td>
</tr>
</tbody>
</table>

Adapted from Yin (2009: 40)

As represented in table 3.5, Yin (2009) suggests a number of tactics in dealing with tests identified in table 3.4. In accordance with table 3.5 I have adopted a number of the tactics highlighted by Yin (2009), to increase the validity of the research, these are explained in more detail in sub-section 3.5.6.
### Table 3.5: Case study tactics for four tests of quality

<table>
<thead>
<tr>
<th>Tests</th>
<th>Case Study Tactic</th>
<th>Phase of research which tactic occurs</th>
</tr>
</thead>
</table>
| **Construct validity** | a) use multiple sources of evidence  
                      b) establish a chain of evidence  
                      c) have key informant review draft study report | a) data collection  
                                                                                  b) data collection  
                                                                                  c) composition |
| **Internal validity** | a) do pattern matching  
                      b) do explanation building  
                      c) address rival explanations  
                      d) use logic models | a) data analysis  
                                                                                  b) data analysis  
                                                                                  c) data analysis  
                                                                                  d) data analysis |
| **External validity** | a) use theory in single-case studies  
                      b) use replication logic in multiple case studies | a) research design  
                                                                                  b) research design |
| **Reliability**    | a) use case study protocol  
                      b) develop case study database | a) data collection  
                                                                                  b) data collection |

Yin (2009: 41)

### 3.5 Conducting the research

Before conducting the research an application for ethical approval was made to the University of Manchester Ethics Committee. The application was heard on the 24th June 2013, by Ethics Committee 5 (Humanities) and following minor amendments, ethical approval was received on the 25th July 2013, reference number 13097.

According to Denzin and Lincoln (2008), a research design outlines a flexible set of guidelines which firstly connect strategies of enquiry, and secondly methods for collecting empirical materials, to theoretical paradigms. To supplement this, Denzin and Lincoln (2008) suggest that strategies of enquiry connect the researcher to methods of collecting and analysing data. Bryman (2008: 31) argues that there is a more distinct separation, suggesting ‘a research design provides a framework for collection and analysis of data’, which is different in nature to the research method which ‘is simply a technique for collecting data. It can involve a specific instrument, such as a self-completion questionnaire or a structured interview schedule, or participant observation whereby the researcher listens to and watches others’ (2008: 31). For the purposes of this study, were a case study strategy has been adopted, the research methods used for collecting empirical materials involve semi-structured interviews, and document analysis.

However, Voss et al. (2002) believe that several challenges exist in conducting case research, these being a) the time to carry out the study, as it can be time consuming, b) it requires skilled interviewers, and c) the researcher must be careful in drawing generalisable conclusions from a limited set of cases whilst ensuring robust research. When conducting this study, I was acutely
aware of the challenges highlighted by Voss et al. (2002), especially the skill required to undertake interviews. I have previous experience, through my professional employment, in carrying out semi-structured qualitative interviews with GPs in particular, and it is acknowledged that it requires a skilled researcher to ensure an effective interview. However, it was believed that in order to gather rich, context specific data to allow a detailed investigation of the research question, the use of a case study strategy was required. Voss et al. (2002) appear to support this by identifying that even though there are challenges in conducting a case research, there are advantages to such an approach,

‘The results of case research can have very high impact. Unconstrained by the rigid limits of the questionnaires and models, it can lead to new and creative insights, development of new theory and have high validity with practitioners – the ultimate aim of the researcher.’ (Voss et al., 2002:1)

In the following sub sections (3.5.1 – 3.5.6) the approaches that I took whilst conducting the study are outlined.

3.5.1 Purposive sampling
Silverman (2008) argues that ‘everybody knows that qualitative research can work fruitfully with very small bodies of data that have not been randomly assembled... [so the role of the researcher is to] explain how you can still generalise from your analysis’ (2008: 377). Consequently, a purposive sample design has been utilised in this study, as Bogdan & Biklen (1983) suggest that adopting a purposive sample involves participants who are most likely to facilitate the development of the emerging theory; such participants will have specific characteristics or knowledge which will add to, support or refute the theory enhancing the researchers understanding of the setting. Denzin & Lincoln (2000) identify that purposive sampling is often relied upon by qualitative researchers,

‘Many qualitative researchers employ... purposive and not random sampling methods. They seek out groups, settings and individuals where... the processes being study are most likely to occur.’ (Denzin & Lincoln, 2000: 370)

Bryman (2008) provides further support for using a purposive sampling method, suggesting that such a method allows the researcher to identify the appropriate sample to specifically address their research question. For the purpose of this study, I have selected sites delivering primary care service in new ways to gain a rich understanding of the research question. Hussey & Hussey (1997) state that a purposive approach is justified and that using a representative case or set of cases is not usually necessary, when using a case study approach.
A) Services delivered in new ways:
This research study focusses on exploring ‘to what extent are twenty first century general practitioners entrepreneurial when delivering primary care services in new ways’ and one of the first purposive sampling considerations relates to the definition of primary care services delivered in new ways. Primary care services delivered via Local Enhanced Services (LESs) were defined as ‘being delivered in new ways’. The BMA describe enhanced services as providing ‘additional services to a higher standard or a wider services provided through primary medical service contracts’ (2014: 1). NHS England (2012) separate enhanced services into two distinct categories

- **Local Enhanced Services (LESs)** – these are schemes agreed by the local commissioning authority in response to the local needs and priorities, which can include adopting national service specifications
- **Direct Enhanced Services (DESSs)** – these offer contractors the opportunity to provide services in line with national priorities and agreements.

However, the introduction of The Health and Social Care Act in 2012 and the development of CCGs resulted in the provision of LESs being altered, with NHS England procurement rules requiring CCGs to offer LESs out to tender, or to procure such services under the any qualified provider (AQP) regulations. LESs have also been rebranded, they are now referred to as Community Service Contracts (CSCs) within primary care (Stirling & Kenny, 2014). Consequently the inclusion criteria for this study meant that a ‘primary care service being delivered in a new way’ was either a LES or CSC.

B) Scope:
To investigate and to develop a greater understanding of the various primary care NHS contexts, I chose to focus on participants from different CCG locations, with data collected from four (n=4) different sites who deliver primary care services in new ways, each of these being within a different CCG locality. All of the sites delivering primary care services in new ways are located within Greater Manchester, and each of the sites resides within a different CCG. There are a number of justifications for limiting the scope to services being delivered within Greater Manchester, these include a) the time and resources required to attend the various sites, b) my professional employment involves contact with NHS professionals within the Greater Manchester footprint, and c) there are large variances in context across Greater Manchester, which limits the necessity to extend this study further afield. It is important to note that this study has excluded services which are delivered from sites within the three Manchester CCGs (North, Central and
South) due to my extensive knowledge of services within these areas, in an attempt to limit bias in the interpretation of the data (this is discussed further in sub-section 3.5.6).

C) Recruitment:
Recruiting primary care health care professionals, and GPs in particular, into research studies is notoriously difficult (Parkinson et al., 2014; Williamson et al., 2007), especially when there is no financial remuneration available to backfill the time to participate (McKinstry, Hammersley, Daly, & Sullivan, 2007; Young et al., 2011). Unfortunately due to this study being part of an MPhil investigation, there was no scope to be able to financially remunerate GPs for taking part. Consequently, I had to rely on my professional contacts to assist with recruitment. I am an NHS employee who has six years experience working in such an environment; so throughout my employment I have been able to make an array of relationships with people from different sectors and NHS organisations, and I had to use a number of these to assist. Recruiting participants with this approach has elements of what Bryman (2008) describes as ‘snowball sampling’, as I relied on my relationship with CCG Commissioning Managers, Specialist Clinicians, and work colleagues to identify GPs which were believed to be involved in the delivery of primary care services in new ways, from within Greater Manchester. This was supplemented by accessing information from multiple resources ranging from a) CCG Board minutes, b) industry magazines, c) local and national priority information, d) conferences, and e) social media, to identify primary care services being delivered in new ways. Recruiting suitable participants was extremely difficult, and it was a time consuming process which required an awful lot persistence and perseverance and the links made via colleagues and professional contacts was essential to the process.

Initial contact with possible participants was made via an introductory email; this also included a participant information sheet (see appendix 1) to provide specific information about the study. Subsequently face to face meetings were arranged to discuss the study in more detail and to obtain confirmation of participation.

D) Sample Characteristics:
Table 3.6 details a) the nature of the service provided in new ways, b) the size of the GP practice involved in the delivery of the new service, c) the profession of the interviewees, d) gender, and e) the position of the professional within their GP practice.
Table 3.6: Nature of the data collection sites and participant information

<table>
<thead>
<tr>
<th>Site</th>
<th>New Service</th>
<th>Size of GP practice service attached to</th>
<th>Profession</th>
<th>Gender</th>
<th>Hierarchy within GP Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site A</td>
<td>Multiple</td>
<td>Large</td>
<td>GP (with specialist interest in heart failure)</td>
<td>Male/Female</td>
<td>Partner/Partner</td>
</tr>
<tr>
<td>Site B</td>
<td>Heart Failure</td>
<td>n/a8</td>
<td>Heart Failure Specialist Nurse</td>
<td>Male/Female</td>
<td>Salaried/Salaried</td>
</tr>
<tr>
<td>Site C</td>
<td>Multiple</td>
<td>Small</td>
<td>Practice Nurse Practice Manager</td>
<td>Male/Female</td>
<td>Partner/Partner</td>
</tr>
<tr>
<td>Site D</td>
<td>Severe Mental Illness</td>
<td>Medium</td>
<td>GP</td>
<td>Male</td>
<td>Partner</td>
</tr>
</tbody>
</table>

As table 3.6 identifies, there is a 50:50 split between the gender of all respondents, however it was not possible to achieve an equal gender split of GP respondents, which is male dominated 80:20. Traditionally there have been more male GPs than females, however as Lind (2014) reports, over the last decade the number of female GPs has risen by over 50%, with the most recent report suggesting that there are more female GPs (20,435) than men (19,801). Although it is important to note that it appears there is still a male domination (15,748 compared to 10,887 female) in GPs who are providers of services (Lind, 2014), rather than salaried GPs, which perhaps explains the male domination of GP respondents, as this study focusses on GPs who are delivering primary care services in new ways. But, as Silverman (2008) argues in a qualitative investigation, it is not always appropriate or necessary to achieve a balanced sample based on demographics such as gender, believing that determinants that provide the biggest breadth of experience within the sample are more important. Hence my decision to focus on four (n=4) primary care services being delivered in new ways, and the GPs involved in the delivery of these.

3.5.2 Interviews
According to Yin (2009), interviews are an essential data source, arguing that they are one of the most important sources of data within a case study approach. Yin (2009) goes on to suggest that interviews should be guided by conversation rather than a structured line of enquiry. Stake (1995)

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7 The size of the practice has been established from the NHS Information Centre QOF figures from 2013/2014 based on the number of patient list size of practices. The specific numbers of patients has not been displayed to ensure anonymity. The size categories are as follows: small < 5,000 patients; medium 5,000-10,000 patients; large > 10,000 patients.

8 N/A - the service doesn’t have a specific link to a GP Surgery, it is delivered at a separate location within the CCG locality and it involves multiple professionals.
supports this, by suggesting that each respondent has a unique understanding and perspective, which should not be limited by the researcher adopting a rigid and structured method of data collection. Rubin & Rubin (1995) further enhance the view that a flexible approach to interviewing should be followed, by suggesting that the researcher should pursue a consistent line of enquiry, but the actual questions in each interview are likely to be fluid rather than fixed. In line with Rubin & Rubin (1995), Stake (1995) and Yin (2009) for this research study a fluid and flexible semi-structured interview schedule was developed, relying on the literature review (chapter 2), documentary analysis and information obtained from a pilot interview.

A) Interview Schedule

Yin (2009) identifies that the researcher must possess the ability to pose and ask good questions, with the desired outcome being for the researcher to create a rich dialogue with the interviewee, by

‘Pondering the possibilities gained from deep familiarity with some aspect of the world, systemising those ideas in relation to kinds of information one might gather, checking the ideas in light of that information, dealing with the inevitable discrepancies between what was expected and what was found by rethinking the possibilities of getting more data, and so on.’ (Becker, 1998: 166)

Hussey & Hussey (1997) identify that when conducting interviews in a phenomenological study the researcher must keep an open mind and should not design specific and rigid questions in advance. However, in order to address the research questions, I chose to develop a schedule of broad themes and topics of discussion in relation to the literature, pilot interviews (sub-section B), document analysis (sub section 3.5.3) and chronological data analysis (sub-section 3.5.4).

Respondents were encouraged to share their own understanding of their services, both in terms of how they were provided and how the decision to provide them was made. Please see table 3.7 for a more detailed explanation of the various topic areas and the specific focusses within these.
Table 3.7: Detailed description of interview topic areas

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information about the service and where relevant the GP Surgery</td>
<td>Practice size/population, Situation urban/rural, Structure, PMS, GMS, GPwSI, People involved in the service, How long the service had been in operation</td>
</tr>
<tr>
<td>How the decision to provide the service was made</td>
<td>Internal practice relationships, External relationships, CCG, Local and national drivers, Financial incentives/gains</td>
</tr>
<tr>
<td>Relationships with the local CCG</td>
<td>What is like? Has this changed over time? Is this any different to the PCT? Does it aid service being delivered in new ways?</td>
</tr>
<tr>
<td>Entrepreneurship</td>
<td>What does this mean? Are you entrepreneurial? Do you need to be?</td>
</tr>
<tr>
<td>Personal characteristics</td>
<td>Motivation, Professional satisfaction, Career development</td>
</tr>
<tr>
<td>Roles and responsibilities</td>
<td>In service delivery, Multiple roles and responsibilities, Internal practice tea</td>
</tr>
</tbody>
</table>

B) Pilot Case Study Interview

Yin (2009) stresses the importance of performing a pilot case study before undertaking the study,

‘A pilot case study will help you refine your data collection plans with respect to both the content of the data of the data and the procedures that follow... it is more formative, assisting you to develop relevant lines of questions.’ (Yin, 2009: 92)

Relying on my professional relationships with NHS and academic professionals, I was able to undertake a two stage piloting process, as represented in table 3.8.
Table 3.8: Characteristics of pilot interviews

<table>
<thead>
<tr>
<th>Stage</th>
<th>Service</th>
<th>Size of GP Surgery service attached to</th>
<th>Profession</th>
<th>Gender</th>
<th>Hierarchy within GP Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Stage</td>
<td>N/A</td>
<td>Small</td>
<td>GP &amp; Senior Lecturer in Primary Care</td>
<td>Female</td>
<td>Partner</td>
</tr>
<tr>
<td>2nd Stage</td>
<td>Summary Records &amp; ICT</td>
<td>Large</td>
<td>GP &amp; CCG Commissioner</td>
<td>Male</td>
<td>Partner</td>
</tr>
</tbody>
</table>

Before the semi-structured interview schedule was developed, the first stage involved an informal interview with an academic GP who has an active interest in NHS primary care policy and practice. I was in the process of developing the research question and this interview assisted with the formalisation of the key topics and themes within current primary care NHS practice.

As discussed in 3.5.2 (A), a set of semi-structured interview questions were developed; after an initial draft. I held an unrecorded telephone interview with a GP involved in the delivery a primary care service in a new way. As Ghauri & Gronhaug (2005) suggest, this piloting was essential as this extra scrutiny aided my understanding of the research problem, whilst also checking the interviewee’s understanding of the research problem and the more specific questions. I was keen to test whether the term ‘entrepreneur’ would be understood by GPs, as early discussions with one of my academic supervisors raised doubt, with it being suggested that ‘innovation’ and ‘enterprise’ might be more appropriate for the GP sample. I explored this during the pilot interview and the term ‘entrepreneur’ was not believed to be a problem. However, it highlighted that GPs may have different perceptions as to what the term ‘entrepreneur’ means within their professional context. To explore this further, and to ensure a greater understanding, I built this question into the final interview schedule. This approach is supported by Ghauri & Gronhaug (2005) who believe that understanding the ‘cultural endowment’ (2005: 134) is an essential part of the interview design process.

C) Conducting the interviews
All of the interviews were conducted face-to-face, involving myself and individual participants. I was acutely aware of the time pressures that GPs and health care professionals faced and

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5 The size of the practice has been established from the NHS Information Centre QOF figures from 2013/2014 based on the number of patient list size of practices. The specific numbers of patients has not been displayed to ensure anonymity. The size categories are as follows: small < 5,000 patients; medium 5,000-10,000 patients; large > 10,000 patients.
interviews were scheduled for times that suited each individual participant; this often resulted in
the interviews occurring outside of normal working hours.

The interviews were recorded using a digital voice recorder, with both verbal and written consent
(see appendix 2) gained by all respondents. I transcribed all of the recorded interviews verbatim,
with all names and identifiers pseudonymised. Notes were made in the transcriptions of any
interruptions i.e. Nurse interrupting the interviews to discuss a clinical or practice matter with the
interviewee, during the scheduled interviews.

3.5.3 Documentation
Documentation has primarily been used in this study to enable me to gain a better contextual
understanding of each of the primary care services being offered in non-traditional ways, which
aided the interview process, and as a means of cross reference to triangulate interview data. As
Yin (2009) notes, documentary information is predominantly available for each of case study
topic, or site of data collection, this takes a number of forms which include:

- Letters, email correspondence and personal documents such as notes
- Agendas, announcements and written reports of events
- Administration documents such as progress reports and internal records
- Formal studies and evaluations of the same case that the researcher is studying
- News clippings and articles from mass or community media sources (2009: 103).

For the purpose of this research study, access to many internal documents was not possible, due
to my limited time and the lack of financial resources of this MPhil investigation. Hence I relied on
a number of publically available resources from:

- **CCG and individual GP practice websites** - for information about LESs, DESs, progress
  reports and evaluation reports (if they existed). Websites were also used to access CCG
  board minutes and patch meeting minutes
- **The Information Centre website** – for demographic information
- **The Kings Fund website** – for evaluation reports and national/local policy information
- **The Nuffield Trust website** – for evaluation reports and national/local policy information
- **Pulse GP E-Magazine** – for information about current GP issues, concerns and
developments
- **NHS England website** – for information about national primary care policy and evaluation
  reports
• Greater Manchester Academic Health Science Network (GM AHSN) website – for information about local primary care service development schemes.

However, it is important to note that I used these documents with care, as Yin (2009) points out that the researcher must be aware that these documents may not be accurate, and it may result in the researcher developing an inaccurate understanding of a certain topic. Consequently in line with Yin (2009), the predominant use of the documents highlighted above, has been to corroborate information from other sources.

3.5.4 Data analysis
Ryan & Bernard (2003) outline that analysing data involves a number of tasks: a) discovering themes and subsequent sub-themes, b) whittling these down to a manageable few and deciphering which themes are important for the particular study, c) developing a hierarchy of themes or codes, and d) linking themes to theoretical models. For this study a single case thematic approach to data analysis was used.

As explained in sub-section 3.5.2, the interview schedule was developed largely from a) the entrepreneurship literature, and b) the documentary analysis of primary care services and the ever changing NHS context. However, a flexible inductive approach to the interviews was adopted to allow the participants subjective understanding to be clearly articulated. Themes were identified from the text using an approach akin to that described by Smith & Osborn (2003); who outline that such an approach to analysis ‘attempts to explore personal experience and is concerned with an individual’s personal perception or account of an object or event’ (2003: 51). I relied on the approach of Smith & Osborn (2003) to ensure that participants views directly informed the themes and sub-themes of this research study.

The Smith & Osborn (2003) method does not require the use of computer technology for analysing interview transcripts, it is a paper based method which involves the researcher analysing each transcript individually and completing the analysis of the transcript before moving on to the next. I initially read each of the transcripts twice and made notes in the left hand margin to record topics, views and ideas along with connections and links to my ‘preliminary interpretations’ (Smith & Osborn, 2003: 67). After this initial stage the transcript was re-read and I made notes in the right hand margin ‘to document emerging themes and titles’ (Smith & Osborn, 2003; 68), using different coloured ink to highlight the different themes and titles. I have attached a page of one of the transcripts as an example of how I approached data analysis in appendix 3; this illustrates how I used different coloured ink, initial notes and connective themes. Adapting
such an approach ensures that the themes generated from the data analysis related directly to the participants ‘personal experience…. or account’ (2003: 51).

The themes identified from the process described above, were listed in chronological order, as they appeared within the transcripts. These were then grouped to develop any linkages between them, with the main themes represented in the results section (chapter 4). Adopting such an approach ensured that I integrated any emerging themes from the early interviews into the interview schedule, to enhance the interviews with future participants.

3.5.5 Validity and reliability in case studies
Validity and reliability are often seen to be problematic when conducting qualitative research, however one of the strengths of adopting a case study approach is the corroboration of data from a variety of evidential sources (Yin, 2009), these being via interview and document analysis. As highlighted in table 3.5 (sub-section 3.4.1), Yin (2009) identifies a number of tactics to address a) construct validity, b) internal validity, c) external validity, and d) reliability. Table 3.9 explains how I addressed these issues within this research study.

Table 3.9: Approaches taken to address the four tests of quality identified by Yin (2009)

<table>
<thead>
<tr>
<th>Tests</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construct Validity</td>
<td>• Data from both interviews and documentation was used</td>
</tr>
<tr>
<td></td>
<td>• A local CCG commissioner and a local primary care policy academic were consulted to discuss the findings of the study, to ensure my understanding of the data was appropriate.</td>
</tr>
<tr>
<td>Internal Validity</td>
<td>• The data was analysed using a thematic framework approach, pulling together common topics and sub-topics, in an explanatory way.</td>
</tr>
<tr>
<td>External Validity</td>
<td>• The data was analysed in line with Rae's (2007b) model of entrepreneurial and managerial working, enhancing this model for the NHS primary care environment as identified in the research problem.</td>
</tr>
<tr>
<td>Reliability</td>
<td>• A protocol for identifying, recruiting, understanding and analysing the information from the various sites within the case study has been followed.</td>
</tr>
</tbody>
</table>

3.5.6 Methods and techniques to minimise bias
As highlighted in the ‘Recruitment’ sub-section 3.5.1 (C), in an attempt to limit any researcher bias, all sites providing services in non-traditional ways were unknown to myself. I am an NHS employee with extensive knowledge of the local context in a number of CCG localities within Greater Manchester, which may have affected the interpretation of the data. All of the case study
sites chosen are GP practices, NHS professionals and CCG localities where I had no previous professional experience.

According to Remenyi, Williams, Money, & Swartz (2002), there are difficulties in obtaining unbiased interview data, these include: a) the difficulties that participants have in accurately recalling all events, b) the difficulty that participants have in expressing their feelings, and c) the suspicion that participants may have in revealing information which may portray either themselves or their superiors in a negative light (2002: 170). To limit the effect of inaccurate data, where possible, data was triangulated between individuals within sites delivering services in new ways, policy, service and practice documentation (as highlighted in the ‘Documentation’ sub section 3.5.3). I was acutely aware of the sensitivity of data supplied by participants and assurances were made regarding anonymity of individuals with practice site names and localities being pseudonymised.

3.6 Chapter summary
In summary, this chapter outlines that for this study a phenomenological (interpretive) paradigm is adopted (3.2.2), utilising a case study strategy similar in approach to Yin (2009), focussing on GPs as the case unit (3.4). A purposive sample, focussing on primary care services delivered in new ways within Greater Manchester (3.5.1), will be relied upon. The primary method of data collection will involve flexible semi-structured interviews (3.5.2), with documentation analysis used to assist with the researcher’s understanding of the context (3.5.3). Data will be analysed chronologically using a paper based approach outlined by Smith & Osborn (2003), identifying themes and linkages. In the following chapter (4) data obtained from the research is displayed.
Chapter 4: Results Section

4.1 Introduction
This chapter presents the data concerning the extent to which twenty first century GPs are entrepreneurial in delivering primary care services in new ways. Section 4.2 presents contextual and demographic information about the four sites of data collection. Section 4.3 details the data focussed around entrepreneurship, with specific focus on whether the GPs are entrepreneurial (4.3.1), the motivations for participants delivering new services (4.3.2), the notion that entrepreneurship can be developed over time (4.3.3), whether opportunities are discovered or created (4.3.4), and the trade-offs involved with delivering new services (4.3.5). The notion of entrepreneurial working and its relationship with managerial working is displayed in section 4.4, with further exploration around managerial support being obtained from other professionals within the practice setting in sub-section 4.4.1.

This chapter also presents the findings of the participants relationship with their local CCG in section 4.5 with specific focus on whether these provide or assist in providing new services (4.5.1), whether these relationships have altered over time (4.5.2), and the time trade-offs that are associated with developing and maintaining relationships (4.5.3).

4.2 The four data collection localities
As previously outlined in the methodology section (chapter 3); this study focusses on data from services that are delivered within four sites within the Greater Manchester CCG footprint. Sites A and D offer a number of LES or DES services and interviewees openly discussed multiple new primary care services, however within sites B and C, a specific new service was discussed. Table 3.6 displays a number of the characteristics of each of the sites, table 4.2 displays further information about the GP contract that each of the sites have along with the various roles that interviewees hold external to the site.
Table 4.2: GP practice contract held by the data collection sites and the external roles that participants hold

<table>
<thead>
<tr>
<th>Site</th>
<th>GP Practice Contract</th>
<th>Role outside the practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site A</td>
<td>GMS</td>
<td>GP1 – CCG board member &amp; LMC member&lt;br&gt;GP2 – No external role</td>
</tr>
<tr>
<td>Site B</td>
<td>n/a&lt;sup&gt;10&lt;/sup&gt;</td>
<td>GP – Member of the ‘Leading Lights’ for cardiology group&lt;sup&gt;11&lt;/sup&gt;&lt;br&gt;HFSN – North west heart failure nursing group member</td>
</tr>
<tr>
<td>Site C</td>
<td>PMS</td>
<td>GP – No external role&lt;br&gt;PN – Locality board member; PN forum chair &amp; clinical nurse champion&lt;br&gt;PM – No external role</td>
</tr>
<tr>
<td>Site D</td>
<td>GMS</td>
<td>GP – CCG board member; Clinical lead for mental health &amp; locality chair</td>
</tr>
</tbody>
</table>

To supplement table 4.2, the following subsections (4.1.1 - 4.1.4) provide contextual information about the services, the operating contract of the GP practices and the positions externally held by participants.

4.2.1 Site A

As highlighted in table 3.6, site A provides a number of ‘new services’ of which the participants discussed a number of these, rather than discussing one particular service at length. These services included a specialist alcohol service, a minor surgery clinic, a podiatry clinic, a prostate specific antigen (PSA) clinic and a cryotherapy clinic,

‘We have done minor surgery for a long time, Doctor (Dr) X set that up years ago and GP1_site_A does it now as well, because there is big demand for minor surgery... but then there are things like warts and moles that need removing and they don’t really need full blown minor surgery, so we started a few years ago. We [the practice] decided to buy our own liquid nitrogen in a flask and there is a supply now that is sent to the health centre, we have to go and get it, so this is a service that we have set up. There are two Drs who do it fortnightly, they take it turn.’ (GP2_site_A)

‘One of the things we have set up recently is a PSA clinic... it is for people with prostate cancer. Historically what was happening was that they [the patients] were going to the hospital clinic and they would go first thing in the morning and they would get their blood test done, sit and wait for several hours and eventually they would see a nurse that said “yes it is okay”, then they would be given an injection. What we decided was that we would do all of our injections in house... instead of having to spend the full morning in a hospital clinic, they could actually have a 5-10 minute

<sup>10</sup> Service used to be provided via a contractual agreement with the local Primary Care Trust (PCT); however this service is currently contracted

<sup>11</sup> The ‘Leading Lights’ group are a collection of clinicians who are interested in cardiology. This group originated from the Greater Manchester and Cheshire Cardiac and Stroke Network (GMCCSN); they have previously assisted with the development of local pathway design ad recommendations concerning primary care.
appointment here which was easier for them... the numbers aren’t huge, I think we are only
talking about 35-40 patients per year, so that is 40 times four appointments per year.’
(GP1_site_A)

‘I have set up an alcohol related service and the idea is that basically it is not for people who are
alcoholics, it is not for those people who have health problems, it is more for the general
population to look at the lower risk... historically we have treated alcohol as the heart attack of the
old, where you did nothing until somebody had a heart attack, well now we have all these steps of
prevention and it is designed to create levels of prevention... it hasn’t been done before in primary
care, but thanks to the CCG and funding, I’ve been able to set up this service.’ (GP1_site_A)

Tables 3.6 and 4.2 show that site A is a large practice; both GP1 and GP2 are partners in the
practice, in fact they are two of eight GP partners as one of the participants identifies ‘an
employed [salaried] Practice Manager, just the eight partners and we have one salaried GP, then
we have usually have two registrars and we’ve got three training doctors’ (GP2_site_A). One of
the participants (GP1) also has an active role outside the practice within the local CCG ‘I am on the
governing body’ (GP1_site_A), whereas GP2 has no formal role outside of the practice setting
‘personally, I’m not involved; I try and go to some of the practice events’ (GP2_site_A).

4.2.2 Site B
Site B is perhaps different to the other ‘new services’ that are provided as this service is not
currently provided from a GP practice locality. It used to be, however it has recently moved and it
is now provided within at a separate location. The service involves the provision of a specialist Tier
2¹² heart failure service.

‘Currently we run a heart failure service that is for the whole of locality B, there is me as the GP
with a specialist interest in cardiology that works for one day a week and currently we have one
and three quarter time heart failure specialist nurses (HFSN), but we are expanding in the next
month or two; we are recruiting two further heart failure nurses, so we will have three and three
quarter time overall. We provide a specialist service for GPs to refer heart failure patients to at
diagnosis if they are having any problems with them [patients], and we also take referrals from
the hospital, so patients who have been in with heart failure, or consultant referrals where they
are seeing patients with heart failure in their clinic but they feel it might be more appropriate if we
see them.’ (GP_site_B)

‘It is mainly a nurse led service.’ (GP_site_B)

‘It was set up by a heart failure specialist nurse [not the HFSN being interviewed] and it was the
first heart failure service location B had to deal with patients with LVSD [left ventricular systolic
dysfunction].’ (HFSN_site_B)

‘The service has probably been in existence for about 8 years... it was a very very small service with
at maximum two nurses, one full time and one part-time, and then after a couple of years a GP

¹² Tier 2 refers to a service that sits between the traditional GP primary care working and secondary
hospitals. They are normally disease focussed and used as a triage to secondary care.
with specialist interest came into the service for some clinical support and the clinics became more robust.’ (HFSN_site_B)

As the HFSN and GP both highlight, this service has been established for a number of years and it initially did not involve a GP; the GP became involved after the inception of the service. The service has also recently undergone further changes with the level of nurse input increasing and it appears that Consultant Cardiologists are due to be brought into the service,

‘The Trust [secondary care provider within this locality] as part of the work with hospital x\(^{13}\) has had an increase in cardiologists and they have just got two with heart failure interests… because there is no space in the hospital for anything that is new, the consultants are going to come here… they are not based here but they are coming here to do sessions, and that is quite a shift because normally consultants don’t come out of hospital and do sessions somewhere else. So this is all part of the new model really.’ (HFSN_site_B)

The GP involved with the service, does not have a formal role within the local CCG, but he/she is involved with a Greater Manchester wide group of primary care clinicians who have a specialist interest in cardiology ‘there are a few GPs who have a specialist interest in cardiology around the Greater Manchester area and we have a sub group that meets up every few months’ (GP_site_B).

The HFSN interviewed from the service does not have any formal or informal roles with the local commissioning group.

4.2.3 Site C

Site C provides multiple ‘new services’ and in the interviews with the Practice Manager, Practice Nurse and GP partners of the practice they were keen to discuss a number of them; the services include a diabetes service, a phlebotomy service, and a dementia service. The participants were also keen to discuss services which historically were classed as new services.

‘In those days it was very unusual to have a COPD [chronic obstructive pulmonary disease] clinic; patients with COPD were just treated in the asthma clinic virtually the same as the asthma patients, there was no specialist care at all. We looked into our practice population and coming from a mining town we had lots of COPD patients… so we set up specialist COPD clinics and we were going to manage these patients in primary care, which hadn’t been done before.’ (PN_site_C)

‘We have signed up for the over 75s DES on health assessments, we have always done an over 75 health check but the DES has added a lot more assessment… it is very prescriptive there is more around physical assessments for mobility, for example the Edmonton tool is used… also included in that, which is a really hot topic, is dementia screening… we do it [dementia screening] opportunistically, however we are now putting aside special appointment time now for myself, as the nurse to do that screening in a more formal way, so what we have done is sign up to the DES which is to do the read coding and identifying people with risk of dementia.’ (PN_site_C)

\(^{13}\) This is a secondary hospital that is not directly located to the locality, but they have a close link due to the nature of the heart failure service.
Table 3.6 demonstrates that within the GP practice setting at site C, both the Practice Nurse and the Practice Manager are partners in the business, they also have a GP partner. This is relatively unusual, especially at the time when the Practice Nurse and Practice Manager became partners, as they were the two people who led the PMS contract application and brought a partner GP in to support them.

‘Ten years ago when the previous GP the Practice Manager and I were working for, put his notification in to retire, there were some interested parties that came into the practice to look around and their suggested way of working made us [Practice Manager and Practice Nurse] quite nervous, because we had a particular ethos and particular type of working, and we wanted to protect that and protect the patients... so the Practice Manager and I had a conversation and the Practice Manager said “if you are looking for a partner then I would be interested”, so we started the process... we didn’t think about a GP partner at the time until we started to have more in-depth conversations about securing a true team.’ (PN_site_C)

It is also important to note that the Practice Nurse participant from this site has an active role within the local CCG ‘I am the nurse champion for our locality [one of six within the CCG] and I sit on the service redesign part’ (PN_site_C). However, neither the Practice Manager nor the GP have specific roles within the CCG or with any other external NHS organisations.

4.2.4 Site D
The ‘new service’ which is delivered at site D is specifically focussed on assessing and monitoring the physical health of people who have severe and enduring mental illness (SMI),

‘With this group of patients, historically some [patients] tend not to engage with primary care and they tend to suffer health inequalities as they don’t tend to come in, in the same way that the general population might, but we know that they [people with SMI] are more prone to cardiovascular disease.’ (GP_site_D)

‘Across the CCG, the average attendance [according to the Quality Outcomes Framework and including the number of patients exempted] is about 80% of this group, with about 20% DNA’ing [did not attend]; at our practice we have managed to get this up to around 95% to attend and in fact last year we got 100% to attend. The main reason being that if they weren’t coming in we would notify their care co-ordinator or the psychiatry service.’ (GP_site_D)

In order to facilitate more people with SMI attending appointments at the GP practice, the GP in question has used a number of different approaches,

‘I will try and allocate appointments... and I think that helps them facilitate attendance and we put the appointments in at the end of the surgery when it tends to be a bit quieter in the waiting room, because some feedback we had from SMI patients, is part of the reason why they don’t like attending their GP surgeries is because they are very busy and noisy and they often have to wait as we often have to fit in emergencies.’ (GP_site_D)

14 Key mental health work assigned from the local community mental health team
As highlighted in figures 3.6 & 4.2, the GP interviewed who leads this service is also a partner within his/her practice, of which there are three partner GPs and four GPs in total. The GP is also a clinical lead within his/her locality ‘it is probably partly driven by my role as clinical lead for mental health for locality D’ (GP_site_D), and has an active role with the local CCG governing body, ‘I have also taken up another employment with the CCG, so I am now a member of the governing body, so I am the GP representative for patch D\(^\text{15}\), so I sit as one of six GP leads’ (GP_site_D).

### 4.3 Entrepreneurship

The literature review ([chapter 2](#)) demonstrates that historically there have been various interpretations of the term entrepreneurship, with there still being no universally accepted definition. Consequently, and as noted in the methodology section ([chapter 3](#)), I was keen to obtain the views of the participants regarding their perceptions of what entrepreneurship meant to them. As you can see from the data below, there did not seem to be a universal view, however a number of participants made specific reference to the creation of ‘money’, ‘invention’ and the development of ‘something new’,

‘Entrepreneur, well I have an example of that because I have been part of a ‘dragons den’, which was a CCG idea where they will listen to ideas and then provide funding of them... it is ground breaking and has never been done before; it is quality.’ (GP1_site_A)

‘Well, it is kind of making new business ventures and services.’ (GP2_site_A)

‘Someone who makes money... who is creative, expressionate and at times mad cap... Someone who is very good at developing business models, I suppose you think of someone as being an entrepreneur if they are high flying in business and develop business quickly... I suppose developing business really and making sure it works well.’ (GP_site_B)

‘You think of money and inventing.’ (HFSN_site_B)

‘If you say entrepreneurial, I think you start making money, and you are doing it through new ways, through innovation and whatever.’ (GP_site_D)

However, both the Practice Manager and the Practice Nurse from site C believed that risk was an important aspect of being entrepreneurial, especially taking a risk,

‘Stepping out of the norm and taking a risk, because it definitely was for us, it was the unknown when we started.’ (PN_site_C)

‘Probably doing something different, exciting and innovative... it was taking the risk.’ (PM_site_C)

\(^{15}\) Patches are groups of GP practices that usually have close proximity to each other, there are normally multiple patches within a CCG.
It is also important to highlight that two GP participants from difference sites (B and D), as displayed in the quotations above, specifically mention the development of ‘business’ and the development of new businesses and services.

### 4.3.1 Are participants entrepreneurial?

I was keen to gather the views of the participants as to whether they perceived themselves to be entrepreneurial, and as the data demonstrate, a number believed they were entrepreneurs,

'I was invited to go to Whitehall and to sit on some of the national nurse committees, again as an entrepreneur and someone who could give a different view on the way general practice was going, because a bit like now, the changes were very fast moving from PCGs [primary commissioning groups] and the transition into the new world then.' (PN_site_C)

'I mean I used to sell tickets outside United [Manchester United Football Club] when I was a teenager and that was a little bit of buying tickets and then selling them on for profit and then with the money I’d made, I used to go in the Stretford End, so it didn’t actually cost me anything in the end... So I have always thought of myself as being a bit of an entrepreneur because of the financial aspect.' (GP_site_D)

'Yes [I am an entrepreneur] because I am good at ideas; I’m not as good at the day to day management; I’m an ideas person and not a manager. We have lots of ideas which we don’t always deliver on; the ideas tend to come from two of us within the surgery rather than from everyone... I would like to work in a way that I could deliver what is required and I would willingly be entrepreneurial and take on lots more roles, take on lots of things that secondary care are doing and put them into primary care.' (GP1_site_A)

The data above illustrates that these participants believed that they were entrepreneurs because they could offer a ‘different view’, create ‘money’ through inventive ways, and were good at developing ‘ideas’. The point that GP1 from site A makes about not being ‘good at the day to day management’ is interesting as it hints that this participant believes that there is a division between the roles of managers and entrepreneurs.

However, some participants were less sure if they were entrepreneurs, but after thinking about their role, believed that on the whole they probably were,

‘I think I’m lower down the scale, I’m certainly not as entrepreneurial as some [GPs involved in a specialist group]... some of these GPs [in specialist group] are really pushing and they want to change things... so I think they are in that category [entrepreneur] of GP that are very business minded and driven in developing services... I think you need to be [entrepreneurial], to be able to survive and compete as a GP, I think I thought that it [developing services] wasn’t probably that important when I first started, but actually, it is very important. To make sure that things are right clinically for your patients, as well that you've got to have the right services, you've got to have the right levels of staff and all these sorts of things.’ (GP_site_B)

‘No [I am not an entrepreneur]. It would be no, because I don’t think that is something that you would ever associate to be in the type of job, especially in the early days. But if I give it a little
more thought, I am doing innovative things and I am moving things [service] forward, I am trying to drive change and other sorts of things, so then yes, possibly I am.’ (HFSN_site_B)

As illustrated above, the GP from site B believes that ‘you need to be entrepreneurial to survive and compete as a GP’, however he/she does not believe that he/she is as entrepreneurial as other GPs, but still he/she has had to develop and become more entrepreneurial to deliver the right services for his/her patients. The HFSN from site B appears to believe that he/she is ‘innovative’ and ‘driving change’, which in line with the participants general views on what constitutes being entrepreneurial, fits. However, the HFSN is cautious about proclaiming to be entrepreneurial as this is something that he/she does not believe that you would initial associate with being a HFSN.

At the other end of the spectrum there was one participant that did not perceive that he/she was entrepreneurial at all,

‘I don’t think I am one to be honest [entrepreneur], I think the practice is but I don’t think I am the one leading it... so I don’t think I would be a particularly good case for you to be entrepreneurial... but there is a role for everyone in primary care as somebody has to cover the work, patients still need seeing.’ (GP2_site_A)

GP2 from site A highlights the notion that not everybody in primary care can be entrepreneurial ‘as patients still need seeing’ and that there is still ‘a role for everyone in primary care’ irrespective of whether they are entrepreneurial or not.

Were possible, I was keen to cross-reference whether the participants interviewed from the same location agreed with the others perceptions about who was entrepreneurial. The data below illustrates that within site A the perceptions of GP1 were supported by his/her practice colleague,

‘I think that Dr x and GP1_site_A are, they have a sort of vision for the future and they want to expand the service.’ (GP2_site_A)

However, at site B the HFSN didn’t particularly support the individual view of the GP regarding his/her view on whether he/she was entrepreneurial,

‘I don’t think that GP_site_B has particularly had a role in moving things [service] forward, as he/she only works one day a week and what can you realistically do in one day a week? I don’t think he would say that he has pushed the service forward.’ (HFSN_site_B)

Two GP participants go one step further and talk about their wider GP practice team; they identify who is and who isn’t entrepreneurial within the practice setting,

‘Out of the 10 GPs here there are three GPs who are leaders who want to work differently and are interested in innovation, you’ve got some people in the middle and then you’ve got two at the back who drag their heels.’ (GP_site_D)
‘The ideas tend to come from two of us in the surgery, rather than from everyone.’ (GP_site_A)

Table 4.3 below summarises the responses of all the participants in relation to the key elements of entrepreneurship, whether they believe they are entrepreneurs, and if this view is supported by participants from the same site.

**Table 4.3: Participants view of entrepreneurship**

<table>
<thead>
<tr>
<th>Site</th>
<th>Participant</th>
<th>Key elements of entrepreneurship</th>
<th>Are you entrepreneurial</th>
<th>Supported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 1</td>
<td>GP(1)</td>
<td>‘new ideas’ ‘ground breaking’</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>GP (2)</td>
<td>‘new business’ ‘vision’ ‘service expansion’</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Site 2</td>
<td>GP</td>
<td>‘making money’ ‘creative’ ‘developing business’</td>
<td>Unsure</td>
<td>No (it was believed that the GP was not entrepreneurial)</td>
</tr>
<tr>
<td></td>
<td>HFSN</td>
<td>‘making money’ ‘inventing’</td>
<td>Probably</td>
<td>N/A</td>
</tr>
<tr>
<td>Site 3</td>
<td>GP</td>
<td>‘new ideas’ ‘forward thinking’</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>PN</td>
<td>‘risk taking’ ‘something new’</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>PM</td>
<td>‘risk taking’ ‘innovation’ ‘doing something differently’</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Site 4</td>
<td>GP</td>
<td>‘making money’ ‘innovation’ ‘new ways’</td>
<td>Yes</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**4.3.2 Motivation(s) to deliver new services**

This research investigated why GPs and health care professionals were keen to develop new services within primary care, when traditional models of service delivery had historically been widely accepted. Respondents had a range of answers, with better patient care being one of the most cited responses,

‘I want patients to be happy with what we deliver and I want all that to come out of a very excellent NHS service.’ (GP2_site_A)

‘We got an award for it [the service] and it was all through identifying the need through our patients... now our patients don’t need to travel, they know where they are coming to and they can park.’ (PN_site_C)
‘I think without wanting to sound too corny, I think you feel like you are contributing in a different way to the community... you hope that the benefits to patients is very positive.’ (PN_site_C)

Another reason that was cited as motivating people to provide services in new ways, was their own clinical expertise and interest,

‘I actually considered staying in the hospital and specialising in cardiology as a career, but I decided to move out to general practice and being able to have this dual role of having a specialist interest and being a GP as well, perhaps having 2 different jobs as well; being able to have a bit of a clinical specialism... A lot of people [have a clinical specialism] but I am just doing it in a more formal way with two different roles.’ (GP_site_B)

‘You could probably consider me to be something of a clinical champion for this piece of work and I think if you’ve got someone with passion and enthusiasm in the practice then it helps.’ (GP_site_D)

The increasing pressures the GPs face within primary care, with particular focus on the time pressures participants were placed under, were cited as reasons why participants wanted to provide new services. Being involved in the development and delivery of such services often acted as an escape from the pressure associated with traditional primary care working,

‘Primary care workload is just rocketing, the GPs are physically under a lot of strain... it is [delivering new services] to try and create something that is giving me more pleasure than what my current workload is.’ (GP1_site_A)

‘The job I do here [as part of the new service] is different, I've got much more time to spend with patients than I have in the GP setting... which is a bonus from an enjoying work point of view.’ (GP_site_B)

‘I could be seeing anything [unpredictability of patients in primary care], I think for most people they can manage the workload as long as they feel that it is reasonable, but sometimes in general practice you are literally just rushing around all day and you are firefighting and increasingly you are getting grief off people because expectations are increasing and in some cases I have no problem with that because the NHS has a responsibility to provide quality, but we've [GPs] got to have the capacity to do that and if you as a GP are looking after 2000 patients, it easy to see how difficult it is to provide quality care to all.’ (GP_site_D)

Two participants go as far to suggest that the pressures that GPs are currently under, could even be stifling entrepreneurial working and limiting the number of new services that are being delivered,

‘The overwhelming reality is that I used to have time to back then [when first joined the GP practice 12 years ago] to look, think, plan and come up with ideas. I had the energy drive and time to deliver on them, the reality is now I just muddle through the day, get to the next one and then the next one, you can’t be creative if you don’t have time.’ (GP1_site_A)

‘GPs are very busy people and unless you’ve got some time set aside to plan and develop services as you would if you were a member of the CCG board, you don’t always have time to make those ideas or things work in practice.’ (GP_site_B)
Two participants believe that career progression and acceptance were key motivators for them when looking at delivering new services,

‘I have some sort of career plan, some idea of progression, I’m 45 and I’m looking forward to working until I’m at least 60, so I’ve got another 15 years... my core activity will always be a GP, because if you stop doing general practice then you can’t do any of the other things.’ (GP_site_D)

‘I think that part of that [providing new services] is based around the comfort that I am at one stage in my career, which I see as the NHS potentially being privatised.’ (GP1_site_A)

One participant from site A also mentions that one of the motivating factors for him/her to deliver new services is based around his/her need to create more wealth,

‘It is basically creating a network of options and trying to offset the huge drop in income that we [GPs] have had.’ (GP1_site_A)

‘What we are doing is taking on these extra roles in order to fund doctors to try and get more man power [within the GP practice] and so the money is going straight through into delivering that.’ (GP1_site_A)

As described above, there are number factors motivating participants to deliver services in new ways, these are summarised in table 4.4.

Table 4.4: Participants motivation(s) for delivering new services

<table>
<thead>
<tr>
<th></th>
<th>Motivation for delivering new services</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>‘career progression’,</td>
</tr>
<tr>
<td></td>
<td>‘making money’,<strong>(personal and for the practice)</strong></td>
</tr>
<tr>
<td></td>
<td>‘patient care’,</td>
</tr>
<tr>
<td></td>
<td>‘something different from the pressures of primary care’,</td>
</tr>
<tr>
<td></td>
<td>‘clinical expertise’</td>
</tr>
<tr>
<td>PN</td>
<td>‘patient care’</td>
</tr>
<tr>
<td>HFSN</td>
<td>‘patient care’, ‘clinical expertise’.</td>
</tr>
</tbody>
</table>

4.3.3 Development of entrepreneurial working over time

The literature review chapter of this study identifies that various authors believe that entrepreneurial skills can be developed over time and in regards to the extent to which GPs are required to be entrepreneurial, this research investigates whether participants believed this to be the case. A number of participants believed that they had developed certain skills over time,

‘Some of the attributes [of an entrepreneur] I feel I have developed over the years I have been here. I think when I originally came here, I thought that it would be great, I can be in a clinical role were I see heart failure patients and that would be the limit of my role, well even before I started doing that I was involved with service development and planning and what the structure of the
service was going to be like, even at the time when I didn’t think it was happening, it was happening... I think [entrepreneurial skills] can be learned over time.’ (GP_site_B)

‘I have had to learn how to make the service survive.’ (HFSN_site_B)

However, one GP from site D states that some people just have natural ability to be entrepreneurial and deliver new services,

‘Part of it is down to whether you consider yourself to have naturally ability to do it [be entrepreneurial] and what you are driven to do; so if I was just coming in and seeing patients and then going home I would be bored.’ (GP_site_D)

4.3.4 The discovery of new opportunities for service provision

The data shows that many participants discovered opportunities from a number of different sources, one of these being the specific patient need within their locality

‘We noticed a trend that there is a demand, as patients were unhappy with secondary care services... prostate and the PSA clinic is something that we are really trying to improve quality and create a level playing field... we’ve also done a lot of work with diabetes... we found that having an in house system with the doctors and nurses saying the same [message] to patients, meant that there was improved faith in the GP [from the patient] and the end result was that we had better weight reduction, we had better sugar control, we had better compliance with medication.’ (GP1_site_A)

‘I was also aware that we live in the North of England where we know that alcohol consumption is much higher than the South of England; the South of England is very much like the American system where when someone says shall we go out for drinks they mean one, whereas up North when they go out for a drink, this means eight.’ (GP1_site_A)

‘We looked into our practice population and coming from a mining town we had lots of COPD patients, so one of our pieces of work... was that we were going to concentrate on our COPD patients and we were going to set up specialist clinics.’ (PN_site_C)

‘I think our advantage [in delivering a new service] was that we knew our patients, others didn’t, so we could state with confidence what our patients need, because we had that inside knowledge.’ (PM_site_C)

‘It [the condition that the service is addressing] is an unmet need at the moment because with this group of patients.’ (GP_site_D)

However, one GP participant from site B suggests that the service he/she was involved with was an opportunity that was created externally, in this case by the PCT at the time,

‘The PCT [at the time] were looking to recruit a GP for this service, so I applied for that and I got on a diploma course aimed at GPs with a specialist interest in cardiology as part of that.’ (GP_site_B)

4.3.5 Trade-off to delivering new services

It is important to note that there are general practice level consequences when primary care services are delivered in new ways. One of the big considerations that the general practice team
need to consider is their capacity to not only deliver the new service, but the consequential effect this has on the capacity to provide their traditional contracted GP services. A number of the GPs from the various sites illustrate these considerations:

‘The partners were quite supportive of me doing it [providing the new service] so I was working nine sessions a week; four and half days a week was in general practice, so what we agreed is that I would leave the practice for two sessions a week to do this [providing the new service], my income would come into the practice as a partnership and we already had a few sessions that we were filling with locums, so actually what we [the partners] did was appoint a salaried GP to take over my sessions [two] and some of the other sessions that locums were previously filling... I have moved GP practices in the last 12 months and what I do now is I do my work in primary care [GP practice] and I now get paid separately for this part, so I am basically doing this [providing a new service] when I am not officially working in the GP practice, so it is a different set up to how it was originally.’ (GP_site_B)

‘I suppose I am looking at two sets of agendas, one being my agenda which is long term health benefit [providing more services in primary care] verses the patient agenda, which is I want to be seen today.’ (GP1_site_A)

‘I would have been quite interested in seeing if you could set up a service to do contraceptive implants that would be quite easy really, this is mainly done in family planning clinics or by GPs who have set up a specific service, but it is balancing that between the impact on appointments, because we are chronically struggling for appointments, it is terrible... Once you start doing that [setting up new services] you lose a normal appointment in the surgery and there is already quite a long waiting list for appointments... if someone wanted to specifically see me, I’m always conscious that they wait two to three weeks [when the researcher checked with the receptionist it was actually just over 4 weeks]. So if I start saying cancel those 20, I’m going to do an implant clinic on a Tuesday afternoon, I’m not sure if that would be a detrimental thing to do when it is already available for the patients to go to. I think my time is best used by actually seeing patients for general practice staff.’ (GP2_site_A)

As highlighted above, the decision to deliver new services in primary care has the knock on effect of reducing the time that GPs delivering such services have to carry out their traditional and core work. One GP from site A points out that it is not always possible to find the appropriate people to fill these gaps,

‘The plan was to train more doctors, but they [NHS] can’t recruit enough junior doctors into the training posts that are available, and I don’t have a huge wide range of GP people that I know who are of the younger age... we are haemorrhaging at the top [age] end with people retiring and we are haemorrhaging at the bottom [age] because nobody is coming in and we are losing people in the middle, so if I am given the extra money to deliver new services I would probably have to go to... we have done Poland already, we’ve had our Polish doctors and they have all gone home, I could go to Ireland perhaps because we [the Dr is Irish, so used in reference to nationality] are in a bit of a crisis at the moment, but I suppose then the issue is do we get Spanish doctors in, or would we go somewhere else in Europe.’ (GP1_site_A)

The point raised by GP2 from site A about the most effective use of time for GPs is an interesting one and one which further exploration and discussion would be merited, especially in light of the
wider national primary care context. As GP1 from site D outlines the difficulties that the increasing number of average patient appointments per annum has on being able to offer new services that were traditionally provided by secondary care,

‘The downside is that you know nationally there is a campaign starting on primary care access and I think a routine appointment for me for routine stuff is about 5 weeks [waiting time]. I was working out the number of appointments that we need based on the recent statistics, it used to be based on 6 appointments per year per patient, but this has gone up to 10... based on these figures and if these are true, we would have to have another 10 full time clinicians working in this surgery alone, to deliver the demand which if you turn it into salaried doctors it is going to be about £800k in core contracts, so we have a lot of problems because we are conflicted, I don’t like that word, but we have conflicting pressures between trying to maximise the quality of patient care and making sure that we deliver a better service in primary care, which we can if we take more and more of the workload out of secondary care. We are going to make our waiting times even longer and that of course has a huge knock on with patient satisfaction and patient contentment.’

(GP1_site_A)

Consequently, the decision to provide new services is one that has to be balanced against the issues raised around, time capacity and utility.

4.4 Entrepreneurial and managerial working

As Rae’s (2007b) model of entrepreneurial management in figure 2.4 (sub section 2.6.7) outlines, in order for there to be new value creation and for the purpose of this investigation, a new service provided, there will be elements of both entrepreneurial and managerial working undertaken. The participants discuss a number of the different facets of managerial working as part of providing a new service. Managing resources is hinted at in the subsection above where GPs and their GP partners discuss ways to back fill time from traditional GP core working. However resource management and appointment allocation are key aspects of the considerations to provide a new service.

‘I would like to see them all twice a year because I think that would be better, the reality is we have a doctor, two nurses and a health care assistant spending a morning a week, every week of the year delivering this, so that is four members of staff, and that is just to see them once a year [patients] and this is only a tiny proportion of our commitment to primary care... so if you are going to decide what needs to be delivered as a service, you need to decide how many people, what does that actually mean for investigations? what does that mean for reviews? How many times a year? and what does that mean for the doctors and nurses the service would require?’

(GP1_site_A)

One of the GP respondents from site D discussed how they largely have sole responsibility for ensuring that resources are in place within the GP practice setting to ensure that anytime out of practice he/she takes is covered accordingly,
‘I mean, I basically will tell them [practice management team] what needs to happen. I don’t know whether it is just the way things are set up here but you would take responsibility, so in terms of the locum [to cover his/her time out of practice], you know, I negotiate with him/her the hours he/she works, the pay he/she gets, what he/she does in those hours, the patients he/she sees, whether he/she does home visits, even down to his/her pension payments, I mean I was heavily involved with that, whilst obviously liaising with the practice manager.’ (GP_site_D)

One participant from site C describes a situation where they had to make a decision about the allocation of resources to a new service, in regards to the financial cost attached to the people delivering it,

‘We had some frail elderly diabetic patients, who needed to fast for their blood tests and I used to do the phlebotomy in my clinics, but of course it got to the point where I was being paid as a senior nurse partner and phlebotomy was really something that could be done by someone else who was not as qualified; the skill mix wasn’t right and it was taking too much of my time, so I identified that we [GP practice] couldn’t afford it... so I put it to the PCG at the time, that we could look at doing some community based satellite clinics.’ (PN_site_C)

One of the GPs from site A discusses that as part of attempting to win bids to provide new services in primary care, that the two GPs who he/she earlier identified as being entrepreneurial had to also submit business plans. Business plans are also something both the Practice Nurse and Practice Manager from site C also highlighted as being part of their roles,

‘I know that Dr x and GP1_site_A have some experience of submitting business plans... it was a massive learning curve because they didn’t get any help and it was kind of trying to teach themselves, but I think the CCG are aware as we did not win any of those bids because I do not think our plans were enough really... anyway the CCG has offered to give us some help with business plans.’ (GP2_site_A)

GP2 from site A not only identified that developing business plans were important parts of the GP role, but that this is a skill which had to be learned over time in order to deliver new services. The HFSN from site B also identifies that he/she has developed skills that have aided her managerial role, over time,

‘I think my skills in terms of communication and negotiation and all of that have changed, I think my personality is quite emotional, not in an unhinged way, but when I care about something then you know about it, kind of thing, so I think I’ve had to reign that in a little bit and be more professional, not that I was not ever unprofessional, but you know what I mean; there are forums where it really doesn’t matter what you are trying to say you are just going to get shouted down, and I’ve had to learn not to take it personally, it is very business driven and I’m very patient driven and the two don’t always go hand in hand.’ (HFSN_site_B)

4.4.1 Managerial support from other professionals
As part of a GP practice team or as part of a service delivery team, there are usually a range of professionals to provide differing skills and support for the delivery of services. This research investigated how this inner working between professionals worked and assisted the development
of new service provision. Within the general practice setting it could be assumed that the Practice Manager would undertake the responsibility for some of the business and managerial working,

‘Even with experience of something like 30 something years in nursing, I wouldn’t have been able to have known the contractual business work that the PM deals with if it hadn’t been for shared working.’ (PN_site_C)

However, what can be seen in site B where there is no specified Practice Manager, is that some of the managerial working is undertaken by the HFSN, where he/she specifically describes a number of managerial processes that he/she is responsible for,

‘Writing pathways, engaging people at the hospital around best practice, developing referral routes... looking at coding... trying to promote GPs to use the service better, adopting choose and book referrals rather than paper referrals.’ (HFSN_site_B)

This is supported by the GP from site B, as he/she believes that the HFSN carries out roles more akin to managerial working,

‘I have passed some of the business and managerial working over to the lead HFSN, to be honest with you, as he/she is full time and does have some management time as well; he/she also has a direct line manager within the organisation, where as I am almost and entity on my own and I don’t seem to have a definite line manager.’ (GP_site_B)

It is important to note that managerial support is not always perceived to be received by other members of the practice team,

‘There is nobody... we have lots of ideas that we don’t deliver through.’ (GP1_site_A)

‘My Practice Manager... I think just sees the job as making sure that the claims are made, staff are happy, so he/she is very much about the process, when it comes to innovation and entrepreneurial working, in this practice it doesn’t come from the Practice Manager, it is very much GP driven, led and GP managed really, because there isn’t really anyone here to delegate to.’ (GP_site_D)

However, the same participant does identify that this is not the case in all practices and he/she actively discusses a practice where the Practice Manager has an innovative role,

‘Down the road we have a Practice Manager who I have to say is very impressive, he/she is innovative and thinks outside of the box; he/she looks at the best ways of bringing new business in.’ (GP_site_D)

4.5 The relationship with the CCG
Table 4.2 illustrates that a number of participants have an accredited role and a contracted affinity with their local CCG, with GP1 from site A and the GP from site D both being members of their local CCG boards. However it is interesting to note that even though they both sit on their CCGs boards, there are still differences in the roles that they have, as GP1 from site A is ‘on the
governing body’ as one of many number of other representatives, whereas the GP from site D is the ‘GP representative for patch 16, so I sit as one of six GP leads’ as well as being the clinical lead for mental health. The Practice Nurse from site C also has an affinity to the CCG, but this is through one of their locality boards rather than CCG governing body itself, as well as being ‘nurse champion for our locality [one of six within the CCG] and I sit on the service redesign party’.

However, it is important to note that none of the other participants have a formal role within their local CCGs and locality boards. The GP and HFSN from site B, are closely associated with external organisations such as the local Leading Lights group and the North West Heart Failure Nurses group, but these are much more clinically focussed and they do not have a direct link with the commissioning of services.

4.5.1 Do relationships with the CCG help in providing new services?
This research investigated whether participants perceived that having a relationship with their local CCG had any impact in the potential to deliver new services. The majority of participants were quite open that obtaining such a relationship was advantageous to new service delivery, especially those participants that have a formal role within the CCG or the locality boards. The Practice Nurse from site C believes that the development relationships via ‘the boards and committees’ of the governing body over a long period time, has resulted in new service opportunities often being presented to their practice by the CCG,

‘I think because the Practice Manager and myself have always been active on the various boards and committees, and seem to have developed a reputation, people tend to come to us with... can you pilot things in your practice.’ (PN_site_C)

Both the Practice Manager and Practice Nurse from site C believe that the Practice Manager’s formalised involvement within the commissioning governing bodies has helped the practice to discover new opportunities,

‘I think the Practice Nurse has the wider view from sitting on the PCG and the PCT; the Practice Nurse has always had an interest in strategic decisions making because that also impacts on us [the practice] and it gives us [the practice] a workable view as sometimes ideas are floated at these meetings. I think you get to know what is new, what is up and coming and you also get to know the reasons why something is coming because obviously it will have been discussed. I feel and I’ve always said that we benefit from the Practice Nurse sitting on the various committees.’ (PM_site_C)

‘You get to know things in advance.’ (PN_site_C)

16 Patches are groups of GP practices that usually have close proximity to each other, there are normally multiple patches within a CCG.
The GP from site D believes that having a formal relationship with the CCG and having an active role results in his/her practice obtaining a better understanding of the opportunities for new service provision that are on the horizon,

‘Well [having a role in the CCG] it puts you in an advantage, you know you’ve got the finger on the pulse... you know what sort of things are coming through, you know what the CCG is going to be focussed on.’ (GP_site_D)

While GP1 from site A goes on to suggest that having a formalised role means that relationships are established with people who have the ability to direct finances to the provision of new services. He/she also comments that this is something which GPs who do not have a role in the CCG are not privy to,

‘There is one huge plus, I am on the governing body... I can actually be there with people who have the purse strings and the finances to look at, and highlight things... I do not think that other GPs see that because they don’t hear what is happening.’ (GP_site_A)

GP1 from site A also believes that relationships with the CCG have wider benefits, as through this relationship, collaboration with a national charity was possible, due to the CCG having knowledge of the alcohol service which the GP was providing. This collaboration has the potential to provide and develop a new service itself,

‘Age Concern has... well the governing body have put us [Age Concern and the GP Practice delivering the alcohol service] together because they were aware of what we are doing and they are aware of what they [Age Concern] are doing nationally in part of the zen cast of a huge national movement about alcohol consumption and healthy drinking and I think as part of this we are fitting in quite well... hopefully if it all comes through Age Concern [as a service provider] are putting a bid in for elderly people and alcohol and we are going to link into that and give them support as well.’ (GP1_site_A)

The GP from site B illustrates the importance and influence that having a formalised role on the CCG has in regards to decisions around new service provision, as he/she believes that as an individual GP the amount of input and influence that you have at CCG can often be minimal, largely due to bureaucratic procedures that exist and the dedicated time, set aside from ‘traditional’ GP practice.

‘It doesn’t always feel that you as an individual GP are influencing that [new service provision] because if you are in a large practice it won’t be you that is going to the meetings [CCG meetings], you can only discuss with your colleagues within the practice and send along a representative who sit with 10 or 12 other GPs and then perhaps some of the GPs who’ve already got some ideas about the decisions that they want to make and are perhaps leading the way. I think that is because to some extent GPs are very busy people and unless you’ve got some time set aside to plan and develop services as you would have if you were a member of the CCG board, then you don’t always have the time to make those ideas make things work really.’ (GP_site_B)
However, even if participants did not have formalised relationships and involvement in the CCG it was still seen to be advantageous for participants to develop working relationships with CCG board members. This is illustrated by the GP from site B who suggests that knowledge of the new service opportunities and general CCG priorities and working is identified through developing relationships with people from the CCG,

“Yes, I have got have an idea what is going on [with commissioning]... this is through osmosis... I mean I link in with the CCG and within the last week or so I’ve sent a couple of emails to some of the board of the CCG... there is a GP development lead at the CCG who is a GP that I know and there is a clinical director GP as well... in fact I know all of the GPs in the CCG to speak to.’

(GP_site_B)

The GP from site B goes on to suggest that this relationship that has developed is perhaps bound by his/her clinical specialist knowledge as the CCG often utilise his/her specialist clinical cardiology specialist knowledge in the design and development of new cardiology initiatives,

‘Because you have got this special interest and I am the only GP in location B who has this kind of title of role, the CCG approach me about certain things, I suppose it is because I am a GP and I can give them a heads up on things from a cardiology point of view... so they do consult me.’

(GP_site_B)

By building these relationships the GP from site B believes that these can be used to suggest service changes or the development of new services, however he/she is acutely aware that these are just suggestions and the power to actually make the final decision is held by the CCG

‘So you can make suggestions and the CCG would listen if you went to them... I think they would listen, but whether something would definitely come of that depends on their priorities as a board.’

(GP_site_B)

Although the HFSN from site B has slightly a different view to the majority of participant’s regarding the importance of developing a relationship with the local commissioning group. He/She believes that because the roles of people within the CCG change rapidly, that in terms of developing relationships for his/her existing service then forming links to GPs and GP practices is much more important, because these tend to remain stable,

‘With the CCG there are people that you know of but their roles changes and they are never the people that you continue to link in with. The GPs, I know some of them because I used to work in GP land, so I know some of them anyway because I worked with them and then you know the ones, you may never have met them, but you have looked after a lot of their patients... so there are GPs and GP practices that we have quite a good working relationship with and that doesn’t tend to change.’

(HFSN_site_B)
4.5.2 Have relationships changed over time?

A number of participants commented on there being a large turnover of staff within the commissioning body and a number of existing and well established relationships have been lost as PCTs became CCGs, with two of the participants commenting that it was like starting all over again.

‘It is different people now because they have got rid of a lot, a lot of people left with the changeover [between PCT and CCG]. We’ve not got many of the same people... we did lose a lot of the admin staff, a lot of really good staff have gone.’ (GP2_site_A)

‘Yes [it has affected our relationship with the CCG], we’d built up relationships [with the PCT commissioning managers], it was like starting again and they also had to learn the role as they came in completely new.’ (PM_site_C)

‘Yes, I think we lost a lot [tacit knowledge] when the PCT went, they [PCT commissioners] had that local knowledge and they understood the practices.’ (GP_site_D)

‘There has been so much change in the CCG, in the past we would have known who to call on, but they have gone. You’d built up good relationships, but it was like starting again.’ (PN_site_C)

‘There has been a change of people over the years... I think a lot of the GPs feel that changes and decisions are made externally, often by a group of GPs but these changes are often instigated upon us.’ (GP_site_B)

As highlighted above, the change-over of staff and the breakdown of relationships were issues for participants; this is perhaps best highlighted by the HFSN from site B,

‘I think in terms of relationships this is quite difficult because there has been so much change that there is hardly anybody from the time when I started working here six years ago that I am still directly linked with now. I have had seven line managers in six years, so there has been no stability with that.’ (HFSN_site_B)

The breakdown and loss of relationships with members and individuals of the commissioning group, due to the change in roles and the make-up of the CCG from the PCT, is a key finding, especially considering the importance that participants placed on developing and maintaining relationships with the commissioning group, in order to provide new services. However, irrespective of the change-over of staff, the perceived loss of tacit knowledge and the breakdown of pre-existing relationships, the GP from site D is not sure if there is any difference in terms of the new CCG commissioning structure being able to provide any further opportunities for new services than the previous PCT,

‘If I am honest I don’t think there is a great deal of difference between when we were PCTs and now we are a CCG, there is still a load of bureaucracy that you’ve got to get through if you want to work differently, if you want to innovate and I have not seen any evidence that we have been effective in wholesale change for example the anti-coagulation service for years people have said that there is an opportunity to redesign the service so it operates differently, but we are still no
further on. In terms of effective service redesign I don’t think the CCG has any more potency than its predecessor [PCTs].’ (GP_site_D)

In fact he/she goes on to state that ‘well realistically, all that has changed when we went from PCTs to CCGs is that we just slimmed down the organisation.’ (GP_site_D)

One of the GPs from site A, identifies that ‘obviously the GPs are who get involved [with CCGs] are the same [as with PCTs]’ (GP2_site_A)

However, the same GP believes that there are differences with CCG structure from the pre-existing PCT structure, with CCGs being more similar to the days of primary care fundholding.

Whilst also noting that this ‘re-inventing of the wheel’ seems to be common place within primary care,

‘Yes it has turned full circle really, but it is just like when you had fundholding and then that finished and then you went back to the normal way and now this [CCGs] is a bit more like fundholding... I think it is just re-inventing the wheel all of the time... you get a bit cynical when you’ve been doing the job as long as I have, because you just think oh well let’s just let this change ride through and then it will change again.’ (GP2_site_A)

4.5.3 Time trade-offs

The time trade-offs which GPs have are not solely concerned with delivering traditional contracted services and new primary care services, they also include the time which GPs and other members of the practice team spend carrying out numerous roles external to the practice, such as CCG or Federation commitments.

‘So it is pretty much cost neutral for myself [involvement in the CCG], but it does mean that I am in the practice less. So we [the partners] felt that it was acceptable as long as the person who replaces me is a long terms person who has the right attributes, because if I am not here and you just get an ordinary locum in, they see a few patients but they don’t really shift the work that a partner does, so it is one of our ex-trainees actually, that is doing two days a week for us and so far this seems to be working well.’ (GP_site_D)

‘One of the issues coming up nationally is Federation and I think behind Federation is the idea that we will try and have a business manager to business plan and direct and as you say, someone to co-ordinate and organise. But ultimately unless Federation can get an extra number of doctors to deliver, I don’t see what they are going to do because I don’t feel that I would morally, ethically or emotionally want to leave my patients for an extra two weeks so I can go away somewhere else that is financially rewarding, because this [being a GP in the practice] is my job; my job is being a GP.’ (GP1_site_A)

The trade-off is so acute in some cases that GP2 from site A explains that one of the GPs within his/her practice has withdrawn from being involved with the CCG, because the time pressure was too much,

‘Dr x was on the board as a Medical Director for the Endocrinology side of things but he/she resigned this year because I think it was just too time consuming and he/she was torn between the
practice and the CCG; he/she did it for a couple of years and then decided to resign and let someone else take over.’ (GP2_site_A)

The decision to be formally involved with the CCG is one which appears to be made based on the expected benefits from involvement verses the effect on the practice.

4.6 Chapter Summary

In summary, to answer the research questions of this study, this chapter provides data concerning the entrepreneurial working of participants (4.3), the relationship between managerial and entrepreneurial working (4.4) and the relationships that participants have with the CCG (4.5). The data displayed in this chapter will be discussed in relation to the literature (chapter 2) in the following chapter (chapter 5).
Chapter 5: Discussion

5.1 Introduction
The overall aim of this research has been to investigate ‘to what extent are twenty first century GPs entrepreneurial when delivering primary care services in new ways?’ This chapter builds on the data in chapter 4 to present a discussion which links the literature presented in chapter 2 with the empirical findings. To address the overall research aim, the research framework in figure 2.6 identifies four research questions, concerning three different levels of the system, these being a) the individual; b) the GP practice/service, and c) the context. In line with data represented in chapter 4, throughout this chapter, the discussion will focus on exploring these questions at the each of the three levels. The first research question focusses on the individual (5.2) and is the essence of this research focussing on the entrepreneurship literature; the second research question relates to the inner working at the GP practice/service level (5.3), with questions three and four largely concerning the context outside of the GP practice/service (5.4).

5.2 The Individual entrepreneur
The literature details the complexities of defining entrepreneurship, with Chell, Howarth, & Brarley (1991); Rae (2007); Casson, (1982) and Anderson (1995) questioning whether a universal definition of entrepreneurship exists. Eisenmann (2013) suggests that the lack of a definition is because the meaning of entrepreneurship is ‘elastic’ and dependent on the view of the expresser. Research participants similarly had a mixed view as to what they understood by entrepreneurship, with descriptions ranging from action based activities, ‘developing business quickly’ to the behaviours of individuals, ‘creative, expressionate and at times mad cap’. However this resonates with Casson’s (1982) view that there are two main approaches in defining entrepreneurship: the functional approach and the indicative approach.

There are some commonalities in participants responses with at least two participants or more stating that entrepreneurship involves, ‘money’, ‘innovation’, ‘risk’, and ‘developing new business’. When participants were talking about money, this was in regards to the making of money and profit, rather than simply handling money. The acknowledgment of making money links back to the work of the classical economic theorists of Cantillon (1975), Say (1803), and Menger (1871). However, this is interesting contextually, as Eisenmann (2013) proposes that entrepreneurship depends on the view of the expresser and within the NHS primary care market.
place, making money is a relatively new concept born out of the organisational changes around the commissioning of services.

In terms of ‘risk’ and ‘innovation’, table 2.2 identifies that both of these have been widely reported by a number of authors as being essential aspects of the definition of an entrepreneur. More recently, as represented in 2.6.1, Bolton & Thompson (2000) include direct reference to innovation, with Burns (2007) including risk as essential in defining entrepreneurship. The responses from participants are therefore aligned with the literature.

Looking at all responses, the data (displayed in 4.3) has not produced a widely accepted universal definition of entrepreneurship and perhaps further enhances the view of Chell et al. (1991) that to continually ask the question, ‘what is entrepreneurship and who are entrepreneurs?’ (1991: 2) is futile. However, the data displayed in table 4.3 identifies a number of elements (both behaviour and action focussed) which participants believe entrepreneurship to involve. This would appear to support a more holistic definition of entrepreneurship which encompasses a number of action based activities and behaviours. Anderson (1995) argues that using the concept of ‘enterprise’ as part of a definition of entrepreneurship, is one way of encompassing the various facets involved. Rae (2007b) includes enterprise in his definition of entrepreneurship, stating that an entrepreneur is ‘a person who acts in an enterprising way, and who identifies or creates and acts on opportunity’ (2007: 3) whereby enterprise involves the use of ‘skills, knowledge and personal attributes which are needed to apply creative ideas and innovations to practical situations. These include initiative, creativity, problem solving and working on opportunities and acting resourcefully to effect change’ (2007b: 3). The data from this investigation does not provide a universal definition, but the key elements of entrepreneurship identified by participants (as displayed in table 4.3), are all contained within Rae’s (2007) definition and would appear to support its wider use.

5.2.1 How entrepreneurial are participants?
To explore whether participants were entrepreneurial, I considered participant’s roles in the development and delivery of new services, with a specific focus on entrepreneurial ‘action factors’ (Bolton & Thompson, 2004: 33), rather than more widely researched personality traits and behaviour approaches. As Deakins (1996) acknowledges, there are a number of methodological problems when attempting to measure personality traits; with the validity of the research around trait based approaches being widely criticised (Amit et al., 1993; Chell et al., 1991; Gartner, 1989; Gray, 1998; Kauffman & Dant, 1998).
Ennew et al. (1998), relying on Casson’s (1982) theory of ‘entrepreneurial judgement’, proposed that all GP fundholders could be classed as one of three types of entrepreneurs: a) a true entrepreneur, b) a partial entrepreneur, or c) a reluctant entrepreneur. Klein (2013) and Walshe (2012) have noted the similarities between GP fundholding and today’s CCG marketplace. However, data from this research highlights that it may be too much of a generalisation to state that all GPs delivering new services are entrepreneurs, even when this small sample is considered. Ennew et al. (1998) based their judgement on the ability of GP fundholders to manage practice budgets and make decisions on the purchasing of health services. This was not always the case for participants, as one of the GP participants explains how this is assigned to another member of the team, ‘I have passed some of that over to the lead heart failure nurse, as she is full time and has some management time... where as I am almost an entity to myself’. The data presented in table 4.3 supports the notion that not all of the participants where entrepreneurial as it details two GP participants who believed that they definitely were not entrepreneurial, one GP who was unsure, and one HFSN who thought they probably were.

In the fundholding work of Ennew et al. (1998), they identified three types of entrepreneurs: a) true entrepreneurs, b) partial entrepreneurs, and c) reluctant entrepreneurs. Relying on these classifications, table 5.1 identifies that all of the participants from sites A, C and D who are explicitly involved in new service delivery can be classed as true entrepreneurs, as they possess motivations which are akin to those described in the literature as being entrepreneurial, as well as being innovative, creative and looking to discover opportunities whilst being alert to take advantage of such opportunities. I have excluded GP2 from site A and the GP from site C, from table 5.1 because they did not appear to be actively involved with a new service, they were involved with the practice and practice decisions but they were not explicitly involved with new service delivery.
Table 5.1: True, partial and reluctant entrepreneurs

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<tr>
<th>Site</th>
<th>Participant</th>
<th>Entrepreneur</th>
<th>Site</th>
<th>Participant</th>
<th>Entrepreneur</th>
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<tbody>
<tr>
<td>A</td>
<td>GP(1)</td>
<td>True entrepreneur</td>
<td>C</td>
<td>n/a²</td>
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<tr>
<td></td>
<td>GP (2)</td>
<td>n/a(^{17})</td>
<td></td>
<td>PN</td>
<td>True entrepreneur</td>
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<tr>
<td></td>
<td>HFSN</td>
<td>Partial entrepreneur</td>
<td></td>
<td>PM</td>
<td>True entrepreneur</td>
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<td>B</td>
<td>GP</td>
<td>Partial entrepreneur</td>
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<td></td>
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<td>D</td>
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I believe that both the GP and the HFSN from site B, portray aspects of entrepreneurial working but are not ‘true entrepreneurs’, and in association with Ennew et al. (1998) I would suggest that they are both ‘partial entrepreneur’s’, due to them possessing some characteristics of entrepreneurial working through i.e. their motives to deliver the new service, but due to their lack of ‘innovative’ behaviour as their tendency was to improve their service rather than radically innovate, and because the opportunity was created via the commissioning group rather than either of them ‘discovering’ the opportunity, like participants from site A, C, and D, I would argue that they are not complete or ‘true entrepreneurs’ but illustrate some or ‘partial’ entrepreneurial behaviours. Ennew et al’s. (1998) classifications, particularly those of the ‘partial’ and ‘true entrepreneur’ appear to be useful and valid when looking at providing new primary care services, as they take into account the differing elements and level of entrepreneurial working of participants.

5.2.2 Motivation(s) to provide a new service

To look at the entrepreneurial actions of participants more closely, this research builds on the work of Boyett & Finlay (1995); Ennew et al. (1998) and Bolton & Thompson (2004) to focus on a) the motives for participants in delivering a new service, b) innovation, and c) Kirzner’s (1973) work of price-quality arbitrage, whilst very much focussing on Rae's (2007b) more holistic view of entrepreneurship.

As displayed in table 2.13, Ennew et al. (1998) identify a number of positive motives for GPs becoming fundholders. Improving patient care, the service and patient choice as being the most (n=9) reported motivational factor. Participants in this research were similarly motivated by ‘improving patient care’ (as noted in table 4.4), with this being the most reported (n=6)
motivation for participants to deliver new services; four participants directly mentioned improved patient care and services, with two others implicitly outlining improvements, one of these being a GP who mentioned ‘an unmet need’ and ‘spending a fair amount of time thinking about how we can be sure that this group of people have had their physical health check’ which resulted in the service being adapted with appointments being scheduled towards the end of clinics, to make the service more patient centric.

Table 4.4 also identifies that clinical expertise was a motivator for two GPs and a HFSN participant. This is slightly outside the remit of the work of Ennew et al. (1998) which focussed on specific motivators for being involved in fundholding, rather than the delivery of a new service. As Kay (2002) notes, fundholding involved GPs having active control in decisions regarding the provision of services and contracts rather than specifically delivering services, which is perhaps why clinical expertise is not necessarily evident in the work of Ennew et al. (1998). However, in line with Boyett & Finlay (1995), clinicians relying on their specialist skills which are superior to their peers to provide specialist new services, resonates with the entrepreneurial theories of Leibenstein (1966) and the Austrian tradition (2.5.4) about entrepreneurs using their ‘knowledge’ to take advantage of slack in the system. The three participants in this research motivated by their clinical expertise were all specialists, one GP had an accredited special interest in cardiology (GPwSI), the other GP had an accredited special interest in mental illness, and the nurse participant was an accredited heart failure specialist nurse (HFSN). All three believed that having a specialist interest and skillset motivated them to provide the services they were involved with and hence could be considered to be operating in an entrepreneurial way,

‘You could probably consider me to be something of a clinical champion for this piece of work and I think if you’ve got someone with passion and enthusiasm in the practice then it helps.’ GP_site_D

The work of Ennew et al. (1998) displayed in table 2.13 highlights that reducing waiting lists to facilitate access to secondary care consultants was a key motivator (second highest), whilst the results from this study appear to show the inverse, with the majority of new services such as diabetes clinics, heart failure clinics and serious mental illness services designed to keep patient care within the practice rather than refer to secondary care. As one GP reports, ‘we do an awful lot of joint injections and historically these are done in secondary care’ GP2_site_A. I would suggest this is part of wider NHS movement to move care closer to home in an attempt to improve access and continuity of care. Hence, it is not surprising that the data from this study and Ennew et al. (1998) is inherently different, due to the different political NHS contexts between GP
fundholding and the current CCG agreements. What is interesting is that the current movement to encourage care closer to home appears to provide opportunities for new services to be delivered in primary care; in line with Kirzner (1982), the data represented in this study illustrates that the people who are ‘alert’ entrepreneurs are those who are able to take advantage of these opportunities that exist within the market place.

Financial incentives (both personal and GP practice level) along with career fulfilment were mentioned as being motives for delivering new services by two GPs and I would argue that these are key characteristics of people behaving entrepreneurial. This is supported in the literature with people being motivated by financial gain and/or generating profit being widely reported as key precursors for entrepreneurial working (Casson, 2003; Chell, 2008; Shane, 2003); the work of Chell et al. (1991)(table 2.7) identifies that another archetypal characteristics of an entrepreneur, is someone who becomes restless and is easily bored. From the interviews with both of these participants it was clear that there drive and motivation to deliver new and multiple services as part of achieving carer fulfilment was partly driven by wanting to have variety in their job.

However, Bolton & Thompson (2004) argue that the motive should be more than just to be involved, or to deliver a new service, they argue that the motivation should be about making a difference. Participants expressed motives to deliver ‘improved patient care’; having a ‘limited career’; striving for ‘continuity of care’, and using their ‘clinical expertise’ fits in with this view. I was a little surprised about some of these motives; as an NHS employee and someone who is familiar with the NHS policy, the phrase ‘patient care’ is one that is used in predominantly all policy and service level documents; however I am cynical at times as to whether ‘patient care’ is always the driving force behind changes to service delivery, with finances often appearing to be as, or in some cases more important, I was reassured and pleasantly surprised that improved levels of patient care, be that through moving services closer to home, improving continuity of care, better car parking etc. really came across as being genuine and heartfelt motivations to deliver new services; patient care was not at all mentioned in a tokenistic way.

However, some motivations such as ‘time pressures/stress of primary care’ are not necessarily about making a difference, they are more akin to escapism from the traditional working of a GP, so it would be difficult to suggest that these were about making a difference, but on the whole it can be argued that the motivations of the majority of participants to deliver new services, were entrepreneurially focussed.
5.2.3 Innovation and ideas

Innovation and new ideas have been widely reported to be important aspects of entrepreneurial working (Bolton & Thompson, 2004; Burns, 2007; Chell et al., 1991; C Ennew et al., 1998; Rae, 2007b; Shane, 2003). All of the participants in this investigation recognised that innovation, creativity and developing something new are important aspects of entrepreneurship, this is displayed in table 4.3. On the whole (n=5), the results demonstrate that most participants were innovative and creative; however, there were three participants that were not. Table 3.6 identifies the services that participants were involved with and all participants from site C and site D are clearly innovators and act creatively to develop and deliver new services. These participants openly talked about some of their services as being ‘ground breaking’ and them being different to the norm, ‘in those days it was very very unusual to have a COPD clinic [in primary care]’, with the GP from site D believing that he/she is ‘one of three GPs [in the wider health centre] who are leaders who want to work differently and are interested in innovation’. It is also clear that GP1 from site A is an innovator and creative in nature as he/she was involved in pitching ideas to the local CCG to obtain funding for an alcohol service, along with GP1 specifically identifying that he/she was an ideas person, ‘the ideas tend to come from one or two of us within the surgery...I’m an ideas person’. However, GP2 from site A is very different to his/her colleague as he/she does not appear to be innovative in the design and delivery of new services, whilst he/she stresses that he/she does not believe himself/herself to be entrepreneurial or innovative and he/she often leaves this to GP1 ‘Dr x, Dr y and GP1 definitely are [entrepreneurial], they have a sort of vision for the future and want to expand the service’. This is important to identify, as it appears that GP1 is not directly involved with the delivery of a new service, his/her practice is, but he/she does not. This is also important to note as GP2 corroborates that GP1 is entrepreneurial and innovative.

Both of the participants from site B involved with the delivery of the heart failure service are different to the majority of participants, as they are less innovative than others involved with new service delivery. I would argue that this is because of the nature of the service, as neither of the two participants were involved in the creation of the service. The GP was involved relatively early on after inception, but he/she applied for a position in the service due to his/her clinical expertise ‘it wasn’t something that I developed but obviously I was there at the very early stage of development’, whereas the HFSN became involved at a later date ‘I joined about two years in’. This is not to say that the GP and the HFSN have not developed the service over time, as they clearly have assisted in the continuous design, promotion and expansion of the service, but they were not involved in the idea to create the service; they appear to be less innovative than the other participants involved in new service delivery. Overall, the majority of participants are
innovative and creative, but it is important to note the degree and extent differed, and there were some who I would not say were innovative or creative.

5.2.4 Price-quality arbitrage
The Austrian school of economics has a view of the entrepreneur, typified by Kirzner (1973), which focusses on the entrepreneur as being the equilibrium force, with the entrepreneur acting as an arbitrageur by exploiting gaps in the market. The work of Ennew et al. (1998) highlighted that for GPs involved in fundholding, the notion of price being used as a bargaining tool for the purchasing of services was not seen to be appropriate; with respondents believing that quality and access where more appropriate than price. Rae’s (2007b) view of entrepreneurship would seem to support this move from price and profit being the dominant factor in entrepreneurial working. However, on the whole the participants in this research appear to have taken a macro-economic view of the market place and the delivery of new services appears to be a combination of reducing the wider cost implication on the NHS and improving the continuity and quality of care that patients received.

The participants from site A and site C all mention how they have developed services based on providing better quality of care for their patients. GP1 from site A describes a number of examples where he/she has developed a service due to perceived poor quality in the alternative, ‘we noticed there is a demand, as patients were unhappy with secondary care services’, with participants from site C being very much driven to provide new services based on the views of their practice patient panel about preferences for quality service delivery. Both participants from site C also believe that delivering the heart failure service increases the quality of care that patients would normally receive from their GP. In 4.3.2 the GP from site C describes better patient access as being an important element of the physical health and SMI service that he/she is involved with. Consequently, in support of Ennew et al. (1998) it is clear that all of the participants involved with new service delivery have taken advantage of ‘quality’ and ‘access’ gaps in the marketplace.

However, in contrast to Ennew et al. (1998), providing services which are cheaper than the alternative has also been identified by two GP participants as a key contributor in the provision of new services. The GP from site D stated that the physical health and SMI service was designed to address the cost of care on the whole health system with GP1 from site A also describing how delivering a prevention service for alcohol limits the impact and cost on the future health care economy. GP1 from site A also identifies that some of the new services he/she is providing in primary care are aimed at saving money in the present day economy. This is typified by providing
a service that secondary care previously provided, ‘funding is an issue because the funding level in primary care is a lot lower, I think around 8% or 9% of what you would get if this takes place in secondary care, so there is a huge discrepancy between payments’. I am not surprised that delivering care at a cheaper price was a contributor, because the current NHS primary care climate is very much centred around better care and at a better price. It is also interesting that two people in question both hold formal roles within their respective CCGs, and with their CCG ‘hats’ on delivering health care savings without reducing the quality of care provision, will be part of their CCG working.

In summary, I would suggest that all of the participants involved with delivering new services have acted in an arbitrageur way by exploiting gaps in the market; in line with Krizner’s (1973) work it is clear that they should be classed as operating entrepreneurially. It is also clear that in support of the work of Ennew et al. (1998) both quality and access are key determinants of gaps within the market place; however, this research does differ from Ennew et al. (1998) in identifying that delivering services at a lower price than the alternative options was a key determinant for two GP participants.

5.2.5 Opportunities created and opportunities discovered

The literature review chapter (2.6.5) notes the academic debate around whether opportunities are created or whether they are discovered, and I have previously identified that a more holistic view of opportunities in line with Bolton & Thompson (2004) and Rae (2007b) would be relied upon, rather than the more profit centred economic stance of Casson (2003) and Shane (2003). As discussed earlier (5.2.4), Kirzner’s (1973) work around price-quality arbitrage focusses on the notion of exploiting gaps in the market, this essentially works on the principle of opportunities being discovered by entrepreneurs. 5.2.4 discusses the nature of the gaps in the market e.g. quality of service, but it is important to explore how, and if, these opportunities were discovered or created.

Participants within this investigation demonstrated a number of ways that they discovered opportunities, with the most widely reported (n=5) adopting a patient centred focus. This is highly evident in the Practice Manager and the Practice Nurse from site C’s discovery of opportunities, as they worked with their practice patient panel to focus on the health and service needs of their population, ‘we could state with confidence what our patients need, because we have that inside knowledge’. They did not just rely on their patient panel, they also investigated the demographics of their patient population to discover opportunities, ‘we looked into our practice population and coming from a mining town we had lots of COPD patients… we are going to set up specialist
clinics’. Furthermore, GP1 from site A identifies that by looking at patient processes and working with his/her patients, new service opportunities were discovered, this is typified in the delivery of his/her PSA clinic, ‘we decided that we would do all of our injections in house, which meant that it saved them [the patient] time, instead of having to spend a full morning in a hospital clinic, they could have a five or ten minute appointment here’. Discovering opportunities through having a patient focus to service provision, is perhaps best summed up by the GP from site D, who simply described discovering opportunities through looking at the ‘unmet need’. One other key area were participants discovered opportunities was via their local CCG, and the relationships that the practice and individual participants had with them, this will be discussed in more detail in 5.4.2.

However, for the two participants from site B, it is clear that the service was not developed through them discovering the opportunity; it was one that was created for them via the local commissioning body at the time. The GP from site B describes how he/she applied for a position that was created for somebody who had a specialist skill set in heart failure, ‘the PCT were looking to recruit a GP with specialist interests in various positions and advertised for a GP for this service, so I applied and got the job’. The HFSN’s involvement followed a similar pattern, as he/she was appointed to replace the initial HFSN who set the service up with the PCT at the time. Hence, I would argue that this does not resonate to them behaving particularly entrepreneurial, as the opportunity was created for them both. But it is worth noting that once they were involved with the service, both participants discuss discovering opportunities; the GP discusses how he/she used his/her relationship with other GPs, local networks and the CCG to promote and further develop the service. The HFSN describes how he/she discovered an opportunity to develop the service through identifying that a gap in knowledge about the heart failure services existence was present on general nursing wards ‘a lot of staff in the hospital had no idea that there even was a heart failure service, so now we are getting a lot of requests to do education sessions...so we are getting more of an interest from within the hospital now, where there wasn’t any before’. So although the original opportunity to deliver the service was created, subsequent service improvements and developments have been discovered by both participants from site B.

Overall, participants from sites A, C and D clearly demonstrate that they discover opportunities for new service provision and as Kirzner (1973) identified, they are ‘alert’ entrepreneurs who are able to take advantage of such opportunities. The two participants from site B who are involved in the heart failure service, had this service opportunity created for them via the local commissioning body, but they have discovered opportunities as time has gone on as a means to develop the service. So I would suggest that to a lesser extent these two participants have
discovered opportunities, but they are not as entrepreneurial and do not discover opportunities in the market to the same extent as the participants from sites A, C and D.

5.3 The GP practice and service delivery level
Understanding the extent to which GP’s behave entrepreneurially provides an insight into how individuals act and behave as part of delivering new services. However, this does not take into account how other people either within the new service, or often the GP practice behave and/or interact with the entrepreneur, especially the roles and interplay between the manager and the entrepreneurs.

5.3.1 Roles in the practice/service
In table 2.10, Burns (2007) outlines a number of characteristics of owner managers, and a number relating to entrepreneurs; the owner manager characteristics are largely associated with business survival, whereas the characteristics of entrepreneurs are more concerned with growth. Rae (2007b) moves slightly away from Burns (2007) to focus largely on the action factors associated with managerial working and entrepreneurial working, as highlighted in figure 2.4. I have utilised this aspect of Rae’s (2007b) model, as part of my research framework (figure 2.6) to develop the research question for this investigation; specifically focussing on if, and how, entrepreneurial working and managerial working takes place within a new service or practice team; Rae (2007b) argues that both of these are needed to create new value, which for this study is new service delivery.

As discussed within sub-section 5.2 and in the following sub-sections, it is evident that participants were involved in entrepreneurial working to various extents as part of delivering new services, but what is also evident, as highlighted in sub-section 4.4, is that participants also performed a number of roles akin to what Rae (2007b) defines as managerial working.

Unsurprisingly, it is clear from the data that managing resources is an essential aspect for developing and delivering a new service; a number of participants discuss resource management as part of the initial decision to deliver the service. For example, the GP from site D discusses how he/she is responsible for backfilling his/her time out of practice, ‘I negotiate with him/her [locum] the hours he/she works, the pay he/she gets, what he/she does in those hours’, with the GP1 from site A describing a number of wider practice related strategic level considerations associated to the delivery of a new service. However, I am more surprised that decisions regarding the terms of a contract are something that a ‘true entrepreneur’ would be involved with; as I would expect that these types of business administration roles would naturally be picked up by the GP/Service...
Manager, rather than the entrepreneur. Although, the make-up and ownership of the GP practice may also affect the roles and responsibilities that individuals take on as part of new service delivery. In the case of the GPs from site A and site D, it is important to mention that they are both senior partners within their respective GP practices (table 3.6), so naturally they will have an overall understanding and vested interest in the financial aspects and running of the business functions of the GP practice. I would suggest that having business interests means that they are both more aware and more concerned with roles normally associated to managerial working.

Interestingly both the HFSN and his/her GP colleague from site B, mention that the HFSN performs the managerial working within the heart failure service as he/she is involved with ‘writing pathways, engaging people… developing referral routes’ amongst others. The HFSN does not ‘own’ the service/practice and has no business orientated financial incentives to perform managerial roles as part of the service delivery model; it appears these managerial roles and responsibilities that he/she has taken on are because of his/her own personal drive for the service to survive due to his/her perception of the value of the service to patients. This in a sense supports Burns (2007) view that his/her roles in the delivery of service are managerial and largely centred around survival, rather than being entrepreneurial.

As 4.4 shows, aside from being involved with contracts, participants were also involved with other aspects of managerial working, as GP2 from site A notes that GP1 developed business plans to pro-actively ask the local CCG for funding to deliver new services. The development of business plans is not something that necessarily resonates with that of entrepreneurial working as they often require high level and detailed resource planning and financial costing, which is certainly more akin to managerial working than that of a ‘true entrepreneur’. This is also a skill which would not necessarily be one that a healthcare clinician would traditionally possess, consequently these are skills which are learned over time, and as GP2 from site A points out, such skills can require extra support ‘it was a massive learning curve because they didn’t get any help [initially]… anyway now the CCG have offered to give us some help with this.’

It is fair to say that there was a mixed response from participants with regards to the support for managerial working that was provided by members of their GP practice/service team; this appears to influence the roles which participants performed to ensure new service delivery. The Practice Manager and Practice Nurse from site C, illustrate ways of working which I would have

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18It is important to note that the ‘business plans’ referred to relate to relatively low level business planning within the healthcare context, rather than more discrete plans referred to in the academic literature. However, these are still relevant due to the lack of skills that clinicians have to complete.
expected, with both of them acknowledging the specialist skills that each of them bring to the GP practice/service. The Practice Nurse implies that he/she relies heavily on the organisation and resource management skills and support of the Practice Manager, with the Practice Manager stressing the importance of the clinical knowledge that the Practice Nurse has, in terms of being able to operationalise new services. However, what is interesting is the two GPs from sites A and D who both actively suggest that they perform aspects of managerial working, state that they get little support from their Practice Manager colleagues. This is important and validates Rae’s (2007b) model, because it is clear that decisions regarding the terms of contracts, referral pathways, resource management have to be made as part of new service delivery and if support is not being provided by the Practice Manager or other member of the GP practice/service, then ultimately this is picked up by the person/people delivering the service. The role of HFSN from site B support this, as it is clear that within the service there is no official Practice/Service Manager, it is delivered by an entirely clinical based team, but due to the HFSN’s dedication to make the service survive, then he/she performs many ‘managerial’ roles.

At the GP practice/service level this joint managerial and entrepreneurial working supports Rae’s (2007b) model of entrepreneurial management; as it is clear from the data that within the GP practice/service both managerial and entrepreneurial work is taking place to create new value; However, what is surprising is that even when there are specific roles within the GP practice/service i.e. Practice Manager, it is not necessarily the case that managerial working is not performed by ‘true entrepreneurs’ as the data illustrate it often is. This shift for GPs and Nurses to carry out ‘business’ and ‘managerial working’ roles, as part of new service delivery, is a shift from their traditional clinical roles i.e. providing appointments for the general health care for their local community, and clinical training.

5.3.2 GP Practice/Service level trade-offs
As part of any new service delivery, it is important that, at the GP practice/service level, decisions and actions to facilitate the introduction and development of the new service are made. The data illustrate that both time trade-offs (4.5.3) and new service delivery trade-offs (4.3.5), were key considerations within the GP practice/service. These difficult decisions appear to arise predominantly due to the ‘hybrid’ operating nature of GP practices, within a quasi-market place. It is clear from the responses of participants that there are multiple factors associated with delivering a new service; there is the entrepreneurial working to develop, design and spot an opportunity, coupled with the managerial working around business plans, contractual terms, resource management and allocation. Within the NHS primary care system, GP practices are
predominantly owned by partners within the practice, table 3.6 illustrates that a number of participants are partners in their practice. They operate within what was traditionally a public sector market to serve the local community; however they have to generate income to be able to operate successfully. Hence, in line with figure 2.5 and the suggestion that hybrid organisations must combine “a profit and not for profit orientation; a public and a private orientation, formability and informality” (Brandsen & Karré, 2011: 828), I would suggest that GP practices are ‘hybrid’ organisations. In line with the literature it is clear that participants experienced ‘trade-offs’ and ‘tensions’ regarding the decision to provide new services. Such ‘trade-offs’ often concerned the impact on resources that new service provision had on the ability to offer traditional patient GP appointments. Both GP1 and GP2 from site A discuss the negative impact on patient care that offering a new service may have on their practice, and how it involves a balancing act to ensure GP and clinical staff resources are used most effective for their practice, ‘I would have been quite interested in seeing if you could set up a service to do contraceptive implants... but it’s balancing that between the impact of appointments... so if I start saying cancel those 20 [appointments], as I’m going to do an implant clinic on a Tuesday afternoon, I’m not sure if that would be detrimental’. Again this is interesting, because it really illustrates the complex resource management decisions that are made at the GP practice/service level to decide if delivering a new service is possible, there are multiple factors to consider because delivering a new service may bring extra income into the practice, but this is likely to have an effect on other aspects of the GP Practice. In 5.2.2 I have discussed that patient care was a key motivator for a number of the participants, so naturally there can be difficult decisions regarding whether offering a new service aimed at improving a certain aspect of patient care i.e. the COPD clinic mentioned by site C, and whether this is worthwhile considering it will require resourcing with appropriate clinicians which will limit the amount of resources to offer other clinical services within the practice. These tensions and trade-offs experienced by participants are in line with Austin et al. (2006) who state that they are normally concerned with a) the mission of the organisation, b) the mobilisations of resources, and c) human resource management.

Hence, it is clear that GP practices are hybrid organisations, the market place which they operate within is muddy and the boundaries between the traditional public and private sectors are blurred. Relying on Von de Donk’s (2001) Societal triangle model (figure 2.5) I would argue that the GP practices/services that participants of this study are employed, sit within the middle triangle (area 3) of the model.
5.4 The external context
Previously I have discussed the individuals within the practice, and discussed the GP practice/service, however in line with the research framework (figure 2.6) it is important to look at the role that the external GP practice context plays within the delivery of new services in primary care. This largely concerns the influence of the local CCGs and the relationships that participants have with them.

5.4.1 Existing relationships
The literature chapter outlines the importance of ‘knowledge’ to entrepreneurs, as Knight (1921) in sub-section 2.5.2 identified, obtaining knowledge within an uncertain market is key for entrepreneurs; Schultz (1980), as highlighted in sub-section 2.5.2, believes that improving knowledge base is important; Schumpeter (1934), as highlighted in sub-section 2.5.3, stressed that obtaining a knowledge of the market place is important for entrepreneurs to be able to introduce new goods and services; and Kirzner (1978) in sub-section 2.5.4 believed that possessing knowledge meant that opportunities were discovered. Rae (2007b) states the importance of knowledge within his definition of an entrepreneur,

‘Using skills, knowledge and personal attributes which are needed to apply creative ideas and innovation with practical solutions.’ (Rae, 2007b: 3)

Within the NHS primary care context, knowledge of the market place can be accessed from numerous places; these include industry magazines, conferences, national and local policy documents and interactions and communication with local CCGs. Within this research, participants have differing levels of involvement with the CCG as table 4.2 illustrates that three out of the eight participants have an active and formal role within their local CCGs, two of the participants are members of regional clinical specialist groups, with three others who do not have any form of established role. This is interesting, especially when this is cross referenced against Ennew et al’s. (1998) identification of the three different categories of entrepreneurs, as discussed in table 5.1. As table 5.2 shows that three out of the four ‘true entrepreneurs’ have a formal role within the CCG, with two of them having more than one role. This is perhaps not surprising due to the entrepreneurial behaviours associated to the participants being ‘true entrepreneurs’, as their preference is to be innovative and creative, to improve patient care and to have achieve career fulfilment. Having an active role within the local CCG and being involved in such commissioning decisions about the local health economy provides participants with an excellent opportunity to be able to exert these tendencies, aspirations and skills.
Table 5.2: The relationship between CCG involvement and True, partial and reluctant entrepreneurs

<table>
<thead>
<tr>
<th>Participant</th>
<th>Entrepreneur</th>
<th>Formalised CCG role(s)</th>
<th>Other role(s) outside the practice/service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site A</td>
<td></td>
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<tr>
<td>Site B</td>
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<tr>
<td>Site C</td>
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<tr>
<td>Site D</td>
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Interestingly, none of the others have any type of formal role within their CCG’s. The two ‘partial entrepreneurs’ from site B are involved with clinical specialist groups and I would argue that this is where they obtain ‘knowledge’ related to their service from; as out of the four different data collection sites this is the service that I would say is the most specialist and its success and survival relies on being fully up to date with the latest clinical evidence and developments. Developing relationships with heart failure consultants and other heart failure clinical champions would enable them to access knowledge and support more freely. Also, as detailed in 4.2.2, over the time of this study the heart failure service has become a more community focussed service, rather than a primary care service. The service has recently moved from being provided by the commissioning group, to the local secondary care provider\(^{20}\), which may have reduced their necessity to have knowledge of the local commissioning context. In this particular instant it

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\(^{19}\) Not involved with the direct delivery of a new service

\(^{20}\) Via the introduction of hospitals being able to apply for Foundation Trust status, which allowed a portion of financial autonomy, there has been a movement for secondary Foundation Trust’s to increase their provision of services into the community setting, as a way of creating extra fiscal return.
appears more beneficial for the GP and HFSN from site B to have relationships with clinical groups than it does with the local CCG.

5.4.2 Are relationships important?
In figure 2.1 Bolton & Thompson (2004) identify that as part of the entrepreneurial process, spotting and exploiting an opportunity21 is a key element; they go further in figures 2.2 and 2.3 (2.6.6) to develop the idea that being an ‘opportunity spotter’ is one of two key roles, the other being a ‘product champion’ and that successful entrepreneurs are able to combine and execute these two roles. Hence, being able to spot an opportunity is important for entrepreneurs and within the context of this research, all four of the ‘true entrepreneurs’ (as represented in table 5.2) believed that having a formal role within the CCG was essential to spotting opportunities and put them in a more advantageous position to others; this is typified by the Practice Manager from site C, ‘it gives us [the practice] a workable view as sometimes ideas are floated at these [CCG] meetings’. There was a wide spread acknowledgement from all four, that they ‘get to know things in advance’ (PN_site_B) and ‘it puts you at an advantage... you know what sort of things are coming through’ (GP_site_D), and as GP1 from site A points out, ‘I can actually be there with people who have the purse strings and the finances to look at, and highlight things... I do not think that other GPs see that because they do not hear what is happening’. The views from these participants, clearly illustrates that having a formal role and relationship with the CCG increases the chances of being able to spot possible opportunities for new service provision. I do not think that this is necessarily surprising, as it seems perfectly sensible that having a role within the CCG means that there is greater access to information and opportunities. However, what I do find surprising was how open, frank and honest participants were in expressing how advantageous it was being involved with the CCG. I was expecting participants to be less forthcoming, due to the possible criticism around the potential for conflicts of interests regarding the provision and commissioning of services.

The advantageous positions that having formal links with the CCG, is further endorsed by the GP from site B, who as table 5.2 identifies, does not have a formal role within the CCG; he/she believes that being on the outside of the CCG results in his/her ability to influence and to understand possible new services often being limited, ‘perhaps some of the GPs [involved in CCG meetings] have already got some ideas about the decisions that they want to make and are perhaps leading the way’. However, although this participant does not have formal role, the CCG

21 The research has taken Rae's (2007b: 3) definition of opportunity, which is ‘the potential for change, improvement or advantage arising from our action in the circumstances’
do consult with him/her around cardiology related commissioning, due to his/her clinical specialism in this area, which has to some extent increased his/her knowledge of possible opportunities, ‘I have got an idea what is going on [with commissioning], this is through osmosis’, but this is on a much lesser extent to those participants who have active and formal roles within the CCG.

5.4.3 Have the recent changes to CCGs had an effect on the ability to deliver new services?

As highlighted in the introduction chapter (1.3.5), CCGs are relatively new primary care commissioning structures, which only received full power from April 2014. The preceding primary care system involved PCTs, which according to Smith et al. (2004) were criticised for having an increasing management and corporate culture, and a lack of clinical engagement and support (Lewis, 2004; NHS Alliance, 2004; Smith & Walshe, 2004). The move to CCGs was designed to put GPs at the heart of commissioning rather than being led by managerial staff, as it was under the provision of PCTs. Within this study a number of participants commented on there being a large turnover of staff (4.5.2), participant believed this to be detrimental to the relationships which they held with their local commissioning bodies; this is best highlighted by the Practice Nurse from site C, ‘there has been so much change in the CCG, in the past we would have known who to call on, but, they have gone. You had built up good relationships, but it was like starting again.’ It is not unexpected that there has been a high turn-over of staff, and building new relationships with new people takes time.

However, what is interesting is that even though the majority of participants acknowledged there had been a large turnover of staff, it appears that many of the GPs who had an association to PCTs (be that formal or informal) are still involved within CCGs, as GP2 from site A notes, ‘obviously the GPs who get involved [with CCGs] are the same [as with PCTs]’. This large turnover of staff appears to be caused by the reduction in the number of non GP staff involved with commissioning, as the GP from site D demonstrates, ‘well, realistically all that has changed from when we went from PCTs to CCGs is that we just slimmed down the organisation’. Not all participants discussed if there was any difference between PCTs, but interestingly in terms of new service provision the two participants who did discuss this, did not believe that there were any more opportunities for service provision within the CCG structure than within the PCT commissioning structure, this is best typified from the GP from site D, ‘if I am honest I still do not think there is a great deal of difference between when we were PCTs and now we are a CCG, there is still a load of bureaucracy that you’ve got to get through if you want to work differently.’ I am slightly surprised by this, as I would have expected that with the national policy of putting GPs at
the forefront of commissioning, and there being a greater number of GPs being involved with commissioning, then participants would have felt like there were more opportunities. However, it is important to mention that at the time of conducting the interviews for this study, CCGs were new organisations and developing their ways of working; becoming established and developing appropriate working processes may have been their primary concerns, rather than new service provision. So, although I am slightly surprised, I should have probably expected that the new service provision opportunities would have been similar.

5.4.4 CCG and national opportunities

In 5.2.5 I have discussed how participants spotted and created new service opportunities and how some of these were discovered, in line with participants behaving entrepreneurially. In the previous section 5.4.3 I have discussed how participants believed that having a role in the CCG allowed them access to more knowledge about opportunities, and whether the change to a CCG structure has affected the number of opportunities. These have both been from the individual and GP practice/service levels looking in an outward facing manner to the external context; however, in line with the research framework (figure 2.6) it is also important to consider the influence that the CCG and the wider national commissioning body has on offering and providing new service opportunities, in an outside looking in manner.

Sub-section 2.6.5 of the literature review briefly outlines the academic debate between whether opportunities are created or discovered. Participants in this research provide examples of new service opportunities that were both discovered and those that were created by their local commissioning group. Site B is perhaps the best example of a service opportunity that was created by the local primary care commissioning body at the time, both the GP and HFSN participants subsequently applied for positions within the service, ‘the PCT were looking to recruit GPs with Specialist Interest in various fields and they advertised and they were keen to recruit a GP for this (HF) service, so I applied and got on the course’ (GP_site_B). It is clear that without the PCT wanting a specialist heart failure service then this opportunity would not have existed, and I would argue that this is an excellent example of the commissioning body exerting their own priorities and influence on what new services are provided.

There are also other examples of services that participants mention as being led/created by the local commissioning body as in site D, the severe mental illness and physical health service has been established through the local commissioning group. However, it is important to note that he/she is also the clinical lead for mental health for the associated CCG and suggests that, ‘you could probably consider me to be something of a clinical champion for this piece of work’.
Consequently it is difficult to be certain if, or how much influence he/she had in the service being created from the commissioning body. But the data does provide a number of different examples where the CCGs influences what new services are offered.

Further to the influence of the local commissioning body, the responses from the two participants from site C, suggest that these opportunities are not bound to local commissioning priorities, but national priorities also create service opportunities. The Practice Nurse in site C discusses a dementia service that has been offered to them as part of a Direct Enhanced Service (DES), which they have taken up, ‘we’ve signed up for the over 75s DES on health assessments... included in that, which is a hot topic is dementia screening... [as a result] we are trying to put aside special appointment time now for myself and the nurse, to do that screening in a more formal way.’

However, it is important to note (this is discussed further in 5.2.5) not all of the new services participants discussed were led/created by either the local or national commissioning bodies. GP1 from site A describes a number of examples where he/she has identified gaps in the market and has then approached the local commissioning body with a business plan to be able to provide the service (as outlined in 4.2.1). He/she also identifies applying for funding for an alcohol related service through a ‘dragons den – where the [CCG] will listen to ideas and they will provide some funding for them’. As discussed in sub-section 5.2.2, ‘improved patient care’ was the most cited motivation for delivering new services and a number of participants mentioned spotting and developing new services through looking at gaps in patient care. The best example being the Practice Nurse from site C who described how his/her practice was able to establish a service through a need identified by his/her patient forum.

Overall the data appear to support the inclusion of both the CCG and national context within the research framework (figure 2.6), especially the push/pull aspects and influence of the CCG (this is illustrated by the double ended arrows) illustrating that there is a two way influence where the CCG creates new service opportunities for individuals or perhaps even GP practices to spot; but on the other hand there is the reaching out from entrepreneurial individuals and GP practices to find gaps, develop new services and influence the CCG to be able to provide the new service in question.

5.5 Chapter summary
In summary, this chapter discusses the research findings of the study, with sub-section 5.2 focusing on the extent to which participants are entrepreneurial, looking in particular at their motivations to provide a new service (5.2.2), the importance of innovation and creation (5.2.3),
price-quality arbitrage (5.2.4) and whether opportunities are created or discovered (5.2.5). This chapter also discusses the entrepreneurial and managerial working (5.3.1) within the GP practice or service, the GP practice/service level trade-offs and tensions (5.3.2) along with the relationships that participants have with their local commissioning bodies (5.4.1), how important these are (5.4.2), how these have changed over time (5.4.3), and if the commissioning bodies priorities influence service delivery (5.4.4). The following chapter (chapter 6) will draw together some overall conclusions from the research findings and discussion to answer the research questions of the study.
Chapter 6: Conclusion

6.1 Introduction
The aim of this concluding chapter is to review the study and to draw conclusions by addressing the research questions (6.2 – 6.6), whilst considering the implications that this has for GP practices (6.9.1) and GP education (6.9.2). Limitations of the research methodology are considered (6.7), along with the strengths of this research (6.8), with the chapter concluding with recommendations for future research (6.10).

6.2 Research question 1:
To what extent does a GP have to be entrepreneurial to deliver a service in a new way?

In conclusion, this research shows that participants are entrepreneurial when delivering services in new ways; however the extent to which they are entrepreneurial differs. 5.2.1 and table 5.1 identify that all participants involved in the delivery of new services were what Ennew et al. (1998) describe as being ‘true’ or ‘partial entrepreneurs’. I have found Ennew et al.'s. (1998) a valid and useful way in classifying the different levels and extents to which participants behave entrepreneurially.

It was to be expected that ‘patient care’ would be a motivator for participants, however as discussed in sub-section 5.2.2 what is more surprising is the extent and the importance that patient care had to decisions regarding new service provision. It was expected that other factors such as finances and personal interests would have been the key motivators.

In terms of the understanding of entrepreneurship itself, sub-section 5.2.3 establishes that all participants believed innovation to be a key element of entrepreneurial working; as predicted by the literature.

This study also supports the view of Kirzner (1973) around the importance of price-quality arbitrage in entrepreneurial working, as 5.2.4 identifies that all participants involved in new service delivery took advantage of ‘quality’ and ‘access’ gaps within the primary care marketplace. However, in complete contrast to the work of Ennew et al. (1998), identified gaps included those involving the opportunity to deliver a service at a cheaper price. This was expected due to the current financial climate of the NHS and primary care in particular, there is an ever increasing national focus around achieving efficiency savings and delivering a quality service at a lower cost.
It is important to note that, although the research question focuses on the GP as the individual that is entrepreneurial within the delivery of new services; it is clear from the participants of this investigation that it was not necessarily just the GPs that were the entrepreneurs.

6.3 Research question 2:  
*How does the inner practice relationship result in a service being delivered in a new way?*

In answer to this research question, at the GP practice/service organisational level, the findings discussed in sub-section 5.3.1 support the use of Rae's (2007b) model of entrepreneurial management (figure 2.4), illustrating that both managerial and entrepreneurial working was essential to create new value, and in the context of this study, a new service.

As 5.3.1 shows managerial working largely concerned the allocation (or rather the re-allocation) of resources as part of new service delivery, with entrepreneurial working involving innovation, opportunity spotting and idea creation.

This study identifies that managerial working was not solely the responsibility of ‘managerial’ staff i.e. Practice Managers; as a number of entrepreneurial clinical staff also carried out managerial roles as part of new service delivery. There may be multiple reasons for this, such as a vested interest in the financial return and business operations of the GP practice/service, due to their partner status and interests.

It is clear that the blurred and complicated quasi-market place which GP practices operate in, means that by nature GP practices are ‘hybrid’ organisations, as they are a blend of characteristics of traditional public, private and third sector organisations outlined in the literature.

As expected due to the hybrid organisational nature of GP practices, participants discussed a number of trade-offs and tensions predominantly relating to the time and resource trade-offs that delivering a new service has within the GP practice.

6.4 Research question 3  
*What influence does the practice relationship with the commissioning group have in delivering a service in a new way?*

Looking at the wider context, outside of the GP practice/service setting, this research identifies that individual participant’s involvement and relationships with their local CCG is highly influential in them being able to deliver a new service.
Relationships allow participants to gain what Kirzner (1973) defines as ‘knowledge’ about possible opportunities to deliver new services that exist within the system, and those who are ‘alert’ can take advantage of such opportunities.

All of the participants who had roles within the local CCG believed that these were advantageous and allowed them access to new service delivery opportunities, that others (those not involved with CCGs) were not privy to, hence the relationships participants have with their commissioning group has a strong influence on the ability to deliver new services.

Consequently there is clear evidence to suggest that having a formal role within the CCG substantially influences and improves the possibility of delivering a new service. In line with the research framework (figure 2.6) it appears valid to include the CCG as part of this model, due to the important influence that they have on the opportunities to deliver new services.

6.5 Research question 4
To what extent do the priorities of the commissioning group have on effect the practice delivering a service in a new way?

Sub-section 5.4.4 identifies that in the delivery of new services, the priorities of the local commissioning groups do have some influence on what is delivered. This is largely through the CCGs provision of opportunities for GPs to deliver services through a LES or DES which are of interest and aligned to their priorities.

However, it is important to note that in the majority of new services participants developed through other areas than just LES’s and DES’s, such as clinical specialisms and patient need.

Hence, this study suggests that the priorities of the local commissioning group do influence new service provision; however it is important to note that I was unable to interview any CCG managers to really understand and explore this further, so I’m cautious to draw completely on these findings.

6.6 Overall contribution
This study provides a number of research contributions, which on the whole resonate to the limited amount of empirical research focussing on entrepreneurship within the NHS primary care system.

The findings show that despite the limited literature, it is valid to investigate the entrepreneurial working of primary care healthcare professionals. The previous work of Boyett & Finlay (1995)
and Ennew et al. (1998) have looked at entrepreneurial working in the NHS related to quasi-market conditions through fundholding, but this study establishes that it is relevant to focus on entrepreneurial working as part of the current (CCG) primary care service delivery structure. This study also shows that GP practices are ‘hybrid’ organisations and do not specifically fit within any of the traditional private, public and third sector organisational types.

Rae’s (2007b) model of entrepreneurial management has been developed from private and public sector working, with a distinct focus on ‘creating new value’. The findings from this study establish that it has relevance within the delivery of new services within the primary care NHS context. However, to look at Rae’s (2007b) model in isolation would perhaps be naive, as this study identifies the importance of the operating and marketplace context. As part of the research framework represented in figure 2.6, Rae’s (2007b) model has relevance at the GP practice/service level of a three level model involving a) the individual, b) the GP practice/service, c) the context.

6.7 Limitations
Due to the exploratory nature of the study, a case study approach was valid, with rich qualitative data being captured, allowing a fuller understanding to be gained about the entrepreneurial working of GPs within the primary care setting as part of new service delivery. However, in hindsight a number of adaptations to the study design may have been made.

Due to the study approach taken, data collected from four different sites as part of a single GP case is not a complete representation of the NHS primary care system. This approach has enabled data to be collected for the purposes of this exploratory study, but the generalisability of the findings is limited.

As with all interviews, the data is inherently subjective and is based on the opinion of the interviewee and the analysis and understanding of the interviewer. In order to limit my prior contextual knowledge, and to limit my subjectivity, site from areas e.g. Central, North and South Manchester CCGs, were exempt from the study.

6.8 Strengths
Obtaining access to primary care practitioners and GPs in particular is notoriously difficult and this is a strength of this research, as it involves in depth semi-structured interviews with GPs who deliver a wide range of new and innovative services, from a range of geographical locations, and who have a mix of interests and influence within their local CCG. Obtaining such rich data enables
this research to be one of only a limited number of studies to explore entrepreneurship within the
GP setting.

The timing of this research is also a strength, because I was able to conduct the interviews
relatively early after the legal enactment of CCGs, which meant the primary context was one that
was still in a process of change and one which meant that participants were probably more open
in their responses, they were less guarded about CCGs than perhaps they would have been about
the PCTs, largely because they were new structures and less formalised relationships.

Finally, a key strength of this study is that it has taken Rae’s (2007b) entrepreneurial management
model, which is largely based around private sector working and has not been used in the NHS
primary care setting before and demonstrated that it has relevance. Whilst outlining that it should
not be looked at in isolation, but has relevance as part of wider entrepreneurial working, as part
of a new service delivery model involving the individual, the GP practice/service, and the context
(local and national) as illustrated in figure 2.6.

6.9 Implications for practice
The research findings of this study have implications for GP practices wishing to deliver new
services and for wider GP education.

6.9.1 GP practices
A key finding from this research was the importance of a member\textsuperscript{22} of the GP practice team
having a relationship, preferably a formal one, with their local CCG. The research establishes that
developing such a link provides the practice with opportunities to deliver new services that can be
exploited and enacted. Another key finding from this study for GP practices is the
acknowledgement that as Rae’s (2007b) model of entrepreneurial management establishes, there
must be both entrepreneurial and managerial working within the practice, for new services to be
delivered. These roles do not necessarily have to be performed by different people, but it is
important for GP practices to acknowledge and ensure that there is sufficient skill base with the
team.

Finally, this research also identifies that GP practices must consider their resources when looking
to deliver new services. Delivering new services, means that GPs and other primary care
professionals have less time to deliver traditional care to the practice population. Consequently it

\textsuperscript{22} This was not necessarily a GP, it could be a Practice Manager or Practice Nurse
is imperative that discussions and decisions are made around the appropriate resourcing when looking to deliver new services in primary care.

6.9.2 Education
A key finding of this research was the acknowledgement that to varying extents GPs are entrepreneurial when delivering new services. The literature review (sub-section 2.6.4) identifies that the modern day view is that entrepreneurs are made with Kuratko & Hodgetts (1998) stating that the techniques of entrepreneurship can be taught and mastered. Consequently, the implications for education are that as part of either pre or post qualification it would be appropriate for GPs to receive some education around entrepreneurship. This study also identifies the importance of managerial working and a number of managerial tasks and roles and identified as being performed by participants, which again has implications for education.

6.10 Recommendations for future research
Due to the lack of research within the field of entrepreneurship in the NHS, and in particular the primary care environment, future research should focus on understanding more about entrepreneurial working within this context. Building on the findings of this study, a number of suggestions for future work are made:

- A larger sample size of people delivering new services within primary care should be selected to further refine the research framework (figure 2.6); this should include the full range of primary professionals involved in the delivery of new services. Key themes of exploration should involve:
  I. Barriers to new service delivery
  II. Further exploration of the roles which entrepreneurs play within the service and GP practice setting and how applicable this is to the roles identified in Rae's (2007) model of entrepreneurial management (figure 2.4)
  III. Motivations for new service delivery
- A qualitative study involving CCG professionals, which focusses on a detailed exploration about the role which the local CCG has in the delivery of new services and how the CCG identifies entrepreneurs and works with them, as part of new service delivery.
- A qualitative study focussing primarily on the humanistic environmental factors of entrepreneurs operating within the NHS primary care system, to gain an increased knowledge about entrepreneurial working within this context. Key themes and areas for exploration should involve:
  I. Education and age
II. Gender

III. Culture

IV. Family background

V. Work experience

- A qualitative investigation focused at the GP practice/service level, to explore the impact and relationship that hierarchy and GP practice ownership has, as part of role allocation and new service development.

- A qualitative exploration about the specific trade-offs and tensions, to further understand how the ‘hybrid’ organisational nature of GP practices affects new service delivery.

- A larger scale quantitative study to understand what NHS primary professionals understand about entrepreneurship and how it affects their work. Key areas of explorations should include:
  
  I. What is understood by entrepreneurship?

  II. Are they entrepreneurs?

  III. Do they know any entrepreneurs?

  IV. What characteristics do entrepreneurs have?

6.11 Concluding comments

The NHS and particularly primary care is facing unprecedented financial pressures, which primary care professionals have to adapt to and find new ways of working to continue to deliver high quality of care. This research has identified that practitioners are required to be entrepreneurial, through identifying gaps and unmet need and being innovative and creative in their delivery of new services. Whilst developing, fostering and nurturing relationships both within the practice and the external CCG are key to developing and delivering new services.
Appendix 1:

Participant information sheet – v.2 (7/8/2013)

Please read this information sheet before signing the CONSENT FORM

Study title: To what extent are twenty first century general practitioners entrepreneurial when delivering primary care services in new ways?

1. What is the purpose of the study?

This study intends to investigate the extent to which general practitioners (GPs) are entrepreneurial in the delivery of primary care services in new ways. The study aims to answer the following research questions:

- How is the decision to create, offer and/or provide the service in a new way made?
- To what extent does the type and seniority of the person/people involved affect this decision?
- Are there any other influential characteristics i.e. Race, Gender etc? And what affect do they have?

2. Why have I been chosen?

You have been identified because your surgery delivers a Local Enhanced Service (LES), which for the purposes of this study is defined as a primary care service being delivered in a new way. As a member of staff at the surgery, your insight and involvement in the discussions around the delivery of the LES will be key to this research study.

3. Do I have to take part?

No, participation is entirely voluntary and there is no expectation for you to take part. If you agree to take part, but change your mind at any stage, you can withdraw from the study at any time. You do not have to give a reason if you decide to withdraw from the study and there will be no repercussions in terms of your professional or employee rights and status.

4. What will happen if I agree to take part?

If you decide to take part in this study you will need to sign a consent form and return in the freepost envelope provided. I will then contact you to arrange a suitable date and time for an interview. This will also provide an opportunity to answer any questions you may have regarding the study or any other aspects of participation. The interview will be face-to-face or by telephone and will last no more than an hour. It will involve questions about how the decision to offer the LES was developed, where the idea originated from, the relationship with the local CCG and the
characteristics and traits of individuals within your practice team. Interviews will be digital recorded and subsequently transcribed to enable researcher to analyse appropriately.

Where appropriate I intend to attend service related business meetings to observe and make field notes of the discussions and interactions between the practice team. All participants of the meeting will be asked to give consent prior to the meeting, if consent isn’t obtained by all participants the researcher will not observe the meeting. Participants are free to withdraw their consent at any time,

5. Will my part in the study be kept confidential?

Yes, every measure will be taken to ensure that your participation is kept confidential by ensuring that your contribution is anonymous. Data gathered from the interview will be stored in a locked cabinet. Data will not be shared and only the researcher and his supervisors will have access to it. Any findings from the study used at conferences presentations, reports and publications will be anonymised and confidentiality protected in line with University of Manchester research ethics policy. Any information stored electronically on a password protected computer will have any identifying information removed before being stored securely and protected by University of Manchester’s secure server. Study data and material may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS trust, for monitoring and auditing purposes, and this may well include access to personal information.

6. Are there any potential risks or disadvantages associated with taking part?

There are no specific risks associated with taking part in this study and but it is recognised that you will be giving up some of your working day to take part in the interview. Interviews will be arranged at a time and place convenient to you.

7. Are there any potential advantages or benefits associated with taking part?

There are no recognised personal advantages to taking part in this study but it is anticipated that participation can be beneficial by providing a greater understanding of how decisions to offer primary care services in a new way are made within your surgery.

8. What will happen to the results of this study?

The research is being undertaken as part of an M Phil and results will form the thesis, they will be stored for 5 years and sections may be used for future studies.

9. Who is organising and funding this study?

The study is organised by the Researcher – Michael Spence and has been sponsored by The University of Manchester.
10. Who has reviewed this study?

This study has been submitted to the University of Manchester Research and Ethics Committee.

11. If you feel there is a problem

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 275 7583 or 0161 275 8093 or by email to research.complaints@manchester.ac.uk

If you decide to take part in this study please return your completed CONSENT FORM to the following address:

<table>
<thead>
<tr>
<th>Researcher contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Michael Spence</td>
</tr>
<tr>
<td>Address: CLAHRC, 3rd Floor, Mayo Building, Salford Royal Foundation Trust Hospital, M68HD.</td>
</tr>
<tr>
<td>Telephone: 07720 94 8915</td>
</tr>
<tr>
<td>Email: <a href="mailto:michael.spence@postgrad.man.ac.uk">michael.spence@postgrad.man.ac.uk</a></td>
</tr>
</tbody>
</table>

Thank you for taking the time to read this information sheet and for considering taking part in the study.
Appendix 2:

Participant CONSENT FORM – v.3 (7/8/2013)

One to One Interviews

Study title: To what extent are twenty first century general practitioners entrepreneurial when delivering primary care services in new ways?

Please read the following and INITIAL the appropriate box.

1. I confirm that I have read and understand the participant information sheet v.2 (7/8/13) for the above study. I have taken time to consider this information and have had any questions answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without any detrimental effect.

3. Interview: I agree to take part in a face-to-face or telephone interview which will be digitally recorded and transcribed for the purpose of analysis.

4. I agree to the use of anonymous quotes in any reports, presentations, publications or other literature related to the progress and dissemination of the study findings.

5. I understand and agree that the data will be stored on a secure computer and that anonymised data may be used again in the future.

6. I understand that relevant sections of data collected during the study may be looked at by responsible individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in the research. I give permission for these individuals to have access to this data.

7. I agree that this data may be stored for up to 5 years and during this time relevant sections may be used in future studies.

Participant name..................................................Sign..................................................Date................

Researcher name..................................................Sign.................................................Date.................

Two copies: one each for participant and one for the study

Site code:

Data collection point:
Appendix 3:

Transcription GP_SLFD_I1_18_5_14

R: Okay, well in terms of the physical health agenda it is probably partly driven by my role as clinical lead for mental health for [CCG] and it is something that I have worked on for a number of years alongside some of the specialists within [organisation] to try and improve the quality of care that we deliver to this group of people.

I: Would that be specialists from secondary care that you are talking about?

R: Yes, Psychiatrists and Nurses working in the Community Mental Health Team (GMW), pharmacists, commissioners, service users... we have tried to pull it all together and develop something that meets the needs, because it is a bigger need at the moment because with this group of patients historically some tend not to engage with primary care and they tend to suffer health inequalities because they don’t look after themselves as well and if they develop and clinical problems they don’t tend to come in, in the same way that general population might, and we know that they are more prone to cardiovascular disease. So as part of the Quality and Outcomes Framework (QOF) the GP through target driven payments we have to deliver a service to this group of people, but what we have tried to do here is work really hard to get them in and get them engaged. So where as across Salford the average attendance rate is about 80% of this group will come in for this check, with 20% defaulting or DNA’ing, at this practice we manage to get around about 95% to attend, and in fact the year before last we got 100% to attend. The main reason why we managed that is because we kept asking them to come in and if they weren’t coming in we notified the Care Co-ordinator (from the CCG) and the psychiatry service, you know its not just a case of more than once and they don’t attend then we discharge them, keep chasing until they eventually do attend. So we have had quite a bit of success with that programme and I think all of the GPs here are aware of the health issues because I have done some education and training around the concepts that we work around this group of people, so they understand the importance and why we need to screen for high lipids, diabetes, metabolic syndrome, elevated BP as well as obviously the risk factors smoking, obesity, lack of exercise and poor diet. So that’s particular area where we are quite effective.

I: So how does that work? You said that you chase people down and make sure that they come in. Is that chased by yourself, your colleagues or by...
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