Appendix 1 Research Design and Methodology

The research design that supported the fieldwork reported in Chapters 5, 6 and 7 was essentially a set of holistic multiple case studies (Yin, 1994). The 12 service-providing institutions each constituted a case study in its own right. This set of 12 studies was intended to be used for a variety of purposes:

- To test the hypotheses that lay behind those decentralist doctrines of the Conservative Government that are discussed in Chapter 3. That is, to attempt to confirm or falsify the proposition that certain distinct types of benefit (for example greater efficiency and responsiveness to users) would flow from the reforms described.
- Within the first objective above, to assess whether experiences at the newly self-governing institutions (that is, GM schools, LSVT housing associations and early-wave NHS trusts) were significantly different from those at the non- or less-self-governing institutions. For this purpose we chose two self-governing institutions and two non-self-governing institutions (or, in the case of the NHS, late trust applications) within each sector to provide points of comparison.
- To provide a set of ordered case study materials that would permit us to test the usefulness of alternative academic theories of organisational change (particular varieties of rational choice and new institutionalist approaches, plus rhetorical analysis – see Chapter 2).

In adopting this design we had very much in mind the guidance offered by Robert Yin (1994). He is one of a number of scholars who have argued that case studies may be considered not merely as a data collection tactic but rather as a comprehensive research strategy in their own right. In particular, case studies are useful in circumstances where the need is for a study that: ‘(a) Investigates a contemporary phenomenon within its real life context, especially when (b) the boundaries between phenomenon and context are not clearly evident’. The case study approach served our purposes because it copes with the technically distinctive situation in which there are many more variables of interest than data points. As a result of this it (a) relies on multiple sources of evidence with the data converging in a triangulating fashion, and (b) benefits from the prior development of theoretical propositions to guide data collection and analysis (ibid., p. 13).

The project was based mainly, but not exclusively, on intensive, semistructured interviewing and documentary analysis carried out at 12 fieldwork sites. More than 160 interviews were carried out, averaging over an hour in length.
The bulk of these were conducted between late 1994 and mid 1995. A smaller number of interviews were completed between September 1995 and February 1996. The purpose of the second round of interviews was to provide a longitudinal check (had anything changed since the first round?), to explore certain key issues in greater depth (especially concepts of performance and accountability) and to secure a measure of respondent validation for the picture formed of the organisation’s circumstances during the first round of fieldwork.

A semistructured interview schedule was designed and piloted for the first round and a different, more focused schedule was created for the second. The interviews were concentrated at fairly senior levels – the research was never intended to focus on the ‘rank and file’. In each hospital we approached the chief executive, other executive directors and a sample of other senior managers and consultants. We also sought interviews with the main local purchasing authority, with non-executive directors and, where appropriate, with the local GP fundholders and the Community Health Council. These latter interviews helped to give us an ‘outside-in’ perspective to complement the main thrust of the research, which was essentially concerned with an ‘inside-out’ perspective. In the secondary schools we interviewed the head teacher, other senior teachers, governors and, in some cases, officers of the LEA. In the housing associations we interviewed chief executives and their top management team, plus members of the board (the chair, councillor and tenant representatives). In the non-opted-out housing departments we interviewed deputy chief executives, directors of housing and their management teams, together with councillors on the Housing Committee and tenant representatives. Foreseeing the amount of data the interview programme would generate (approximately 3000 separate responses) we decided at an early stage to pre code our questions and employ software (Textbase Alpha) that would permit us to sort out themes and patterns automatically.

The 12 fieldwork sites were carefully chosen. We selected two pairs (four in all) in each of the three sectors (healthcare, education and housing). To give a reasonable geographical spread, each pair was drawn from a different part of the country, although we excluded Greater London on the ground that the capital suffered from some unique problems (at least in degree) that we did not see as central to our research. One factor that posed a problem for our original research design was the rapid emergence within the NHS of a position where virtually all hospitals were becoming trusts (this had not been the original intention). This meant that we could no longer pursue our plan of contrasting a pair of acute trust hospitals with a pair of directly managed units that had not opted to become trusts. We therefore selected two ‘early’ trust applicants (second wave) and two ‘late’ trust applicants (fourth wave).

In addition to our interview programme, we collected a large number of institutional documents (annual reports, Citizen’s Charter publications, accounts, management handbooks and so on) and conducted a general literature search on the subjects of managerial autonomy, decentralisation and devolution in public service contexts.
Appendix 2  Interview Schedules

Set out below are the interview schedules used for the main phase of the fieldwork. There were separate versions for:

- Case study organisations that had become self-governing (that is, early-wave NHS trusts, GM schools, LSVTs).
- Case study organisations that had not chosen to become self-governing, or had done so only late in the day (that is, fourth-wave NHS trusts, LEA schools, local authority housing departments).
- Other actors (for example, NHS purchasing authorities, GPs, LEAs).

Because of our use of Textbase Alpha software the numbers of the questions are not always in sequence.

Interview schedules for use in structured interviews: version for self-governing units

Identifying underlying goals and values

1. When trust status/opting out/voluntary transfer was first discussed, what were the main intentions?
2. How widely were these shared? [Follow-up supplementary questions to establish identities of any groups with different values/goals.]
3. What were the main considerations influencing the drafting of the submission? [For trust status/grant-maintained status/voluntary transfer and so on.]

Benefits and drawbacks of self-governance

4. What do you see as having been the main benefits of [grant-maintained status/trust status/voluntary transfer]?
5. Can you give examples of these benefits having been realised in practice?
6. Have there been drawbacks?
7. Can you give examples of the drawbacks?
8. What further changes do you envisage in the longer term?

[Prompt: ask for both benefits and drawbacks if both are not offered.]
9. Are there areas where, in your view, more autonomy is obviously desirable? If so, what are they?
19. Has autonomy made any difference to the organisation's relationship with important external bodies?

Respondent's concept of performance

10. What signs would you look for as indicators that a [GMT/NHS trust/voluntary transfer] was performing well?
11. What would be the warning signs indicating that it was performing badly?
12. Is this information [that is, the indicator data referred to by the respondent in answering the previous two questions] actually collected by management?
13. Has the performance data for this unit contained any surprises?
14. What happens to the performance data that is collected? [Follow up with more detailed questions on this to discover whether such information is fed into key decision-making processes, and into divisional or personal objectives. Also, are there any declared standards or targets for these dimensions of performance and are there any incentives or penalties connected to such standards/targets?]
15. How much of such performance information is published or otherwise released into the public domain?
16. Who, if anyone, takes an interest when it is released?

Models of performance change

17. What are the main requirements if a [GM/NHS trust/voluntary transfer] is significantly to improve its performance? [Then develop this with subsidiary questions exploring whether the respondent considers environmental, resource, organisational or personal/leadership factors to be the most important.]
18. Is there evidence that specific incentives or penalties have improved performance?

Interview schedule for use in structured interviews: version for units that are non-self-governing or latecomers to self-governance

Identifying underlying goals and values

1. What were the main reasons for not making an early bid for trust status/grant maintained status/voluntary transfer?
2. How widely were these shared? [Follow-up supplementary questions to establish identities of any groups with different values/goals.]
Benefits and drawbacks of self-governance

3. Have you made gains in flexibility and autonomy even without this status? If so, what are they?
4. Can you give examples?
5. What would have been the main benefits of grant-maintained status/NHS trust status/voluntary transfer?
6. What would have been the main drawbacks?
7. What further changes do you envisage in the longer term?
8. Are there areas where, in your view, more autonomy is obviously desirable?
19. Has autonomy made any difference to the organisation’s relationship with important external bodies?

Respondent’s concept of performance

9. What signs would you look for as indicators that a [LEA school/NHS trust/housing department] was performing well?
10. What would be the warning signs indicating that it was performing badly?
11. Is this information [that is, the indicator data referred to by the respondent in answering the previous two questions] actually collected by management?
12. Has the performance data for this unit contained any surprises?
13. What happens to the performance data that is collected? [Follow up with more detailed questions on this to discover whether such information is fed into key decision-making processes, and into divisional or personal objectives. Also, are there any declared standards or targets for these dimensions of performance and are there any incentives or penalties connected to such standards/targets?]
14. How much of such performance information is published or otherwise released into the public domain?
15. Who, if anyone, takes an interest when it is released?

Models of performance change

16. What are the main requirements if a [LEA school/NHS trust/housing department] is significantly to improve its performance? [Develop this with subsidiary questions exploring whether the respondent considers environmental, resource, organisational or personal/leadership factors to be the most important.]
17. Are specific incentives or penalties required to achieve lasting performance improvement, and if so, what form should they take?

Interview schedule for use in structured interviews: version for other actors

20. Have you noticed any changes in the performance of the [trust/school/housing department] since it acquired trust status?
21. What has been the nature of any such changes?

22. To what do you attribute these changes [wholly or partly to trust status, or to something else – if so, what?]

23. What would you look for in a model or ideal relationship between a trust and a purchasing authority/GP fundholder? [This question is designed to bring out the dimensions of performance that the GPs believe to be the most important.]

24. How does the actual performance of the [trust/school/housing department] measure up to the model developed above?
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